Chiropractic Works P.C

21790 Coolidge Hwy| Oak Park Mi 48237
Tel (248) 398-1650 | Fax (248) 398-1653

One Time Authorization Agreement

I,_____ , _____ request
Patient Name (PRINT) Medicare Number

that payment of authorized Medicare benefits be made to Chiropractic Works P.C. for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services (formerly known as the Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ Date_____
Patient Signature

Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that Chiropractic Works' "Notice of Privacy Practices" has been provided to me.

I understand I have the right to review Chiropractic Works' Notice of Privacy Practices prior to signing this document. The notice of Privacy Practices for Chiropractic Works describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Chiropractic Works.

The Notice of Privacy Practices of Chiropractic Works is also provided on request at the Main Administrative desk of this practice. This Notice of Privacy Practices also describes my rights and Chiropractic Works' duties with respect to my protected health information.

Chiropractic Works reserves the right to change the Privacy Practices that are described in the notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or ask for one at the time of my appointment.

I have the right to revoke this consent, in writing, except to the extent that Chiropractic Works has acted in reliance on the consent.

Patient Acknowledgement

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____ _____
Patient/ Personal Representative Signature | Name of Patient/ Representative (PRINT) | Date

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Informed Consent to Massage Therapy Treatment

I hereby request and consent to the performance of massage therapy by the Doctor of Chiropractic or therapist/technician named below or other therapists/technicians at Chiropractic Works P.C. Chiropractic care and massage therapy are often used in conjunction. While chiropractic centers on the nervous system and musculoskeletal dysfunction related to hard tissues like the spine, bones, and joints, massage therapy focuses on both the hard and soft tissues, these compatible therapies often benefit the patient in many ways. Receiving chiropractic care either before or after a therapeutic massage can increase the effectiveness of both treatments, improve range of motion, promote faster healing, extend the length of both treatments' benefits, and improve range of motion, promote faster healing, extend the length of both treatments' benefits, and improve overall function.

I understand and agree (initial each below):

_____ I hereby consent to receiving massage therapy for the above noted purposes, including such assessments, examinations, and techniques that may be recommended by my chiropractor and/or therapist.

_____No sexual advances of any kind will be tolerated either from the chiropractor, massage therapist or the patient. Sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature will constitute sexual harassment and will not be tolerated, resulting in immediate termination of the session, and I will be liable for payment of the scheduled treatment.

_____I acknowledge that the technician, when explaining the proposed treatment to me, will explain the nature of the treatment, the expected benefits of the treatment, the material risks and side effects of the treatment proposed (and any alternative options), potential consequences of not having the treatment, and the precise area(s) of the body that will be touched. I acknowledge that physical touch or contact is only in the context of assessment and treatment processes for which I have given informed consent.

By signing, I affirm that I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from Chiropractic Works P.C. I understand that at any time I may withdraw my consent and treatment will be stopped.

_____	_____	_____
Patient Name (Print)	Patient/ Guardian Signature	Date

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MEDICARE Patient Intake Form

Name_____ Date_____

What is the chief complaint?_____

Area of complaint_____

What was the date of onset of this condition? _____

Give details on how the pain started_____

Frequency of pain:

( ) Other ( ) Constant (~100% of the time) ( ) Frequent (~75%-50% of the time) ( )Occasional (~50%-25% of the time ( )Intermittent (<25% of the time) ( ) On and Off pain ( ) Random ( ) Recurring

If the discomfort radiates, where does it travel to (choose all that apply)? If it does not travel, choose NON RADIATING

( ) Non Radiating ( ) Radiating,

Where is the pain radiating? ( ) Arms ( ) Legs

Rate you pain from 1 to 10? 10 being the worsts

1 2 3 4 5 6 7 8 9 10

Additional Complaints Present_____

Allergy or Sensitivity Y/N? Describe_____

Describe the quality of this complaint's discomfort (please circle all that apply):

Dull Sharp Aching Burning Shooting Tightness Stiffness

Tingling Numbness Nausea Palpitations Anxiety/Panic Depression General Malaise

Fatigue

Is the condition getting better/ worse? Explain_____

_____

What functional activity has noticeably worsened from said condition?

