

Welcome to Vermillion Chiropractic, P.C.

Financial Agreement and Office Policies

Notice: Everything done in this office either for diagnostic or treatment purposes is a valuable and billable service and it is the patient's responsibility to know what chiropractic services their insurance covers. If you do not understand why a procedure is being down or have a question of the cost of a service please ask. We are happy to explain the purpose and cost of any service. If you make an advance appointment and for some reason you must miss your appointment, it is **your responsibility** to notify this office at least 1 hour before your appointment time or Vermillion Chiropractic, P.C. reserves the right to charge your account for the missed office visit. If your account is 30 days past due, Vermillion Chiropractic, P.C. reserves the right to add a service charge up to 20% per annum or \$5 per month to your total remaining balance.

____ I will pay any insurance indicated co-pay or deductible fees that are due after each office visit or after an explanation of benefits has been received from the insurance company. **I understand that it is my responsibility to know what my chiropractic benefits are.**

____ I have no health insurance or health insurance will not cover Chiropractic care and will pay full balance after each visit.

____ I will provide Vermillion Chiropractic, P.C. with auto insurance for billing, understanding that I am ultimately responsible for payment of all charges that may accrue to my account.

____ Worker's compensation claims will be billed accordingly under the patient's work comp. insurance with the understanding that if any service is denied the patient is personally responsible for their account balance unless other agreements have been made.

____ Medicare will cover the adjustment fee only. Medicare does not cover exam, x-ray or any other service provided by this office. All services will be billed to Medicare and patient's supplemental insurance.

____ Medicaid patient will pay \$1.00 per visit for an adult. There is no co-pay for children under 18 years of age.

Patient Contact Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: Male Female Date of Birth: _____ Age: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Single Married Divorced Widowed **E-Mail (contact purposes only):** _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse's or Parent's Name(s): _____

How did you find out about our office? _____

Emergency Contact: _____ Number: _____

By signing, I have read and understand all information contained in this document that pertains to my account with Vermillion Chiropractic, P.C. and I authorize the release of necessary information for review by any third party responsible for payment where applicable.

Patient Signature _____ Date: _____

Patient Intake Questionnaire

List any **Allergies:**

- Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Penicillin Ragweed/Pollen Rubber
 Seasonal Allergies Shellfish Soaps Wheat X-Ray Dye Other: _____

List any **Surgeries:**

- Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist Other: _____
 None

List **ALL Past Medical History** conditions:

- Ankle Pain Arm Pain Arthritis Asthma Back Pain Broken Bones Cancer Chest Pains Depression Diabetes
 Dizziness Elbow Pain Epilepsy Eye/Vision Problems Fainting Fatigue Foot Pain Genetic Spinal Condition
 Hand Pain Headaches Hearing Problems Hepatitis High Blood Pressure Hip Pain HIV Jaw Pain Joint Stiffness
 Knee Pain Leg Pain Menstrual Problems Mid-Back Pain Minor Heart Problem Multiple Sclerosis Neck Pain
 Neurological Problems Pacemaker Parkinson's Polio Prostate Problems Shoulder Pain Significant Weight Change
 Spinal Cord Injury Sprain/Strain Stroke/Heart Attack Other: _____

List **Names of Medications/Dietary Supplements** you are taking:

- None 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Reason: Anxiety Muscle Relaxers Pain Killers Insulin Birth Control Cardiovascular Allergy Seizure

List your **Family History:**

- Arthritis Asthma Back Pain Cancer Depression Diabetes Epilepsy Genetic Spinal Condition High Blood Pressure
 Heart Problems Multiple Sclerosis Neurological Problems Parkinson's Polio Prostate Problems Stroke/Heart Attack
 Other: _____

What is your favorite position to sleep in? Back Side Stomach

How much water do you drink per day? _____ oz.

