FOR OFFICE USE ONLY:
Patient Number _____
Doctor _____
Insurance _____
Emp. Initials _____

PATIENT INFORMATION

Please give your Driver's license and insurance card to the front desk for your records.
Patient Name: Last _____ First _____ Date _____/_____/_____
Address _____ City _____ State_____ Zip_____
Cell Phone (_____) _____- _____ Home Phone (_____) _____-_____ Birth date_____/_____/_____ Age_____
Sex: ___M___F Driver's License # _____Patient Soc. Sec. # _____-_____-_____
Marital Status S M D W Children # ____ Spouse's Name _____
Person responsible for payment _____Patient Employed by _____
Occupation _____ Work phone (_____) _____-_____
Referred by _____ E-mail _____
Have you ever been to Chiropractor before? YES NO
Have you ever had similar complaint? YES NO
Have you filed an Employment Auto accident or Personal injury claim? (Please circle if so)

CURRENT COMPLAINTS

Complaint 1_____

How severe is the problem?
- ☐ Mild
- ☐ Mild to moderate
- ☐ Moderate
- ☐ Moderately severe
- ☐ Severe

How frequently does it occur?
- ☐ Constant
- ☐ Frequent
- ☐ Intermittent
- ☐ Occasional

When was the onset?
- ☐ A day ago
- ☐ Several days ago
- ☐ About a week ago
- ☐ Several weeks ago
- ☐ About a month ago
- ☐ Several months ago
- ☐ About a year ago
- ☐ several years ago

Movement:
- ☐ Cramps
- ☐ Spasm
- ☐ Stiffness
- ☐ Restricted movement
- ☐ Inflexibility

What makes it feel better?_____

What makes it feel worse?_____

If you are being re-evaluated, what percent improvement have you had?
_____%

Complaint 2_____

How severe is the problem?
- ☐ Mild
- ☐ Mild to moderate
- ☐ Moderate
- ☐ Moderately severe
- ☐ Severe

How frequently does it occur?
- ☐ Constant
- ☐ Frequent
- ☐ Intermittent
- ☐ Occasional

When was the onset?
- ☐ A day ago
- ☐ Several days ago
- ☐ About a week ago
- ☐ Several weeks ago
- ☐ About a month ago
- ☐ Several months ago
- ☐ About a year ago
- ☐ several years ago

Movement:
- ☐ Cramps
- ☐ Spasm
- ☐ Stiffness
- ☐ Restricted movement
- ☐ Inflexibility

What makes it feel better?_____

What makes it feel worse?_____

If you are being re-evaluated, what percent improvement have you had?
_____%

Complaint 3_____

How severe is the problem?
- ☐ Mild
- ☐ Mild to moderate
- ☐ Moderate
- ☐ Moderately severe
- ☐ Severe

How frequently does it occur?
- ☐ Constant
- ☐ Frequent
- ☐ Intermittent
- ☐ Occasional

When was the onset?
- ☐ A day ago
- ☐ Several days ago
- ☐ About a week ago
- ☐ Several weeks ago
- ☐ About a month ago
- ☐ Several months ago
- ☐ About a year ago
- ☐ several years ago

Movement:
- ☐ Cramps
- ☐ Spasm
- ☐ Stiffness
- ☐ Restricted movement
- ☐ Inflexibility