( ) None ( ) Employment ( ) Homemaking ( ) Lifting ( ) Personal Care ( ) Sitting ( ) Standing
( ) Walking ( ) Sleeping ( ) Social Life ( ) Traveling and/or Driving

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Past Patient History (mark all that applies)

Musculoskeletal Complaints

( ) None ( ) Arthritis ( ) Back Pain ( ) Neck Pain ( ) Shoulder Pain ( ) Cramping ( ) Elbow/ Wrist Pain ( ) Foot/ Ankle Pain ( ) Gout ( ) Fracture ( ) Hip Disorders ( ) Implants/ Plates ( ) Joint/ Muscle Pain/ Stiffness ( ) Knee Pain ( ) Osteoporosis ( ) Poor Posture ( ) Scoliosis ( ) Swelling, Redness or Deformity of Joints ( ) TMJ Issues

Neurological Complaints

( ) None ( ) Temporary Loss of Vision, Smell, Taste, or Hearing ( ) Anxiety/ Panic ( ) Depression ( ) Difficulty Concentrating ( ) Dizziness ( ) Epilepsy / Seizures ( ) Headaches ( ) Memory Issues ( ) Numbness ( ) Pins and Needles Sensation ( ) Sleeping Issues ( ) Stroke ( ) Wake Muscles ( ) Other_____

Head and ENT Complaints

( ) None ( ) Blurred or Double Vision ( ) Cataracts ( ) Earaches ( ) Ringing of the Ears ( ) Changes in Head Dimensions ( ) Hearing Loss ( ) Ear Infections ( ) Dental Problems ( ) Difficulty Swallowing ( ) Eye/ Vision Problems ( ) Eye Surgery ( ) Eye Glasses/ Contact Lenses Needed ( ) Glaucoma ( ) Gum Problems ( ) Headaches/ Migraines ( ) Hoarseness ( ) Nose Congestion/ Sinus Problems ( ) Postnasal Drip ( ) Sore Throat ( )Swollen Lymph Nodes ( ) TMJ issues ( ) Other_____

Cardiovascular Complaints

( ) None ( ) Blood Clots ( ) Chest Pain/ Tightness ( ) Congenital Heart Defects ( ) Coronary Artery Disease ( ) Dyspnea ( ) Excessive Bruising ( ) Heart Attack ( ) Heart Murmur ( ) High Blood Pressure ( ) High Cholesterol/ Triglycerides ( ) Leg Pain when Walking ( ) Low Blood Pressure ( ) Lower Extremity Edema ( ) Palpitations ( ) Rheumatic Fever ( ) Swollen Legs/ Feet ( ) Varicose Veins ( ) Postnasal Drip ( ) Other_____

Respiratory Complains

( ) None ( ) Apnea ( ) Asthma ( )Blood in Sputum ( ) Emphysema ( ) Hay Fever ( ) Persistent Cough ( ) Pneumonia ( ) Shortness of Breath ( ) Snoring Issues ( )Tuberculosis ( ) Wheezing Other_____

Gastrointestinal Complaints

( ) None ( ) Abdominal Pain ( ) Black/ Bloody Stool ( ) Bloating ( ) Bowel Changes ( ) Colitis ( ) Colon Cancer ( ) Constipation ( ) Chron's Disease ( ) Difficulty Swallowing ( ) Food Sensitivities ( ) Gastric Reflux ( ) Heartburn ( ) Hemorrhoids ( ) Jaundice ( ) Liver Disease ( ) Nausea/ Vomiting ( ) Pancreatitis ( ) Severe Diarrhea ( ) Ulcer ( ) Other_____

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Name_____ Date_____

Genitourinary Complaints

( ) None ( ) Blood in Urine ( ) Incontinence ( ) Kidney Stones ( ) Painful/ Frequent Urination
( ) Urinary Infections ( ) Sexual Dysfunction ( ) Other_____

Endocrine Complaints

( ) None ( ) Cushing's Syndrome ( ) Diabetes ( ) Excessive Thirst ( ) Constantly Feeling Hot/ Cold
( ) Heat/ Cold Intolerance ( ) Hyperparathyroidism ( ) Hypoparathyroidism ( ) Increased size of Hands/ Feet ( ) Increased Urination ( ) Pancreatic Conditions ( ) Polydipsia ( ) Polyuria ( ) Purple Striae ( ) Steroid Treatment ( ) Testosterone Deficiency ( ) Estrogen Deficiency ( ) Other_____

Dermatological/ Hemopoietic Complains

( ) None ( ) Blood in Stool ( ) Change in Hair/ Nails ( )Easy Bruising ( ) Eczema ( ) Excessive Acne
( ) Excessive Hair Loss ( ) Flushing ( ) Gum Bleeding ( ) Hypo/ Hyper Pigmentation ( )Psoriasis
( ) Skin Cancer ( )Psoriasis ( ) Skin Pigmentation Issues ( ) Skin Trouble/ Rashes ( ) Other_____

