



NEW PATIENT FORMS
Please print clearly

GENERAL INFORMATION (please complete in detail, all information is confidential)

Patient Last Name: _____		First Name: _____		MI: _____	
Address: _____				Number of Children: _____	
City: _____ State: _____ Zip: _____				Spouse Name: _____	
Phone (Home): _____				Phone: _____	
Email: _____					
Phone (Work): _____		Phone (Cell): _____			
Today's Date / /	Age	Date of Birth / /	Sex: M F	Social Security Number - -	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
In Care of: _____		Relation: _____		Phone: _____	
(Parent or financially responsible person)					
Patient Employer's Name: _____				EMPLOYED	
Address: _____				<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
City: _____ State: _____ Zip: _____				<input type="checkbox"/> Retired <input type="checkbox"/> Not Employed	
Phone: _____ Occupation: _____				STUDENT	
				<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
Referred By: _____					
If you were not referred to us, how did you hear about Maximized Health Chiropractic? _____					

INSURANCE INFORMATION

COMMERCIAL INSURANCE AND MEDICARE ONLY

<i>Primary Insurance Company Name</i>		

Type: _____	Group: _____	Private: _____
Membership/Cert #: _____		
Policy / Group #: _____		

AUTOMOBILE ACCIDENT / WORKER'S COMPENSATION ONLY

Insurance Company: _____	Claim #: _____	Policy #: _____
Address: _____	Phone: _____	Fax: _____
City: _____	State: _____	Zip: _____
Adjuster's Name: _____		
Attorney's Name: _____	Contact Name: _____	Phone: _____
Address: _____		

NEW PATIENT FORMS

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PLEASE FILL IN THE APPROPRIATE SPACES. (All information you give is confidential.)

MAJOR COMPLAINT: _____

How long have you had this condition? _____ Date of Onset: _____

Have you had this symptom or condition before? Yes No If yes, when? _____

Are your symptoms accident related? No Auto accident Work accident If yes, when? _____

Previous Chiropractic care? No Yes Chiropractor's Name: _____

What was the reason for your initial visit? _____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine?

Did you follow it? Yes No If not, why? _____

Why are you changing Chiropractors? _____

What surgeries have you had? _____

List drugs that you now take (prescription and non-prescription). _____

Name other doctors you have seen for this condition: _____

What are your health goals? _____

How do you expect to achieve these goals? _____

Please indicate if you have had any of these symptoms in the last 12 months:

<input type="checkbox"/> Fractured bones <input type="checkbox"/> Auto Accidents _____ 0-1 yrs ago _____ 1-5 yrs ago _____ 5 or more <input type="checkbox"/> Other Accidents, falls Describe _____ <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Convulsions, Epilepsy <input type="checkbox"/> Skin Problems <input type="checkbox"/> Cancer <input type="checkbox"/> Frequent Colds, Flu <input type="checkbox"/> Depressed <input type="checkbox"/> Irritable <input type="checkbox"/> Anemia <input type="checkbox"/> Allergy, Sinus <input type="checkbox"/> Under Stress <input type="checkbox"/> Eating Disorders <input type="checkbox"/> Trouble Sleeping <input type="checkbox"/> Trouble Concentrating <input type="checkbox"/> Learning Disability <input type="checkbox"/> Mood Changes	<input type="checkbox"/> Neck Pain or Stiffness R L <input type="checkbox"/> Numbness, Tingling, Pain in Arms, Hands, Fingers R L <input type="checkbox"/> Shoulder Pain R L <input type="checkbox"/> Jaw Pain or Clicking (TMJ) R L <input type="checkbox"/> Difficulty in Excessive Standing, Sitting, Riding, Bending, Lifting, Twisting: _____ <input type="checkbox"/> Numbness, Tingling, Pain in Buttocks, Legs, Feet, Toes R L <input type="checkbox"/> Foot Trouble R L <input type="checkbox"/> Upper Back Pain or Stiffness <input type="checkbox"/> Mid Back Pain or Stiffness <input type="checkbox"/> Lower Back Pain or Stiffness <input type="checkbox"/> Pain with Cough or Sneeze <input type="checkbox"/> Hip Pain R L <input type="checkbox"/> Bedwetting <input type="checkbox"/> Ear Infections <input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Headaches: <input type="checkbox"/> Tension <input type="checkbox"/> Migraine <input type="checkbox"/> Dizziness <input type="checkbox"/> Ringing in Ears R L <input type="checkbox"/> Hearing Loss R L Both <input type="checkbox"/> Blurred or Double Vision <input type="checkbox"/> Chest Pain <input type="checkbox"/> Asthma <input type="checkbox"/> Heart Problems <input type="checkbox"/> Stroke <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Liver Problems <input type="checkbox"/> Gall Bladder Problems <input type="checkbox"/> Digestive Problems <input type="checkbox"/> Ulcers <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Impotence <input type="checkbox"/> Kidney Trouble <input type="checkbox"/> Menstrual Problems (PMS) <input type="checkbox"/> Pregnant (now) <input type="checkbox"/> Fertility Problems <input type="checkbox"/> AIDS, HIV
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On a Scale from 1 to 10, identify your current level and type of pain.

