

Cary Chiropractic Offices

Dr. Alan R. Barthen

395 C Cary-Algonquin Rd - 847.639.0010

Date _____

Name _____ Male ___ Female ___ Birthday _____

Address _____ City, State/Zip _____

Social Security Number _____ Marital Status: **M S W D**

Home # _____ Work# _____ Cell# _____

Email _____

Height _____ Weight _____ Number of children _____ Pregnant: **Y N**

Employer _____ Occupation _____

Address _____

Insurance Policy Holder _____ Relationship _____

Insurance Company _____ ID # _____

Date of Birth of Insured _____ Social Security Number of Insured _____

Emergency Contact Information

Name _____ Relationship _____ Phone number _____

Whom may we thank for referring you to us? _____

Chiropractic History

Doctor _____ Phone _____ Last Seen _____

Address _____ Consulted for _____

Medical History

Doctor _____ Phone _____ Last Seen _____

Address _____ Consulted for _____

Medications (OTC and prescriptions) _____

Accidents _____ Date _____

_____ Date _____

Surgery _____ Date _____

Past Health History

<input type="checkbox"/> Recent Infection	<input type="checkbox"/> Recent Fever	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Corticosteroid Use	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke (date _____)	<input type="checkbox"/> Dizziness/Fainting
<input type="checkbox"/> Numbness	<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/> Depression	<input type="checkbox"/> Headaches	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Low/Mid Back Pain	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Aortic Aneurysm	<input type="checkbox"/> Arthritis

Reason for consulting this Office _____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I authorize this office to release any information including diagnosis and the records of any treatment or examination rendered to my or my child during this period of care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment for all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____

(signature of parent if the patient is a minor)

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202



ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ Date _____

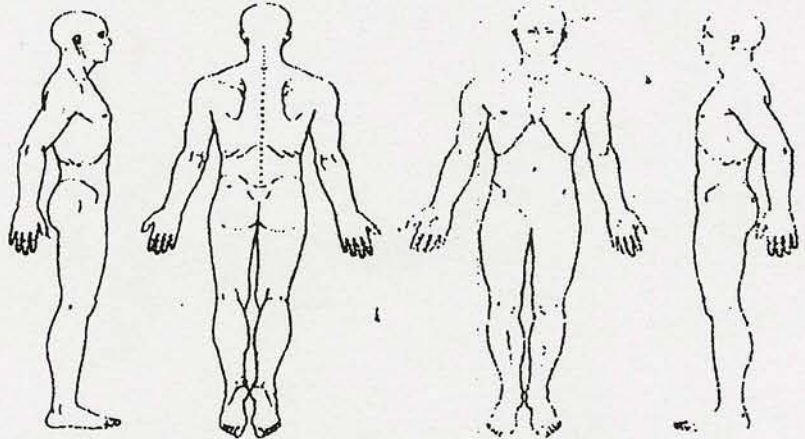
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

- None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)

- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

7. In general would you say your overall health right now is...

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____

Date _____

Oswestry Low Back Pain Questionnaire

This questionnaire is designed to enable us to understand how much your back pain has affected your ability to manage everyday activities. Please answer each section by circling the letter that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just circle the one choice that most closely describes your problem right now