Previous Chiropractic Care? Yes/ No, if yes describe _____

Medications Y/ N, if yes, list all_____

_____

Surgeries Y/ N, if yes, describe_____

_____

Other Illnesses? List all_____

_____

Any Accidents Y/N? describe_____

_____

For Mothers: Any Children Y/ N? How many? _____

Social Habits

( ) None ( ) Social Drinker ( ) Light Drinker ( ) Moderate Drinker ( ) Heavy Drinker ( ) Alcoholic
( ) Recovering Alcoholic ( ) Does Drink, Smoke and/ or do other Drugs ( ) Doesn't Drink, Smoke and/ or do other Drugs ( ) Every day Smoker ( ) Social Smoker ( ) Occasional Smoker ( ) Ex-Smoker
( ) Use of Chewing Tobacco ( )Drinks Caffeine ( ) Drinks Caffeine Daily ( ) Drinks Caffeine Occasionally
( ) Doesn't use Recreational Drugs ( ) Uses Recreational Drugs ( ) Heavy use of Recreational Drugs
( ) Drug Addicted ( )Recovering Drug Addict ( ) Other_____

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Name_____ **Date**_____

Family History

( ) None ( ) Diabetes ( ) Cancer ( ) Tumor ( ) Hypertension ( ) Progressive Neurological Disorders
( ) Congenital Anomaly ( ) Extremity Issues ( ) Fractures ( ) Hereditary Disorders
( ) Hospitalization ( ) Neuromuscular Issues ( ) Trauma/ Injury ( ) AIDS/ HIV/ Venereal Disease
( ) Alcoholism ( ) Alzheimer's ( ) Anemia ( ) Anorexia ( ) Arthritis ( ) Asthma ( ) Bleeding Disorder
( ) Breast Lumps ( )Bronchitis ( ) Bulimia ( ) Chemical Dependency ( )Depression ( ) Emphysema
( ) Epilepsy ( ) Heart Disease ( ) Hepatitis ( ) Herniated Disk ( ) High Blood Pressure ( ) Low Blood Pressure ( ) High Cholesterol ( ) Kidney Disease ( ) Liver Disease ( ) Migraines ( ) Miscarriages
( ) Multiple Sclerosis ( ) Natural Labors ( ) C- Section ( ) osteoarthritis ( ) Osteoporosis ( ) Pacemaker
( ) Parkinson's Disease ( ) Pinched Nerves ( ) Pneumonia ( ) Polio ( ) Pervious Chiropractic Care
( ) Prostate Problems ( ) Psychiatric Care ( ) Rheumatoid Arthritis ( ) Stroke ( ) Suicide Attempts
( ) Thyroid Problems ( ) Ulcer ( ) Vaginal Infection ( ) Other_____

Doctor's Notes_____

_____

_____

For insurance Purposes and Health Compliance records, we need some information on your primary care medical physician.

_____ _____ _____
Physician's Name Phone No. Fax No.

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Revised Neck Pain Disability Questionnaire

Please read: this questionnaire is to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the one choice that mostly applies to you.

Pain Intensity
( ) No pain at the moment
( ) Mild pain at the moment
( ) Moderate pain at the moment
( ) Fairly severe pain at the moment
( ) Very severe pain at the moment
( ) Most imaginable pain at the moment

Personal Care
( ) Personal care is normal without extra pain
( ) Personal care normal with extra pain
( ) Personal care painful/ slow and careful
( ) Manage most personal care with some help
( ) Needs help every day in most aspects of care
( ) Difficulty dressing and washing/ stays in bed

Lifting
( ) Lifts heavy weights with no pain
( ) Lifts heavy weights with pain
( ) Can lift heavy weights from a table
( ) Can lift light weights from a table
( ) Can lift only very light weights
( ) Cannot lift or carry anything

Reading
( ) No pain while reading
( ) Slight pain while reading
( ) Moderate pain while reading
( ) Moderate pain prevents reading
( ) Severe pain prevents reading
( ) Cannot read at all

Headaches
( ) No headaches
( ) Slight, infrequent headaches
( ) Moderate, infrequent headaches
( ) Moderate, frequent headaches
( ) Severe, frequent headaches
( ) Constant headaches

Concentration
( ) Can concentrate without difficulty
( ) Can concentrate with slight difficulty
( ) Can concentrate with fair difficulty
( ) Can concentrate with a lot difficulty
( ) Can concentrate with extreme difficulty
( ) Cannot concentrate at all

Work
( ) Work is unrestricted
( ) Can do usual work but no more
( ) Can do most usual work, but no more
( ) Cannot do usual work
( ) Can hardly do any work
( ) Cannot do any work

