REGISTRATION & INFORMATION

PATIENT INFORMATION

DATE______________________________

PATIENT NAME____

ADDRESS____

CITY_______________ STATE_____________ ZIP_______________

EMAIL____

SEX ☐ M ☐ F DOB____________________

☐MARRIED ☐SINGLE ☐DIVORCED ☐WIDOWED ☐MINOR

WHO MAY WE THANK FOR REFERRING YOU? ☐ INTERNET ☐NEWSPAPER ☐RADIO

☐ PERSONAL REFERRAL____________________☐ OTHER______________________

PHONE NUMBERS

HOME PHONE#__________________ CELL#_____________________

BEST TIME & PLACE TO REACH YOU___________________________

EMERGENCY CONTACT INFORMATION

NAME____

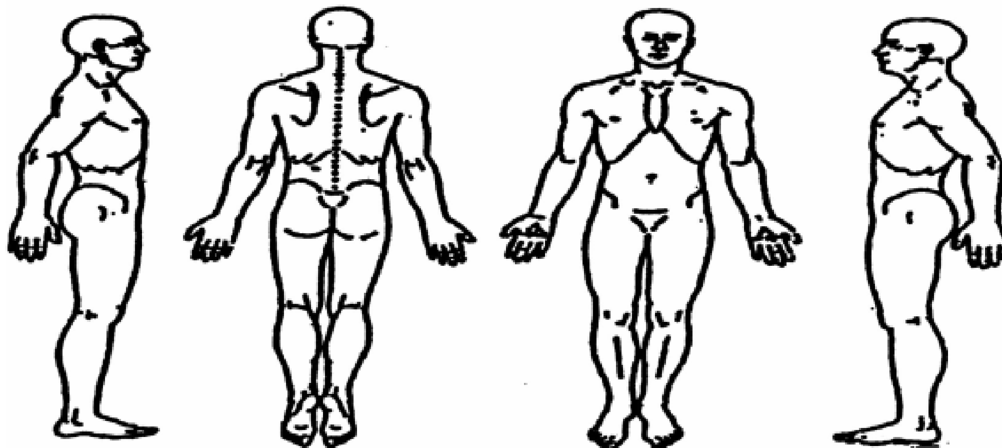
PHONE#__________________RELATIONSHIP_______________

PATIENT INTAKE FORM

Patient Name: ______________________________ Date: _______________

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:___________________

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10 (*Please check)*

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____________
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? ___________

11. How do you think your problem began?

____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

____

14. What concerns you the most about your problem; what does it prevent you from doing?

____

15. What is your: Height___________ Weight _____________ Date of Birth ___________
Occupation ____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite			**For Females Only**
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:____________________________						

20. List all prescription medications you are currently taking:

____

21. List all of the over-the-counter medications you are currently taking:

____

22. List all surgical procedures you have had:

____

23. What activities do you do at work?
□ **Sit:** □ Most of the day □ Half the day □ A little of the day
□ **Stand:** □ Most of the day □ Half the day □ A little of the day
□ **Computer work:** □ Most of the day □ Half the day □ A little of the day
□ **On the phone:** □ Most of the day □ Half of the day □ A little of the day

24. What activities do you do outside of work?

____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why ____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?____

Patient Signature X ______________________________________ **Date:**____________________

IRREVOCABLE ASSIGNMENT OF BENEFITS FORM

This Irrevocable Assignment of Benefits Agreement ("Agreement") is made and entered into by and between:

Patient Information:
Name: ____
Address: ____
Phone Number: ____

Chiropractic Provider:
Provider Name: *Bartay Chiropractic*
Address: *352 Stone Hill Drive Brenham, TX 77833*
Phone: *979-836-5591*

- **Assignment of Benefits**

The undersigned Patient, by signing below, irrevocably assigns to Bartay Chiropractic all rights, benefits, and claims to any and all insurance benefits or other payments under the relevant insurance policy(ies), including but not limited to Personal Injury Protection (PIP), health insurance, or other claims available through any third-party payer for medical services rendered by Bartay Chiropractic.

- **Direct Payment to Bartay Chiropractic**

The undersigned Patient directs that all payments or benefits payable under the applicable insurance policy or any third-party payer for services provided by Bartay Chiropractic be paid directly to Bartay Chiropractic. This includes all payments for medical care provided up to the full amount of the outstanding balance for such care.

- **Irrevocability of Assignment**

The undersigned Patient understands and agrees that this assignment is irrevocable and cannot be rescinded without the express written consent of Bartay Chiropractic. This assignment will remain in effect until all charges for services rendered have been paid in full.