Patient Name: _____ Date: _____ % Disability: _____

<p>1. PAIN INTENSITY</p> <p>a. The Pain comes and goes and is very mild</p> <p>b. The pain is mild and does not vary much</p> <p>c. The pain comes and goes and is moderate</p> <p>d. The pain is moderate and does not vary much</p> <p>e. The pain comes and goes and is severe</p> <p>f. The pain is severe and does not vary much</p>	<p>6. Standing</p> <p>A I can stand as long as I want without pain</p> <p>B I have some pain while standing, but it does not increase with time</p> <p>c. I cannot stand longer than one hour without increasing pain</p> <p>d. I cannot stand longer than 1/2 hour without increasing pain</p> <p>e I cannot stand longer than ten minutes without increasing pain</p> <p>f. I avoid standing because it increases pain right away</p>
<p>2. PERSONAL CARE</p> <p>A. I would not have to change my way of washing or dressing in order to avoid pain</p> <p>B. I do not normally change my way of washing or dressing even though it causes some pain</p> <p>C. Washing and dressing increases the pain, but I manage not to change my way of doing it.</p> <p>D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.</p> <p>E. Because of the pain, I am unable to do some washing and dressing without help.</p> <p>F. Because of the pain I am not able to do any washing or dressing without help.</p>	<p>7. SLEEPING</p> <p>A. I get no pain in bed.</p> <p>B. I get pain in bed but it does not prevent me from sleeping well</p> <p>C. Because of pain my normal nights sleep is reduced by less than a quarter</p> <p>D. Because of pain my normal nights sleep is reduced by less than one half</p> <p>E. Because of pain my normal nights sleep is reduced by less than three quarters</p> <p>F. Pain prevents me from sleeping at all</p>
<p>3. LIFTING</p> <p>A. I can lift heavy weights without extra pain</p> <p>B. I can lift heavy weights but it causes extra pain</p> <p>C. Pain prevents me from lifting heavy weights off the floor.</p> <p>D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.</p> <p>E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently located.</p> <p>F. I can only lift very light weights, at the most</p>	<p>8. Social Life</p> <p>A. My social life is normal and gives me no pain</p> <p>B. My social life is normal, but increase my degree of pain</p> <p>C. Pain has no significant impact on my social life apart from limiting my more energetic interests e.g. dancing, etc</p> <p>D. Pain has restricted my social life and I do not go out very often</p> <p>E. Pain has restricted my social life to my home</p> <p>F. I have hardly any social life because of the pain</p>
<p>4. WALKING</p> <p>A. Pain does not prevent me from walking any distance</p> <p>B. Pain prevents me from walking more than 1 mile</p> <p>C. Pain prevents me from walking more than 1/2 mile</p> <p>D. Pain prevents me from walking more than 1/4 mile</p> <p>E. I can only walk while using a cane or crutches</p> <p>F. I am in bed most of the time and have to crawl to the toilet</p>	<p>9. Traveling</p> <p>A. I get no pain while traveling</p> <p>B. I get some pain while traveling but none of my usual forms of travel make it worse</p> <p>C. I get extra pain while traveling but it does not compel me to seek alternate forms of travel</p> <p>D. I get extra pain while traveling which compels me to seek alternative forms of travel</p> <p>E. Pain restricts all forms of travel</p> <p>F. Pain prevents all forms of travel</p>
<p>5. SITTING</p> <p>a. I can sit in any chair as long as I like without pain</p> <p>b. I can only sit in my favorite chair as long as I like</p> <p>c. Pain prevents me from sitting more than an hour</p> <p>d. Pain prevents me from sitting more than 1/2 hour</p> <p>e. Pain prevents me from sitting more than 10 minutes</p> <p>f. Pain prevents me from sitting at all</p>	<p>10. Changing degree of pain</p> <p>a. My pain is rapidly getting better</p> <p>b. My pain fluctuates but overall is definitely getting better</p> <p>c. My pain seems to be getting better, but improvement is slow at present</p> <p>d. My pain is neither getting better nor worse</p> <p>e. My pain is gradually worsening</p> <p>f. My pain is rapidly worsening</p>

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Neck Pain Disability Index Questionnaire

This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each section by circling the letter that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just circle the one choice which most closely describes your problem now.