Low...moderate...intense...emergency
1 2 3 4 5 6 7 8 9 10

A = Ache

B=Burning

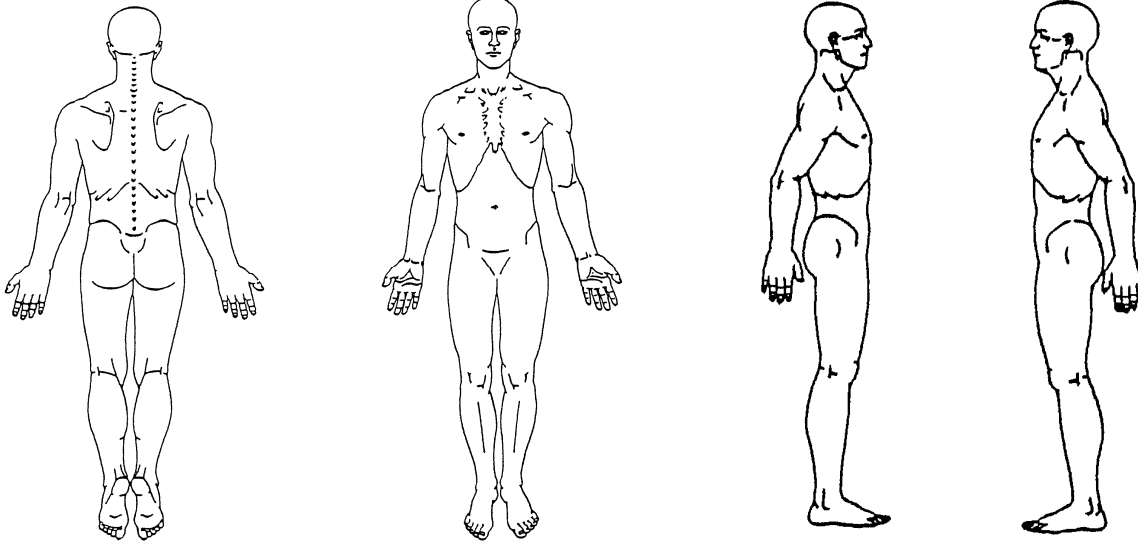
N=Numbness

P = Pins & Needles

S = Stabbing

O = Other

Please Circle the Specific Area & Note Pain Level and Type



1. Which pain or condition identified is the **worst**? _____

2. How **long** has it bothered you? _____

3. Please describe what makes your condition or symptoms **worse** _____

4. Please describe what makes your condition or symptoms **better** _____

PLEASE CIRCLE ONE:

5. Spinal problems can cause painful symptoms. Is your pain **sharp** or **dull**?

6. Spinal problems can cause symptoms that may be **constant** or **occasional**.

7. Are your symptoms worse in the **A.M.** or **P.M.**?

8. Do your pains/symptoms **radiate** into an extremity or **stay in one area**?

STRESS AND INJURY HISTORY

The average adult experiences literally dozens of impacts that could cause spinal problems. Please inform us of ANY that you have experienced. If a question does not apply to you, please respond with N/A (not applicable).

1. When was your most recent auto accident? Date: _____
 - a. Speed: _____
 - b. Front collision / side collision / rear-end collision? _____
 - c. Was treatment received? YES NO
 - i. If yes, where? _____

2. When was your most recent stress, strain or injury? _____
 - a. Was any treatment needed? YES NO
 - i. If yes, Describe injury and treatment: _____

3. Please describe ANY other injury to your spine, minor or major, that the doctor should know about.

4. Please describe ANY other health conditions or concerns that the doctor should know about.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

It is important that each patient understand both the objectives and the methods of chiropractic care. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral Subluxation. Our chiropractic method of correction is by specific adjustment of the spine and the use of stretching and exercising to maximize the improvement.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of both muscle and nerve function, and interference to the transmission of nerve impulses, resulting in a lessening of the body's ability to function properly.

