Wright Chiropractic Health Center

Patient Information and History

PATIENT INFORMATION

Date:_____ ID #(office use)____
Name_____
Last First Middle
Address_____
_____

Sex: __M __F Age:____ Birth Date_____
Social Security #_____
If patient is a minor, parent's Social Security Number:_____
Occupation_____
Employer_____

__Single __Married __Separated __Divorced
Spouse's Name_____
Spouse's Occupation_____
Spouse's Employer_____

Who **or what** may we thank for referring you?
_____

CONTACT INFORMATION
Home_____ Work_____
Cell#_____Carrier_____
Email :_____
In case of an emergency, contact:
Name_____
Relationship_____Number_____

ACCIDENT INFORMATION
(IF APPLICABLE)
Is this due to an accident? __Y __N
If yes: Auto Work Home Other
To whom did you report the accident?
Auto Insurance Worker Comp Employer

*Please note this office does not file Worker's Comp.

INSURANCE INFORMATION

(PLEASE PRESENT INSURANCE CARDS TO FRONT DESK)

Primary Insurance _____
Subscriber's Name_____
Subscribers SS#_____DOB_____
Relationship to Patient_____
Secondary Insurance_____

Assignment and Release

I authorize that payment of insurance benefits be made on my behalf to Dr. Heather Wright, DC/Wright Chiropractic Health Center for any services rendered to me. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other Health Insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on approved claim forms or electronic claims, my signature authorizes releasing of the information to the insurer or agency shown. I understand that this provider may not be a preferred provider if my insurance is not listed on the financial disclosure as an in network provider. Coinsurance and the deductible are based upon the charge determination of the carrier.

_____ _____
Patient/Guardian's Signature Date

PATIENT CONDITION (ALL QUESTIONS SHOULD BE ANSWERED)

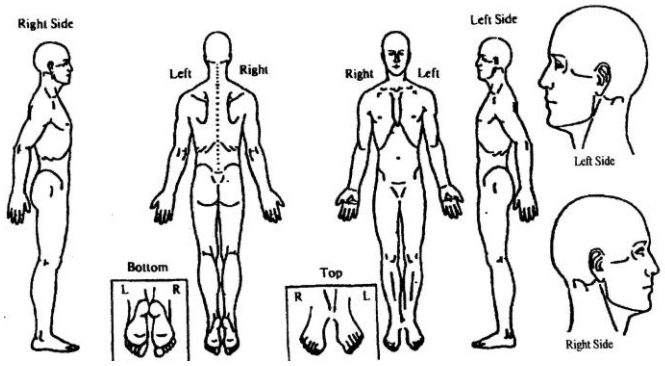
Main Reason For this visit_____
When did the symptoms first appear_____*Was onset: __Gradual __Sudden Is it getting worse? __Y __N
Cause_____
How often do you experience Symptoms?
__Constant (100%) __Frequent (75%) __Intermittent(50%)
__Occassional(25%) __Rare (10% or less)

Type of Pain: __Sharp __Dull __Throb __Numb __Ache
__Shooting __burning __Tingle __Cramp __Stiff __other

Where does it radiate to?_____
What gives relief?_____
What makes it worse?_____

Does it interfere with:__Work __Daily Activities __Sleep

Rate the pain from 0 (no pain) to 10 (worst pain felt) _____



PLEASE MARK ALL AREAS OF PAIN (INCLUDING ANY RADIATIONS) ON THE FIGURE BELOW

HEALTH HISTORY

Have you ever seen a Doctor of Chiropractic before? __Y __N Who?_____
List other Doctors you have seen for this condition:
Who:_____Address_____When:_____
Who:_____Address_____When:_____
What treatment have you received for this condition?
__Medication __Physical Therapy __Chiropractic Services __Surgery __Other:_____

Who is your family Physician?_____address_____Phone_____
May we Send him/her an update on your treatment in our office? Y N