Patient Name: _____ Date: _____ % Disability: _____

<p>1. PAIN INTENSITY</p> <p>A. I have no pain at the moment.</p> <p>B. The pain is very mild at the moment.</p> <p>C. The pain is moderate at the moment.</p> <p>D. The pain is fairly severe at the moment.</p> <p>E. The pain is very severe at the moment.</p> <p>F. The pain is the worst imaginable at the moment.</p>	<p>6. CONCENTRATION</p> <p>A. I can concentrate fully when I want to with no difficulty.</p> <p>B. I can concentrate fully when I want with slight difficulty.</p> <p>C. I have a fair degree of difficulty in concentrating when I want to.</p> <p>D. I have a lot of difficulty in concentrating when I want to.</p> <p>E. I have a great deal of difficulty concentrating when I want to.</p> <p>F. I cannot concentrate at all.</p>
<p>2. PERSONAL CARE</p> <p>A. I can look after myself normally without causing extra pain.</p> <p>B. I can look after myself normally, but it causes extra pain.</p> <p>C. It is painful to look after myself and I am slow and careful.</p> <p>D. I need some help, but manage most of my personal care.</p> <p>E. I need help every day in most aspects of self-care.</p> <p>F. I do not get dressed; I wash with difficulty and stay in bed.</p>	<p>7. WORK</p> <p>A. I can do as much work as I want to.</p> <p>B. I can only do my usual work, but no more.</p> <p>C. I can do most of my usual work, but no more.</p> <p>D. I cannot do my usual work.</p> <p>E. I can hardly do any work at all.</p> <p>F. I cannot do any work at all.</p>
<p>3. LIFTING</p> <p>A. I can lift heavy weights, without extra pain.</p> <p>B. I can lift heavy weights, but it gives extra pain.</p> <p>C. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example, on a table.</p> <p>D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently located.</p> <p>E. I can lift very heavy weights.</p> <p>F. I cannot lift or carry anything at all.</p>	<p>8. DRIVING</p> <p>A. I can drive my car without any neck pain.</p> <p>B. I can drive my car as long as I want with slight pain in my neck.</p> <p>C. I can drive my car as long as I want with moderate pain in my neck.</p> <p>D. I cannot drive my car as long as I want because of moderate pain in my neck.</p> <p>E. I can hardly drive at all because of severe pain in my neck.</p> <p>F. I cannot drive my car at all.</p>
<p>4. READING</p> <p>A. I can read as much as I want to with no pain in my neck.</p> <p>B. I can read as much as I want to with slight pain in my neck.</p> <p>C. I can read as much as I want to with moderate pain in my neck.</p> <p>D. I cannot read as much as I want because of moderate pain in my neck.</p> <p>E. I cannot read as much as I want to because of severe pain in my neck.</p> <p>F. I cannot read at all.</p>	<p>9. SLEEPING</p> <p>A. I have no trouble sleeping.</p> <p>B. My sleep is slightly disturbed (less than 1 hour sleepless).</p> <p>C. My sleep is mildly disturbed (1-2 hours sleepless).</p> <p>D. My sleep is moderately disturbed (2-3 hours sleepless).</p> <p>E. My sleep is greatly disturbed (3-5 hours sleepless).</p> <p>F. My sleep is completely disturbed (5-7 hours sleepless).</p>
<p>5. HEADACHES</p> <p>A. I have no headaches at all.</p> <p>B. I have slight headaches which come infrequently.</p> <p>C. I have moderate headaches which come infrequently.</p> <p>D. I have moderate headaches which come frequently.</p> <p>E. I have severe headaches which come frequently.</p> <p>F. I have headaches almost all of the time.</p>	<p>10. RECREATION</p> <p>A. I am able to engage in all of my recreational activities with no neck pain at all.</p> <p>B. I am able to engage in all of my recreational activities with some pain in my neck.</p> <p>C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.</p> <p>D. I am able to engage in a few of my usual recreational activities because of pain in my neck.</p> <p>E. I can hardly do any recreational activities because of pain in my neck.</p> <p>F. I cannot do any recreational activities at all.</p>

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Consent For Use and Disclosure of Health Information

This notice describes how chiropractic and medical information about you may be used and disclosed, your rights as a patient, and ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPAA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

We May Release or Disclose Your Health Information:

- For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.
- For billing and collection purposes, we may release records of your health care and information that you have provided to your insurance carrier or other financially responsible parties.
- For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the Front Desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices please see the "NOTICE OF PRIVACY PRACTICES" binder in reception or ask for a copy at the Front desk.

Name (Printed please)

Signature

Date

If you are a minor, or if you are being represented by another party:

Personal Representative (Printed)

Personal Representative Signature

Date