What makes it feel better?_____

What makes it feel worse?_____

If you are being re-evaluated, what percent improvement have you had?
_____%

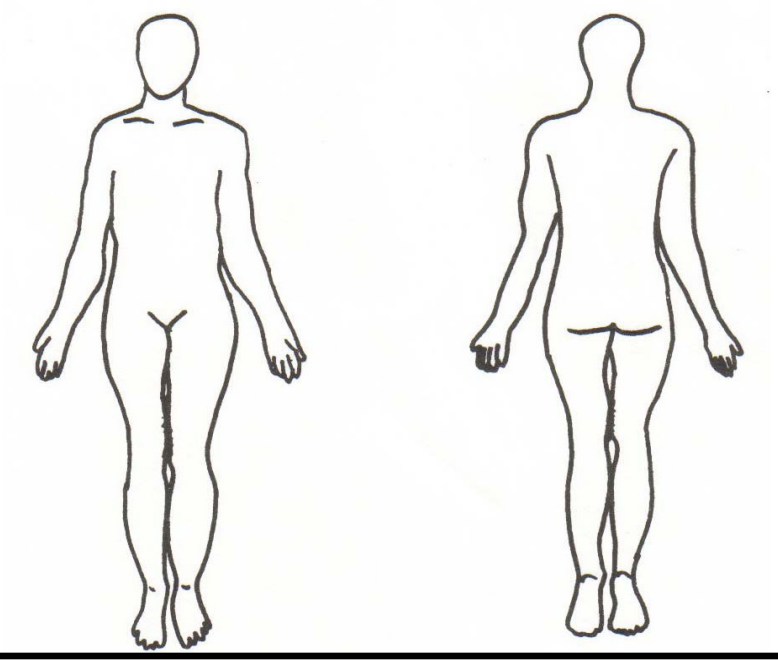
PATIENT PAIN PROFILE

PAIN DRAWING:

INSTRUCTIONS: ***Mark the area on your body where you feel the described sensations:***

- ***Use the appropriate symbol***
- ***Mark the areas of spread***
- ***Include all affected areas***

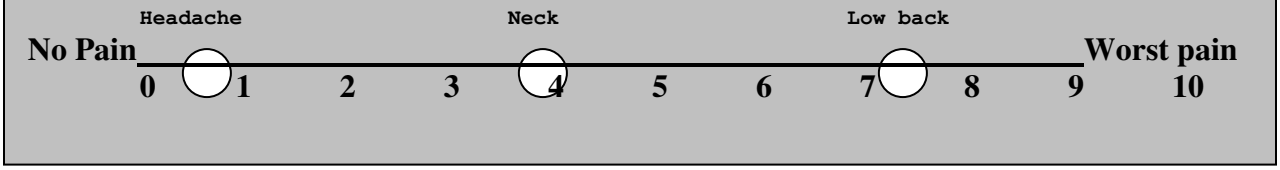
KEY:	
Numbness / Tingling	**=======**
Pins & Needles	**oooooooo**
Burning pain	**xxxxxxxx**
Dull / achy pain	**……**
Sharp / Stabbing pain	**////////////////**



VISUAL PAIN SCALE

INSTRUCTIONS: ***Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate a score for each complaint. Please indicate your pain level right now, and average pain.***

Example:



What is your pain RIGHT NOW?

No Pain_____Worst pain

0 1 2 3 4 5 6 7 8 9 10

What is your TYPICAL or AVERAGE pain?

No Pain_____Worst pain

0 1 2 3 4 5 6 7 8 9 10

PATIENT'S INITIAL_____DATE_____

Health History

Please indicate whether the following applies to the "I" Individual, "F" Family Member, or "B" Both.

☐ Abdominal Pain	☐ Bulimia	☐ Hay Fever	☐ Kidney Disease	☐ PMS
☐ Acid Reflux (GERD)	☐ Colon Cancer	☐ Headaches	☐ Kidney Stones	☐ Polio
☐ Allergies	☐ Convulsions	☐ Heart Attacks	☐ Knee Pain	☐ Prostate Cancer
☐ Angina/Chest Pain	☐ Depression	☐ Heart Disease	☐ Leg Pain	☐ Prostate Problems
☐ Anorexia	☐ Diabetes	☐ Hepatitis A	☐ Liver Disease	☐ Rapid Heart Rate
☐ Anxiety	☐ Dislocated Joints	☐ Hepatitis B	☐ Low Blood Pressure	☐ Rectum Cancer
☐ Aortic Aneurysm	☐ Dizziness	☐ Hepatitis C	☐ Lower Back Pain	☐ Scoliosis
☐ Arm Pain	☐ Duodenum Ulcer	☐ Hernias	☐ Lung Cancer	☐ Shoulder Pain
☐ Arthritis	☐ Emphysema	☐ High Blood Pressure	☐ Mid-Back Pain	☐ Sinus Trouble
☐ Asthma	☐ Epilepsy	☐ High Cholesterol	☐ Migraine	☐ Spinal Disc Disorder
☐ Blood Disorder	☐ Esophageal Cancer	☐ HIV/AIDS	☐ Multiple Sclerosis	☐ Stomach Cancer
☐ Bone Cancer	☐ Fainting	☐ Hyperthyroidism	☐ Neck Pain	☐ Stroke
☐ Brain Cancer	☐ Fatigue	☐ Hypothyroidism	☐ Osteoporosis	☐ Underweight
☐ Breast Soreness	☐ Fibromyalgia	☐ Irregular Bowel Habits	☐ Overweight	☐ Upper Back Pain
☐ Breast Cancer	☐ Gouty Arthritis	☐ Irregular Menstruation	☐ Painful Urination	☐ Vision Problems