Date of last: Physical Exam_____ Spinal X-ray_____ Blood Test_____ Urine Test_____
Spinal Exam_____ Chest X-ray_____ MRI,CT,Bone Scan_____ OB/GYN Exam_____

PLEASE CIRCLE ANY SYMPTOMS YOU HAVE HAD IN THE LAST MONTH

Balance Impairment	Headaches	Memory Loss	Dizziness	Nausea	Nervousness
Sleeplessness	Chest Pains	Ringing in Ears	Lightheaded	Visual/Sensory Disturbance	
PMS/Menstrual pain	Jaw Pain	Loss of Concentration			

List any abdominal complaints(gas, pain, etc)_____
List any respiratory complaints(coughing, congestion, difficulty breathing, etc)_____
List any cardiac complaints(arm pain, chest pain, shortness of breath etc)_____
List any reproductive /Urinary complaints(abnormalities, pain, etc)_____

PLEASE CIRCLE ANY SYMPTOMS YOU CURRENTLY HAVE OR HAVE EVER HAD

AIDS/HIV	Cataracts	Herniated Disk	Parkinsons	Tuberculosis
Anemia	Chemical Dependency	Herpes	Pinched Nerve	Tumors
Anorexia	Diabetes	High Blood Pressure	Pneumonia	Ulcers
Appendicitis	Emphysema	Hi Cholesterol	Polio	Varicose Veins
Arthritis	Epilepsy	Jaw/TMJ Pain	Prosthesis Whiplash	Fatigue
Asthma	Glaucoma	Kidney Problem	Psychiatric Care	Other:
Blood Clots	Goiter	Liver Disease	Rheumatoid Arthritis	_____
Breast Lump	Gout	Mononucleosis	Rheumatic Fever	_____
Bronchitis	Heart Disease	Multiple Sclerosis	Scarlet Fever	_____
Bulimia	Hepatitis	Osteoporosis	Stroke	_____
Cancer	Hernia	Pacemaker	Thyroid Problem	_____

INJURIES AND SURGERIES YOU HAVE HAD	**DESCRIPTION**	**DATE**
Accidents/Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE TAKING
Medication/Supplement _____ For_____
Medication/Supplement _____ For_____
Medication/Supplement _____ For_____

LIST ANY ALLERGIES:_____
LIST ANY DISEASES/ILLNESSES THAT RUN IN THE FAMILY_____

SOCIAL HISTORY

Are you Pregnant? __Y __N __Unsure Due Date_____OB/GYN:_____

Indicate Exercise Level: None Moderate Daily Heavy

Indicate any Work activities that Apply:
Long term Sitting Long Term Standing Repetitive Motions Heavy Labor Light Labor

Indicate any Lifestyle/Habits you have:
___Smoking: ___Packs/Day ___Coffee/Sodas/Caffeine: ____Cups/Day
___Alcholoic Beverages ___Drinks/Day ___High Stress Level : Reason_____
___Poor Diet/High salt,fat,or sugar intake

Please list your Hobbies and recreation activities:_____

I understand that Completion of a History and exam does not mean that I have been accepted as a patient. It will be decided based on the history and exam whether I can be accepted as a patient. Fees will still be due for the exam even if I cannot be accepted as a patient.

Signature_____ Date_____

FINANCIAL POLICY – PAYMENTS TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us. Our Facility & staff are not responsible for what a payer and/or representative may tell us, including mis-quoted benefits, coverage and liability**.**