We do not offer to diagnose or treat any diseases or condition other than vertebral Subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

I _____ have read and fully understand the above statements.
(Print name)

I, therefore, accept chiropractic care on this basis.

Signature

Date

Consent to evaluate and adjust a minor child.

I _____ being the parent or legal guardian of _____

have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature

Date

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period _____ .

Signature

Date

POLICIES

1. All first visit charges are payable when services are rendered, if your visit is promotional or you have a gift certificate, please inform the chiropractic assistant.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary.
3. Method of payment you plan to use to take care of today's charges, if any?

Cash Check Visa/MasterCard/AMEX

I _____ understand and agree that health and accident
 (Print name)

insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Maximized Health Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Maximized Health Chiropractic will be credited to my account upon receipt. *However*, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Maximized Health Chiropractic to obtain a credit report if deemed necessary.

 Patient Signature

 Date

 Guardian Signature Authorizing Care

 Print Name

 Date

In case of emergency, notify: _____

Relationship: _____

Address:

Phone number(s): _____

ASSIGNMENT AND MEDICAL INFORMATION RELEASE FORM

This form will help us coordinate the exchange of information and release of 3rd party reimbursement.

Assignment of Insurance Benefits and Payment Guarantee

I, _____ (Patient) assign to Maximized Health Chiropractic and/or Dr. Craig Burns (MHC) any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patient for services rendered by MHC. Patient also assigns to MHC any and all contractual rights Patient has against insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by MHC. Patient hereby directs all insurers and other persons possibly responsible for Patient's healthcare cost to make all payments for healthcare services rendered by MHC directly to MHC.

Release of Information

Patient hereby authorizes MHC to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all test of any type or character of patients such persons as MHC deems appropriate.

Please provide Primary Care Physician's information:

Doctor's Name: _____

Office/ Clinic Name: _____

Address: _____

Clinic Phone Number: _____

Doctor's E-mail: _____

Specialty or scope of practice: _____

If referred by specialist please provide their information as well:

Doctor's Name: _____

Office/ Clinic Name: _____

Address: _____

Clinic Phone Number: _____

Doctor's E-mail: _____

Specialty or scope of practice: _____

(Please do not neglect to fill in your Doctor's information)

Signature of Insured / Guardian_____
Please Print Name_____
Date

NAME: _____ DATE: _____

HEADACHE DISABILITY INDEX – (FOR HEADACHE PATIENTS ONLY)

INSTRUCTIONS: Please **CIRCLE** the correct response:

1. I have a headache: [1] 1 per month [2] more than 1 but less than 4 per month [3] more than 1 per week
2. My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off “YES”, “SOMETIMES”, or “NO” to each item. Answer each question as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F2. Because of my headaches I feel restricted in performing my routine daily activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E3. No one understands the effect my headaches have on my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E5. My headaches make me angry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E6. Sometimes I feel that I am going to lose control because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F7. Because of my headaches I am less likely to socialize.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E9. My headaches are so bad that I feel I am going to go insane.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E10. My outlook on the world is affected by my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E11. I am afraid to go outside when I feel that a headache is starting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E12. I feel desperate because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E14. My headaches place stress on my relationships with family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F15. I avoid being around people when I have a headache.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F17. I am unable to think clearly because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F18. I get tense (e.g. muscle tension) because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19. I do not enjoy social gatherings because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E20. I feel irritable because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F21. I avoid traveling because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E22. My headaches make me feel confused.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E23. My headaches make me feel frustrated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F24. I find it difficult to read because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F25. I find it difficult to focus my attention away from my headaches and on other things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NAME: _____ DATE: _____

NECK PAIN DISABILITY INDEX – (FOR NECK PAIN PATIENTS ONLY)

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** 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. CHOOSE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

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

NAME: _____ DATE: _____

BACK PAIN DISABILITY INDEX – (FOR BACK PAIN PATIENTS ONLY)

PLEASE READ: This questionnaire is designed 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 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. CHOOSE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

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