Other History_____

Patient Exercises: ☐ Moderately ☐ Occasionally ☐ Rarely ☐ Regularly ☐ Never

Patient uses alcohol: ☐ Excessively ☐ Moderately ☐ Occasionally ☐ Rarely ☐ Never ☐ Quit _____

Please list any previous injuries and/or accidents with date: _____

_____

_____

Past Surgical History (Indicate date, location, surgeon's name, type of surgery, and complications):

_____

_____

Past Hospitalizations (Indicate date, reason for hospitalization, and complications:

_____

_____

History of Pregnancy: _____

Diagnostic Testing and Procedures:

☐ Plain X-Rays	Date: _____	Location: _____	Results: _____
☐ CT Scan	Date: _____	Location: _____	Results: _____
☐ MRI	Date: _____	Location: _____	Results: _____
☐ EMG	Date: _____	Location: _____	Results: _____
☐ Bone Scan	Date: _____	Location: _____	Results: _____
☐ Ultrasound	Date: _____	Location: _____	Results: _____

☐ Nerve Block Injection	☐ Trigger Point Injection	☐ Epidural Injection	☐ Botox Injection
☐ Other: _____	☐ Other: _____	☐ Other: _____	☐ Other: _____

Environmental Allergies: _____

Food Allergies: _____

Medication/Drug Allergies: _____

Current Medications and Vitamin Supplements: (Please use reverse side if more space is required.)

NAME:	STRENGTH:	FREQUENCY:	NAME:	STRENGTH:	FREQUENCY:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

PATIENTS' INITIALS____ DATE_____

Neck Pain and Disability Index

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. In each section, please fill in ONE box only which most closely describes your problem.

Section 1 Pain Intensity

- **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.

Section 2 Personal Care

- **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.

Section 3 Lifting

- **A**. I can lift heavy weight without extra pain.
- **B**. I can lift heavy weight but it gives extra pain.
- **C**. Pain prevents me from lifting heavy weights off the floor, but I can manage it they are conveniently positioned**.**
- **D**. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- **E**. I can lift very light weights.
- **F**. I cannot lift or carry anything at all.

Section 4 Reading

- **A**. I can read as much as I want with no pain in my neck
- **B**. I can read as much as I want with slight pain in my neck.
- **C**. I can read as much as I want with moderate pain in my neck.
- **D**. I can't read as much because of moderate pain in my neck.
- **E**. I can hardly read at all because of severe pain in my neck.
- **F**. I cannot read at all.

Section 5 Headaches

- **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 of the time.

Section 6 Concentration

- **A**. I can concentrate fully when I want with no difficulty.
- **B**. I can concentrate fully when I want with slight difficulty.
- **C**. I have a fair degree of difficulty in concentrating when I want.
- **D**. I have a lot of difficulty in concentrating when I want.
- **E**. I have a great degree of difficulty in concentrating when I want.
- **F**. I cannot concentrate at all.

Section 7 Work

- **A**. I can do as much work as I want.
- **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 can hardly do any work at all.
- **E**. I cannot do my usual work.
- **F**. I can't do any work at all.

Section 8 Driving

- **A**. I can drive my car without any neck pain.
- **B**. I can drive my care 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.
- **D**. I can't drive my car as long as I want because of moderate pain.
- **E**. I can hardly drive at all because of severe pain in my neck.
- **F**. I can't drive my car at all.

Section 9 Sleeping

- **A**. I have no trouble sleeping.
- **B**. My sleep is slightly disturbed (less then 1hr. sleepless).
- **C**. My sleep is mildly disturbed (1-2 hrs. sleepless).
- **D**. My sleep is moderately disturbed (2-3 hrs. sleepless).
- **E**. My sleep is greatly disturbed (3-5 hrs. sleepless).
- **F**. My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 Recreation

- **A**. I am able to engage in all recreational activities with no neck pain.
- **B**. I am able to engage in all my recreational activities, with some pain in my neck**.**
- **C**. I am able to engage in most, but not all of my usual recreational activities because of my neck pain**.**
- **D**. I am able to engage in a few of my usual recreational activities because of my neck pain**.**
- **E**. I can hardly do any recreational activities because of pain.
- **F**. I can't do any recreational activities at all.