1. **Our Facility will file initial insurance claims for you. Secondary claim submission and /or additional reports or documents sent for your benefit may result in an additional filing medical report charge, which you are responsible to pay.**
2. **Co-pays, deductibles and all non-covered service charges are due the day the service is rendered and are the patient's sole responsibility.**
3. **Patients are responsible for charges on all service(s) and/or product(s) which 1) are non-covered (regardless of in our out of network status) or 2) may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet the cost of service.**
4. **All account balances, including automobile claims must be paid within** 90 days **of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, and judgment. If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.**
5. **A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, or massage therapy.**
6. **The Facility offers the use of Care Credit to patients preferring to use a credit type payment plan. Any agreement made is between Care Credit and the Patient. Patient is responsible for any and all charges for services rendered.**
7. ***A service charge is computed by a periodic rate of 1 ½ % per month- 18% per annum & is added to all balances owed 60 + days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fees.***
8. **Missed appointments that are not canceled at least 24 hours prior to appointment time will be subjected to a Missed Appointment Fee at the Office's discretion. The Fee will be the patient's sole responsibility.**
9. **Patient consents to use of cell phone as a contact when necessary for any and all purposes including, but not limited to communication about care or accounts, collection calls, appointment reminders, etc.**
10. **If your Insurance does not pay within** 60 days **of the service date, <u>the patient</u> becomes responsible for the FULL amount owed on that service date, REGARDLESS of whether insurance is supposed to pay, will pay or does pay in the future and regardless of benefits quoted, in or out of network status of the provider, or any billing errors made or perceived to have been made by WCHC. Any credit that results from future payments by insurance company will be applied to patient account, and a refund check will be issued at patient request.**
11. **If the patient at any point during the treatment plan** discontinues care**, voluntarily or involuntarily, their balance IN FULL of rendered care becomes immediately due REGARDLESS of whether insurance is supposed to pay, will pay or does pay in the future and regardless of benefits quoted, in or out of network status of the provider, or any billing errors made or perceived to have been made by WCHC.**
12. **Checks drawing on insufficient funds, closed account, stop payments or other reasons of non-payment will be assessed a $30 fee. If the fee and original check amount are not paid to the office in a reasonable amount of time after notification, the matter will be turned over to the County or district attorney.**

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document and fully understand and have all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient Signature (if minor, parent must sign) Date

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient; "Chiropractor" refers to Dr. Heather Wright, BS, DC, CCEP.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 providers who may be involved in the treatment directly and indirectly.'
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 below 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 treatment payment or health care operations. I also understand you are not required to agree to my requested restricts, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PERSONAL INFORMATION CAN BE GIVEN ONLY TO THOSE YOU LIST

1. Please list the **name** and **relation** and **phone number** of any person(s), if any, whom we may inform about your general medical condition, your diagnosis, prognosis **AND APPOINTMENTS**. (i.e. spouse, sibling, school nurse, or other.)

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2. Please list the **name** and **home number,** if any to whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**

_____

_____

2. If other than your home address, please print the primary address of where you would like all correspondence from our office sent. _____
3. If other than you home phone number, please print the telephone number of where you want to receive calls about your appointments, lab and x-ray results or other health care information. _____
4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "**CONFIDENTAL"**
5. **Appointment reminders may be texted to you. Please indicate if you do not want us to text your appointment reminders. Please inform the front desk in writing when turning in paperwork.**

By my signature below I give Wright Chiropractic permission to contact me, and/or leave me messages using any of my contact information collected in my paperwork unless specifically excluded here: Do not contact me at:_____

_____ _____ _____

Signature of Patient /Representative Printed Name of Patient Date

INFORMED CONSENT
Wright Chiropractic Health Center, PA
702B Eureka St
Weatherford, TX 76086

PATIENT NAME _____

The primary treatment used by doctors of chiropractic is the spinal manipulation, also called spinal adjustments. Extremity adjustments may also be performed if your case warrants.

- **The nature of the chiropractic adjustment.**
  The doctor will use their hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.
- **This is a multi-doctor office.**
  This is a multiple doctor office. While you will have a primary provider who sees you the most, you will on occasion be seen by a different doctor in the office or if appropriate, transferred to one of the other doctors in the office. By signing this consent, you are agreeing to this and understand.
- **The material risks inherent in chiropractic adjustment.**
  As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, nausea, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.
- **The probability of those risks occurring.**
  Muscle soreness, tightness, and general discomfort is the most common reaction to the adjustments, especially in the beginning of treatment. Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."
- **Ancillary treatments.**
  In addition to chiropractic adjustments, the Doctor may use additional following treatments:

Electrical Muscle Stim
Ice Therapy
Heat Therapy
Ultrasound/Iontophoresis
Cold Laser Therapy
Traction
Kinesiotaping
Flexion/Distraction
Nutritional Counseling/Supplements
Massage
Exercise and Stretching Rehab
Balance and Proprioception Training

These treatments involve the following additional significant risks:
Potential Burns, injuries from falls/loss of balance, muscle injuries, frostbite

- **The availability and nature of other treatment options.**
  Other treatment options for your condition will be discussed in your Report of Findings and may include (but are not limited to:)
  - Self-administered, over-the-counter analgesics and rest
  - Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers. Physical Therapy
  - Hospitalization with traction Massage
  - Surgery

- **The material risks inherent in such options and the probability of such risks occurring include:**
  - Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

  - Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.

  - Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

  - The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mis- hap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.
- **The risks and dangers attendant to remaining untreated.**
  Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high. Eventual Surgery May arise from lack of treatment or failure to follow-through with recommendations.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Heather Wright and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____

DATE Printed Name

_____

Signature

_____

Signature of Parent or Guardian (if a minor)

Patient Name:_____Date:_____ Signature:_____

General Oswestry Disability Index

everyone must complete

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.
- ❑ I can look after myself normally but it is slightly painful.
- ❑ 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 my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, 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 (i.e. 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 only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than ¼ of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ 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 sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

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 me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ an hour.
- ❑ Pain prevents me from standing for more than 10 minutes.
- ❑ Pain prevents me from standing at all.

Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but causes some extra pain.
- ❑ My sex life is nearly normal but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

Section 9 – Social Life

- ❑ My social life is normal and causes 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, i.e. sports.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

Section 10 – Traveling

- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over two hours.
- ❑ Pain restricts me to short necessary journeys under 30 minutes.
- ❑ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ❑ No
- ❑ Yes (if yes, please state the type of treatment you have received)

Name:_____ Date:____/____/_____

Low Back Pain

Everyone must fill out

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box which most closely describes your current condition**.

Pain Intensity

- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad but I can manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me with moderate relief from pain.
- ☐ Pain medication provides me with little relief from pain.
- ☐ Pain medication has no affect on my pain.

Personal Care (Washing, Dressing etc.)

- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Lifting

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (ex. 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 only very light weights.
- ☐ I can not lift or carry anything at all.

Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk with crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

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 for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Standing

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but increases my pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than ½ hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Sleeping

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

Social Life

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex. sports, dancing etc.)
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Traveling

- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ My pain restricts travel over 2 hours.
- ☐ My pain restricts my travel over 1 hour.
- ☐ My pain restricts my travel to short necessary journeys under ½ hour.
- ☐ My pain prevents all travel except for visits to the doctor/therapist or hospital.

Employment/Homemaking

- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pan prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores

George's Test

Patient Name_____ Date:_____

Please circle the correct response, and sign and date when completed.

Have you ever been diagnosed or told you have any of the following?

1. High Blood Pressure (hypertension)	Yes	No
2. Hardening of the arteries (arteriosclerosis)	Yes	No
3. Diabetes	Yes	No
4. Heart or Blood Vessel disease	Yes	No
5. Bone spurs in your neck (cervical spondylosis)	Yes	No
6. Whiplash injury or cervical sprain	Yes	No
7. Have any of your blood relatives suffered a stroke?	Yes	No
If yes, WHO:_____		
8. Were you ever a smoker? From_____to_____	Yes	No
9. Do you take any medication on a regular basis?	Yes	No
What?(Cumadin, heparin, aspirin, anti-hypertension, etc)		
SAME AS INTAKE or:_____		
10. For Women: Have you ever taken oral contraceptives?	Yes	No
From_____ to _____		

Have you had any of the following, even short, temporary attacks **in the last year**?