Driving
( ) Can drive without pain
( ) Driving causes slight neck pain
( ) Driving causes moderate neck pain
( ) Cannot drive long due to severe pain
( ) Can hardly drive due to moderate pain
( ) Pain prevents driving

Sleeping
( ) No difficulties sleeping
( ) Sleep is mildly disturbed
( ) 1-2 hours of loss sleep
( ) 2-3 hours of loss sleep
( ) 3-5 hours of loss sleep
( ) 5-7 hours of loss sleep

Recreation
( ) Recreation is not affected
( ) Some neck pain, but doesn't affect activity
( ) Some activity is affected by pain
( ) Most activity is affected by pain
( ) Activity severely restricted by pain
( ) Cannot do any activity

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Revised Oswestery Chronic Low Back Pain Disability Questionnaire

Please read: this questionnaire is to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the one choice that mostly applies to you.

Pain Intensity
( ) Pain comes and goes and is mild
( ) Pain is mild and does not vary
( ) Pain comes and goes and is moderate
( ) Pain is moderate and does not vary
( ) Pain comes and goes and is severe
( ) Pain is severe and does not vary

Personal Care
( ) Does not change habits to avoid pain
( ) Does not change habits/ some pain
( ) Does not change habits/ increase pain
( ) Changes habits/ increase pain
( ) Unable to do some personal care without help
( ) Unable to wash or dress without help

Lifting
( ) Lifts heavy weights with no pain
( ) Lifts heavy weights with pain
( ) Cannot lift heavy weights off the floor
( ) Can lift heavy weights from a table
( ) Can lift light weights from a table
( ) Can lift only very light weights

Walking
( ) Pain does not prevent walking
( ) Cannot walk more than 1 mile
( ) Cannot walk more than ½ mile
( ) Cannot walk more than ¼ mile
( ) Can walk only with crutches
( ) Bedridden and must crawl to the bathroom

Sitting
( ) Can sit in any chair as long as desired
( ) Can sit only in the favorite chair as long as desired
( ) Can sit no more than 1 hour
( ) Can sit no longer than ½ hour
( ) Can sit no more than 10 mins
( ) Cannot sit at all due to pain

Standing
( ) Can stand for an unlimited time without pain
( ) Some pain standing/ doesn't increase with pain
( ) Cannot stand for more than 1 hour
( ) Cannot stand for more than ½ hour
( ) Cannot stand for more than 10 mins
( ) Cannot stand at all

Sleeping
( ) No pain in bed
( ) Gets pain in bed, but sleeps well
( ) Normal sleep reduced by ¼
( ) Normal sleep reduced by ½
( ) Normal sleep reduced by ¾
( ) Cannot sleep at all due to pain

Traveling
( ) Travel without pain
( ) Travel causes some pain, but not made worse
( ) Causes extra pain/ no change in form
( ) Causes pain/ uses alternate travel
( ) Pain restricts all form of travel
( ) Pain restricts travel except lying down

Social
( ) Normal and causes no pain
( ) Normal but causes extra pain
( ) Limits energetic interests
( ) Pain limits/ doesn't go out as often
( ) Pain restricted social life to home
( ) Pain restricts all social life

Changing Degree of Pain
( ) Pain is rapidly improving
( ) Pain fluctuates but is improving
( ) Improvement is slow
( ) Pain level is unchanged
( ) Pain is gradually worsening
( ) Pain is rapidly worsening

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Medical Release Form

Authorization for Release of Medical Information

Patient Name _____

Date of Birth _____ Social Security No _____

Phone No _____

Address _____
Street Apt. # City State Zip

To Release my Health Information to:

Chiropractic Works P.C
Name of Person/Organization

21790 Coolidge HWY | Oak Park | MI | 48237
Street Address | City | State | Zip

This Authorization applies to the Fellow Information:

All Records X-Rays MRI CT Office Notes Exams & Reports

I here authorize the above, it's director, admin and clinical staff or assignees, medical information services and billing department to release any and all medical records and information relating to my care and treatment including x-rays, photographs, electronic and digital files and any other records, unless I expressly direct or specify otherwise. I understand that medical information may include records, if any relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R part 2; psychiatric/ psychological services and social work records and any information regarding communicable diseases and infections, defined by Michigan Department of Public Health Rule, which can include tuberculosis, venereal diseases, sexually transmitted diseases, acquire immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or ARC. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rules.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and sent it to the hospital, doctor, or other custodian or medical information. I understand that revocation will not apply to information that has already been released in response to this authorization. A copy of this authorization is a valid as the original.

_____
Signature of Patient/ Representative Date

Name of Patient/ Representative (PRINT)

Description of Representative's Authority