Have you had any auto or other accidents? No Yes

Describe: _____

Date of last physical examination: _____

Do you smoke? No Yes

Do you drink alcohol? No Yes – how many per day? _____

Do you drink caffeine? No Yes – how many per day? _____

Do you exercise? No Yes (what forms and how often? _____

Very Important

Have you ever had chiropractic care? No Yes

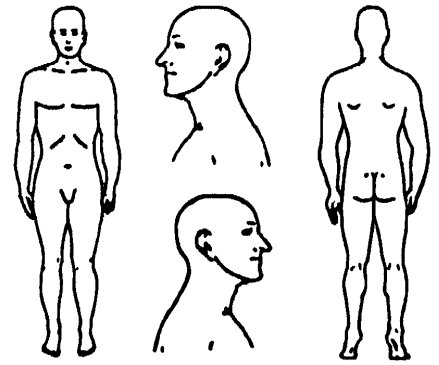
When? _____ Why? _____

Where? _____

Were X-rays take? No Yes

When was your last adjustment? _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM



What is your major complaint? _____

Date problem began? _____

How did this problem begin (falling, lifting, etc.) _____

Have you had this condition in the past? No Yes

Please rate your symptoms on a scale of 0 to 10 (0= no pain and 10= excruciating pain)

- 0 1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities? (0= no effect and 10= no possible activities)

- 0 1 2 3 4 5 6 7 8 9 10

How is your condition changing since you first noticed your symptoms?

- Getting Better Getting Worse Staying the Same

How intense is the pain?

- Minimum Mild Moderate Severe Unbearable

Describe what your symptoms feel like:

- Burning Dull Numb Radiating/Traveling* Sharp Shooting Stabbing Tightness Tingling Throbbing

*If pain radiates or travels to another body part (legs, arms, head, etc.) where does the pain travel to? _____

What makes your pain better?

- Chiropractic Therapy Heat Ice Pain Medicine Sleep/Rest Stretching Exercise

What do you expect out of today's visit?

- Become pain free Learn how to manage condition Reduce Symptoms Resume Normal Activity

How often do you experience your symptoms?

- Constant (76 – 100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

What activities aggravate your condition (working, exercise, etc.)? _____

What made you choose chiropractic as a treatment for a condition? _____

What is your SECOND complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.) _____

Have you had this condition in the past? No Yes

Please rate your symptoms on a scale of 0 to 10 (0= no pain and 10= excruciating pain)

- 0 1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities? (0= no effect and 10= no possible activities)

- 0 1 2 3 4 5 6 7 8 9 10

How is your condition changing since you first noticed your symptoms?

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Pain Questionnaire

Pain Intensity:

- 0 I have no pain.
- 1 Pain comes and goes and is very mild.
- 2 Pain is constant and is very mild.
- 3 Pain comes and goes and is moderate.
- 4 Pain is constant and is moderate.
- 5 Pain is constant and is severe.

Personal Care:

- 0 I look after myself normally w/o causing extra pain.
- 1 I look after myself normally but it causes extra pain.
- 2 It is painful looking after myself; I am slow/careful.
- 3 I need help but manage most of my personal care.
- 4 I need help every day in most aspects of self-care.
- 5 I don't get dressed, was w/difficulty, stay in bed.

Lifting:

- 0 I can lift heavy weight w/o extra pain
- 1 I can lift heavy weight but it causes extra pain.
- 2 Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- 3 Pain prevents lifting heavy weights but I can manage medium conveniently positioned weights.
- 4 I can only lift very light weights.
- 5 I cannot lift or carry anything at all.

Walking:

- 0 Pain does not prevent me walking any distance
- 1 Pain prevents me from walking more than one mile.
- 2 Pain prevents me from walking more than ½ mile.
- 3 Pain prevents me from walking more than ¼ mile.
- 4 I can only walk using a cane or crutches.
- 5 I am in bed most of the time and crawl to the toilet.

Sitting:

- 0 I can sit in any chair as long as I like.
- 1 I can only sit in my favorite chair as long as I like.
- 2 Pain prevents me from sitting for more than 1 hour.
- 3 Pain prevents me from sitting for more than ½ hour.
- 4 Pain prevents me from sitting for more than 10 min.
- 5 I avoid sitting as it increases my pain straight away.

Standing:

- 0 I can stand as long as I want w/o extra pain.
- 1 I can stand as long as I want but w/ extra pain.
- 2 Pain prevents standing for more than 1 hour.
- 3 Pain prevents standing for more than ½ hour.
- 4 Pain prevents standing for more than 10 min.
- 5 Pain prevents me from standing at all.