Office Use Only **Score:_____**

PATIENT'S INITIAL_____DATE_____

Low Back Pain and Disability Index

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please fill in ONE box only which most closely describes your problem.

Section 1 Pain Intensity

- **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 very severe.
- **F**. The pain is very severe and doesn't vary much.

Section 2 Personal Care

- **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.

Section 3 Lifting

- **A**. I can lift heavy weight without extra pain.
- **B**. I can lift heavy weight but it gives extra pain.
- **C**. Pain prevents me from lifting heavy weights off the floor.
- **D**. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- **E**. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- **F**. I can only lift very light weights at the most.

Section 4 Walking

- **A**. I have no pain while walking.
- **B**. I cannot walk more then one mile without increasing pain.
- **C**. I cannot walk more then ½ mile without increasing pain.
- **D**. I cannot walk more then ¼ mile without increasing pain.
- **E**. I can walk with crutches.
- **F**. I cannot walk at all without increasing pain.

Section 5 Sitting

- **A**. I can sit in any chair as long as I like.
- **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 then a half hour.
- **E**. Pain prevents me from sitting more then 10 minutes.
- **F**. I avoid sitting because it increases pain straight away.

Section 6 Standing

- **A**. I can stand as long as I want without pain.
- **B**. I have some pain on 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 a ½ hour without increasing pain.
- **E**. I can't stand for longer then 10 minutes without increasing pain.
- **F**. I avoid standing because it increases the pain straight away.

Section 7 Sleeping

- **A**. I get no pain in bed.
- **B**. I get pain in bed but it doesn't prevent me from sleeping well.
- **C**. Because of pain my normal night's sleep is reduced by < 1/4.
- **D**. Because of pain my normal night's sleep is reduced by < 1/2.
- **E**. Because of pain my normal night's sleep is reduced by < 3/4.
- **F**. Pain prevents me from sleeping at all.

Section 8 Traveling

- **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.

Section 9 Social life

- **A**. My social life is normal and gives me no pain.
- **B**. My social life is normal but increases the degree of pain.
- **C**. Pain limits my more energetic interests, e.g. dancing, ect.
- **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.

Section 10 Changing Degree of Pain

- **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.
- **D**. My pain is neither getting better nor worse.
- **E**. My pain is gradually worsening.
- **F**. My pain is rapidly worsening.

Office Use Only **Score:_____**

PATIENT'S INITIAL_____DATE_____

HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Patient signature_____ **Date**_____

Authorization and Assignment

AUTHORIZATION TO BILL INSURANCE: I understand my insurance will be billed for services rendered at Total Health Systems, PC.

AUTHORIZATION TO RELEASE INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any moneys due him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

MEDICARE ASSIGNMENT *(if applicable)*: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

ACKNOWLEGMENT AND UNDERSTANDING: I hereby acknowledge;

That if there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or if a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Total Health Systems PC, will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

SPECIAL CONSIDERATION: I understand that should I have a financial hardship and am unable to completely satisfy my deductible/copay/or coinsurance I will notify Total Health Systems, PC and a separate written contract will be created and signed.

Patient signature_____ **Date**_____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, PHYSICAL THERAPY, AND/OR CHIROPRACTIC CARE. I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Total Health Systems, P.C. I understand, and am informed that, while extremely rare, there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient signature_____ **Date**_____

Parent/Legal guardian name (please print)_____

Guardian Signature_____ **Date**_____

TOTAL HEALTH SYSTEMS
Multi-Specialty Clinic
Chiropractic • Medical • Physical Therapy • Massage Therapy • Nutrition

Chesterfield (586) 949-0123 ◆ Clinton Township (586) 228-0270 ◆ Washington (586) 781-0800
TotalHealthSystems.com

Health and Medical Information Release Form

I, _____, give permission to Total Health Systems, PC, its staff, associates, and its employees, to share private and medical information with my medical doctor, _____, as well as his or her staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Total Health Systems, PC. ***The sole purpose for this is to provide more efficient and comprehensive care to our patients.***

Signature: _____ Date: _____

Medical Doctor Info

Name of Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____Fax: _____