QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck				Low Back			
No pain	**0**	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**	**worst possible pain**

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1 – What is your pain RIGHT NOW?

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**worst possible pain**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**worst possible pain**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**worst possible pain**

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

The contact information you provide us will be held in confidence and will only be used for documentation in your healthcare file and for contacting you regarding issues related to your care at New Hope Functional Chiropractic.

Name: _____ Age _____

Date of Birth_____ Gender*(circle)* : Male Female

Mailing Address:_____ City:_____

State: _____ Zip Code _____ Home Phone # _____

E-Mail *(if applicable)* _____ Cell Phone #_____

Work Phone #(*if applicable*)_____

How would you like us to contact you for appointment reminders? *(please circle)*

Home Phone/ E Mail /Cell Phone/ Work phone If by cell phone, who is your cellular provider?_____

Employer _____ Occupation _____

Spouse/Partner *(if applicable)*: _____ Phone:_____

Emergency Contact:_____ Phone:_____

How were you referred to our office? *(please circle)*

Website/ Newspaper article/ Seminar/Meeting/ Advertisement

Another healthcare practitioner_____ Friend_____

Other _____

In general, please describe what concerns bring you into our office today:

_____

_____

_____

If so, how long ago did these symptoms begin? _____

If you are experiencing any pain or discomfort today, on a scale of 1 to 10 *(1 meaning "very mild" and 10 meaning "extremely severe")*, how would you describe your current symptoms?

☺ 1 2 3 4 5 6 7 8 9 10 ☹

Do you have any **allergies** or food sensitivities that you are aware of? Please describe:

_____

_____

Have you ever suffered a fracture or concussion, or have you been in an auto accident? Please describe:

_____

Please circle any surgical procedures you have experienced:

PROCEDURE	DATE	PROCEDURE	DATE	OTHER (*Please list*)
Tonsillectomy		Thyroid		
Gall bladder		Stomach		
Back Surgery		Knee		
Dental Surgery		Shoulder		
Female Organs		Foot		
Appendectomy		Rectal		
Hernia		Sinus		

*Please circle or **write in** symptoms that you are experiencing currently or in recent history:*

Energy and Mood	**Gastro-Intestinal**	**Eye/Ear/Nose/Throat**	**Respiratory**
Fatigue	Abdominal pain	Asthma	Chest pain
Anxiety or depression	Gas/bloating	Earache	Difficulty breathing
Poor concentration	Constipation	Hearing problems	Chronic cough
Sudden weight loss or weight gain	Diarrhea		Cold/hayfever/ congestion
Mood swings	Poor digestion	Sinus problems	
Sleep disturbances			
OTHER:	OTHER:	OTHER:	OTHER:

Genito-Urinary	**Musculo-skeletal**	**Cardio-Vascular**	**Skin/Allergies**
Bed wetting	Back pain	High blood pressure	Sensitive skin/skin eruptions
Frequent or painful urination	Foot/knee/shoulder or wrist pain	Chest pain	Psoriasis
Blood in urine/stool	Tremors/twitching	Strokes	Eczema
Prostate pain	Joint inflammation	Varicose veins	Bruise easily
OTHER:	OTHER:	OTHER:	OTHER:

Cancer: Type: _____ **Date of Diagnosis:** _____

Please list any prescription medications you are currently taking:

_____

_____

Please list any nutritional supplements (vitamins, minerals) you are currently taking:

_____

_____

_____

Have you ever been vaccinated? (please circle) YES NO

If so, when were your most recent vaccinations (including flu vaccination)?

_____

_____

_____

Please share anything else you believe is relevant to your health concerns here:

_____

_____

_____

_____

Are you consulting any other healthcare practitioners for the concerns that brought you into our office today? YES/NO

If so, may we consult with him/her in order to better coordinate your care? YES/NO

Practitioner's Name and Telephone #

_____

The information on this document is true to the best of my knowledge.

_____/_____

Signature Date

Consent for Treatment

I understand that my outpatient registration, treatment or series of treatment by New Hope Functional Chiropractic is necessary because of my condition. I voluntarily authorize and consent to the usual examination and treatments ordered by the Doctor and staff.

Request for Records:
I hereby authorize Dr. Austin, Dr. Sherman and / or any associates of New Hope Functional Chiropractic to request any medical records, x-rays, and specialized testing results, including serum and tissue testing results for the purpose of giving a better diagnostic picture. I permit a copy of this authorization to be used in requesting my records from any and all health care facilities, Physician and health care providers.

Payment & Insurance Release:
I permit a copy of this authorization to be used in place of the original by New Hope Functional Chiropractic. I authorize release to the Health Care Financing Administration and it's agents any information needed to determine these benefits are payable.
I authorize any holder of medical information about me to be released to any of the above named health insurance or their contracted claims paying agents, and all information necessary to determine if these benefits are payable.
When I pay by check, I expressly authorize this provider, if my check is dishonored or returned for any reason, to debit my account for the amount of the check plus a processing fee of $30.00 plus any applicable sales tax. The use of a check for payment is my acknowledgment and acceptance of this policy and its terms.
I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I authorize payments of benefits to the provider of service when the provider of service accepts assignment on the claim.
I further agree and understand that if the need arises, accounts delinquent by 90 days may be placed into legal collection agency. I understand and agree that I am responsible for all court cost, collection fee, filing fees and attorney fees that are incurred to collect my debt.