11. Blurred Vision	Yes	No
12. Double Vision	Yes	No
13. Diminished or partial loss of vision in one or both eyes	Yes	No
14. Complete loss of vision in one or both eyes	Yes	No
15. Ringing, buzzing, or unusual noise in the ear(s)	Yes	No
16. Hearing loss in one or both ears	Yes	No
17. Slurred speech or other such speech problems	Yes	No
18. Difficulty swallowing	Yes	No
19. Dizziness	Yes	No
20. Temporary lack of understanding	Yes	No
21. Loss of consciousness, even momentary blackouts	Yes	No
22. Numbness or loss of sensation in your face, hands, feet or other parts of your body	Yes	No
23. Any other abnormal sensations in your body	Yes	No
24. Weakness, clumsiness or loss of strength in any body part	Yes	No
25. Sudden collapse without loss of consciousness?	Yes	No

Patient Signature Date

DOCTOR'S NOTES Hypertension & Subclavian Artery Stenosis/Occlusion (seated)

1. Record the blood pressure : LEFT ___/____ RIGHT ____/_____ see exam

2. Is this indicative of hypertension?	Yes	No
3. Is there >10 mmHg difference b/w arms	Yes	No
4. Is the radial artery on the low side feeble on unpalpable	Yes	No
5. Is there a bruit over the subclavian artery either side (if bruit then poss vasc consult before other procedures)	Yes	No

(if bruit then poss vasc consult before other procedures)

Carotid artery Stenosis/Occlusion

6. Is there a bruit over either Carotid bifurcation	Yes	No
7. Is either bifurcation feeble or absent palpably comparatively	Yes	No

(If either stenosis or occlusion is suspected, do not due the last maneuver)

Vertebro-Basilar Artery Functional Maneuver

Have the patient do full rotation and hyperextension, counting down from 20. Bilateral.

Did any of the following occur: Slurred speech, nystagmus, dizziness, faintness, blurred vision, etc Yes No

_____ _____

Examiner's Initials Date symptom was: while in position or when coming back from position

Wright Chiropractic Health Center
Patient Privacy Rights- Patient Information

Patient information will remain completely confidential and will never be sold. Patient information obtained in permanent records will be used solely for the business of Wright Chiropractic Health Care. Any disposal of records will be done in such a manner that the information contained within will be illegible and unobtainable to other parties. This will include any or all of the following: shredding, incineration, and silver recovery. Use of Patient information for marketing will not occur without your written permission, excluding any face-to-face disclosures or community service promotions.

While every attempt to protect your information will be made, overheard communications in the office may be unavoidable. Calling your name in the waiting room and sending mail to your house are all considered routine and normal disclosures.

Non-routine disclosures of patient information will not be released without a written valid authorization by the patient. This includes release of any information to family, friends, attorneys, insurances that are not the patient's health insurance company, and any other such release.

You have the following rights with your Protected Health Information (PHI) :

1) The right to have access to, review, and request changes of errors to your health records
2) The right to obtain a copy of these records at a reasonable cost incorporating the supplies and labor of copying and postage (if applicable.)
3) The right to protest procedures you feel are not protecting your PHI and submit a complaint to Dr. Wright, the privacy director.
4) In the case of an independent minor, the health care provider will use her discretion to approve or deny access of the minor's records to a parent.
5) For non-routine use or information disclosure, the patient will have to grant written permission. Routine releases of information that would not require express patient permission includes all activities to carry out treatment, payment, or health care operations.
6) The right to object to specific disclosure by Wright Chiropractic.
7) The right to receive notice of how your PHI will be used by Wright Chiropractic Health Center
8) The right to receive information by an alternative means. This office will use your home address and phone number and occasionally your work number, all provided by you on your intake form, to issue reminders and correspondence. Should you desire not to be contacted using that information, you may provide an alternative way for the office to contact you. In the case of an emergency, your emergency contact will be used.
9) The right to receive an accounting for all disclosures by this office
10) The right to file a formal complaint with the Secretary of the Department of Health & Human Services concerning any breach of these rights.