- **Authorization to Release Information**

The undersigned Patient hereby authorizes Bartay Chiropractic to release any necessary medical information to the insurance company, third-party payer, or attorney for the purposes of processing claims and obtaining payment.

- **General Provisions**

This Agreement constitutes the entire understanding between the Patient and Bartay Chiropractic with respect to the subject matter herein and supersedes all prior agreements or understandings, whether written or oral.
This Agreement shall be governed by and construed in accordance with the laws of the state in which the services are rendered.

- **Patient's Acknowledgment and Agreement**

By signing below, the undersigned Patient confirms and acknowledges:

- The Patient understands that Bartay Chiropractic will seek direct payment from the insurance company or any third-party payer for services rendered.
- The Patient understands that Bartay Chiropractic may not wait for the outcome of any settlement or judgment, and may seek payment from any available insurance benefit or payment from the third-party payer.
- The Patient agrees to cooperate with Bartay Chiropractic, the insurance company, and the attorney to facilitate the timely and proper payment of all charges.

Patient's Signature

X Signature: ______________________________Date:__________

Chiropractic Provider's Signature:

Ronald A Bartay, D.C.

X________(initial) ***CONSENT FOR TREATMENT***

I hereby allow Bartay Chiropractic to examine, treat, and perform diagnostic test and office procedures that the provider deems necessary.

X________(initial) ***NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGMENT OF RECEIPT***

By signing below, I am stating that I have read and received a copy of the Notice of Privacy Practices for Bartay Chiropractic. (Copy located on waiting room table, you will also receive a copy in your report folder.)

I have read and agree to the Financial Agreement, Assignment of Benefits, Release of Information, and Consent For Treatment as listed above. My signature below also indicates that I have reviewed a copy of the Bartay Chiropractic Notice of Privacy Practices and I have indicated any restrictions on my protected health information above. Everything I have filled out is true to the best of my knowledge. Scanned Signatures suffice as originals.

X____

Patient or Responsible Party **(Sign and print)** Date

X____

Guardian of minor **(Sign and print)** Date

X-ray Consent Form

Patient name:____________________________________ Date:________________________

BOX 1 & 2 WOMEN ONLY

☐ I understand that if I am pregnant and have X-rays taken that expose my lower torso to radiation, it is possible to injure the fetus.

☐ I have been advised that the 10 days following onset of a menstrual period are generally considered safe for X-ray exams (low risk of pregnancy during that time).

With those factors in mind, I am advising my doctor:

I am pregnant _______Yes _____No _____Don't know

BOX 3 MEN & WOMEN

☐ **An X-ray may be performed on me with my consent.**

Signature:X____ Date:______________________________

PRIMARY CARE PHYSICIAN RELEASE

Please help us help you? We would like to contact your primary care physician with our opinion and findings, and let them know about your care in order to better serve you. Please fill out the form below with the proper information. Thank you!

Primary Care Physician/Medical Dr.:____

Address:____

Phone Number:____

May we contact them in regards to your care?☐ YES ☐ NO

Patient's Name____ Number____________ Date____________________

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____________ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient's Name____ Number_____________ Date_____________________

NECK DISABILITY INDEX

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. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____________ %ADL______

Section 6 – Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments____

%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Certification Information

Dear Patient: The US government is now requiring that we supply them with the following information

Patient Demographics:

Name: (Print clearly) ____________________________ **Today's Date:** _____________

Date of Birth: _________________

Ethnicity: (Please check)

□ Hispanic or Latino	□Not Hispanic or Latino

Race: (Please check)

□White	□ American Indian/ Alaskan Native	□ Asian
□ Black/African American	□ Native Hawaiian/ Pacific Islander	□ Two or more

Preferred Language: (Please check)

□ English	□ Spanish	□ French	□ German	□ Italian
□ Mandarin	□ Cantonese	□ Tagalog	□ Japanese	□ Other__________

If the Government needs to contact you, how would you like this confidential communication to be received?

Phone Number: ______________________

Phone Call: ☐ Text Message: ☐

Home □	Work □	Cell □

Email:____

Smoking Status:	□ Smokes every day	□ Smokes some days	□ Former Smoker	□ Never Smoked

Prescribed Medicines

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	**# of MD refills issued?**	**Quantity of Pills:**	**Strength:** i.e. 10 mg	**Dose Form:** i.e. Capsule	**MD's instruction:** i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line:

Check here if you do not have any medicinal allergies: ☐

Name of Drug: i.e. penicillin	**Symptom:** i.e. headache

Have you been diagnosed with: (Please circle)

Asthma? □	Diabetes? □