Consent for Treatment of a Minor:
I (We) being the parent, guardian, or custodians of _____,
A minor, the age of _____, do hereby authorize, request and direct Dr. Austin, Dr. Sherman and /or any other associates to perform in his/her judgment and necessary examinations, x-rays, and recommended treatment for the condition.

_____ _____
Date Patient's Signature

_____ _____
Witnessed By: Parent/Guardian's Signature-if applicable

Financial Policy

Health Insurance

◦Drs. Austin and Sherman accept assigned benefits for most major health insurance plans. This means you will pay the estimated portion figured by our front office staff at the appointment and the insurance company will send New Hope Functional Chiropractic a partial reimbursement check. If there is a balance after insurance pays New Hope Functional Chiropractic then we will send you a statement for any balance left unpaid. If there is a credit after insurance pays New Hope Functional Chiropractic, then we will send you a refund check.

◦If a check is sent to you directly by a payor, or automatically transferred to your bank account, payment to New Hope Functional Chiropractic is due within 10 days of receipt.

◦New Hope Functional Chiropractic files all claims electronically. This should help speed up the process with insurance companies that receive electronic claims.

◦New Hope Functional Chiropractic allows 60 days for health insurance reimbursement. If insurance does not send payment by this time then the patient or representative is billed for the full balance.

-OR-

ChiroHealthUSA

ChiroHealthUSA is a contracted network that allows doctors to set and accept discounts on their services for patients. When you join the ChiroHealthUSA Program you are entitled to similar 'in-network' discount just like the insurance companies. New Hope Functional Chiropractic is a member of this network of professionals and is dedicated to helping you get the care you need at a fee you can afford.

New Hope Functional Chiropractic has entered into a contract with ChiroHealthUSA to accept discounted fees from their 'usual customary and reasonable' charges. By joining the ChiroHealthUSA Program, you immediately become a member and are eligible to enjoy these discounted fees. Your membership is $49.00 for the entire year and includes your dependents. Upon completion of the application, New Hope Functional Chiropractic will collect the enrollment fee and submit your application for processing. You will receive a membership card by mail.

Patient's Signature

Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

•Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that care/treatment directly and indirectly.

•Obtain payment from third-party payers.

•Conduct normal healthcare operations such as quality assessments and physician certifications. I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out care/treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____

Signature: _____

Parent/Guardian Signature: _____

Date: _____

OFFICE USE ONLY
I ATTEMPTED TO OBTAIN THE PATIEN'T SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

*DATE:*_____*INITIALS*_____*REASON:*_____

Consent for Radiology

I, _____, give New Hope Functional Chiropractic my consent to take any and all x-rays needed to better understand my condition. I have been fully informed of the possible risks and safety standards of this office.

I also give my consent for films of my child/ren for the same reasons, if applicable.

For Ladies Only:

To my best knowledge, I am not pregnant and know of no contraindications for x-rays at this time. _____ (initial)

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

CONSULTATION FORM

INFORMED CONSENT FOR INFRARED LASER THERAPY

Laser therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasm and promotes vasodilation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks. However, your results may be minimal or insignificant. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, preexisting health conditions, thermal effects, excessive pressure from the probe, and laser over-stimulation. Laser light can damage the retina in your eye. Always wear the laser protective glasses provided.

The most common adverse effects are:

1. Temporary increase in pain during application of laser.
2. Temporary increase in pain the following day after laser therapy.
3. Mild bruising from vasodilation or direct pressure of laser tip.
4. Temporary dizziness.
5. Reactions when photosensitizing drugs are used with laser therapy.

I understand the risks of laser therapy and agree to the treatment program outlined by my doctor.

Patient Signature: _____ Date: _____

Please Print Name: _____

Date of Birth: _____

Employee Witness: _____ Date: _____

Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is a legal requirement in California. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a mechanical device or machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with stroke or not. Recent evidence suggests that it is not (2008, 2015, 2016), although the same evidence suggests that the patient may be entering the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous dissection of the vertebral artery. If we think this is happening, you will be immediately referred to emergency services.

Anecdotal stories suggest that chiropractic adjustments may be associated with strokes that arise from the vertebral artery; this is because the vertebral artery is actually located inside the neck vertebrae. The adjustment that is suggested to increase the strain on the vertebral artery is called the "extension-rotation-thrust atlas adjustment." We do not do this type adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. It is estimated that the incidence of this type of stroke ranges between 1 per every 400,000-3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Two other potential problems that are *not* quantifiable because they are extremely rare and may have no association with chiropractic adjusting are carotid artery injury and spinal dural tear resulting in a leak of cerebral spinal fluid.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. These problems occur so rarely that there are no available statistics to quantify their incidence.

Cauda Equina Syndrome: Cauda Equina Syndrome occurs when a low back disc problem puts pressure on the nerves that control bowel, bladder, and sexual function. Representative symptoms include leaky bladder, or leaky bowels, or loss of sensation (numbness) around the pelvic sexual organs (the saddle area), or the inability to urinate or to start a bowel movement. Cauda Equina Syndrome is a medical emergency because the nerves that control these functions can permanently die, and those functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves, and the window to do so may be as short as 12-72 hours,

depending. If you have any of these symptoms, tell us immediately, and if we can't be reached, go the emergency department.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may overstretch some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their incidence.

Rib and other Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their incidence.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat or ice can burn or irritate the skin. The result is a temporary increase in pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their incidence. Never put a home ice pack directly on the skin, always have an insulating towel between.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

_____ _____

Patient's Name Printed Today's Date

_____ _____

Patient's Signature Parent or Guardian Signature For Minor