Sleeping:

- 0 I have no trouble sleeping.
- 1 I can only sleep well by taking medications.
- 2 I get less than 6 hrs before the pain wakes me.
- 3 I get less than 4 hrs before the pain wakes me.
- 4 I get less than 2 hrs before the pain wakes me.
- 5 Pain prevents me from sleeping at all.

Changing Degree of Pain:

- 0 My pain is decreasing and I am getting better.
- 1 My pain fluctuates but I am getting better.
- 2 My pain is decreasing; improvement is slow.
- 3 My pain is not changing – not better or worse.
- 4 My pain is increasing; gradually getting worse.
- 5 My pain is rapidly increasing – getting worse.

Social Life:

- 0 My social life is normal and no extra pain.
- 1 My social life is normal but increases pain.
- 2 Pain has no significant effect on my social life apart from limiting more energetic interests.
- 3 Pain restricts my social life; I don't go out often.
- 4 Pain has restricted my social life to my home.
- 5 I have no social life because of pain.

Pain Intensity:

- 0 I can travel anywhere w/o extra pain
- 1 I can travel anywhere but with extra pain.
- 2 Pain is bad but I can take journeys over 2 hrs.
- 3 Pain restricts me to journeys less than 1 hr.
- 4 Pain restricts me to short journeys under ½ hr.
- 5 Pain prevents travel, except to my doctor.

Patient Signature _____

Date: _____

Informed Consent Form

Patient Name: _____ Date: _____

Provider Name: Paul J. Roob, D.C.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including examination, test, various modes of physical therapy and/or diagnostic X-rays, on me (or on the patient named above, for whom I am legally responsible) which are recommended by the doctor of chiropractic named above, and/or other licensed doctors of chiropractic who now or in the future render treatment to me, while employed by, work for, or at, the office, or at any other related office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic and / or with other office or clinic personnel the nature, purpose and any risk of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disk injuries, strokes, dislocations, paralysis and strains/sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known by him, is in my best interest.

I have read, or have had read to me, the above explanation of chiropractic adjustment and related treatment. By signing below, I state that I have weighted the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks. I hereby give my consent to that treatment. I intend this consent for to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I have received, or been offered a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact Paul J Roob D.C. at Vermillion Chiropractic Clinic (605-624-9101). I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

Patient Signature: _____ Date: _____

Auto Accident

Name: _____ Accident date: _____

I was: Driving with both/left/right hand on the wheel Passenger in the front/back seat.

Vehicle was (parked, speeding, slowing down, etc.):

Where was your vehicle hit?

Light conditions: Dawn Dusk Full Daylight Night

Road conditions: Dry Damp Wet Ice Covered Snow Covered

Visibility: Fair Poor Excellent Good

Bracing Status: I was able to brace for the impact

I was aware the accident was impending but unable to brace

I was not aware the accident was impending

Opposing vehicle type _____

Opposing vehicle speed _____ My vehicle speed _____ Headrest Position: High Middle Low Not Sure

Admitted to hospital: yes/no Admission time: _____ Number of Days: _____

Transportation to hospital: _____ Doctor: _____

Injury Locations:

Front of head

Left arm

Right arm

Chest

Back of head

Left hand

Right hand

Low back

Left of head

Fingers on left hand

Fingers on the right hand

Mid back

Right of head

Left shoulder

Right shoulder

Upper back

Forehead

Left elbow

Right elbow

Front of neck

Nose

Left leg

Right leg

Back of neck

Front of face

Left hip

Right hip

Left of neck

Left of face

Left knee

Right knee

Right of neck

Right of face

Left shin

Right shin

Left wrist

Right wrist

Additional Information:

Activities of Daily Living

Please write in the appropriate number. Only answer the items that apply to you.

- 1 = I can do it without any difficulty.
- 2 = I can do it without much difficulty.
- 3 = I manage to do it by myself, despite marked pain.
- 4 = I manage to do it, despite the pain, but only if I have help.
- 5 = I cannot do it at all, because of the pain.

Personal Care and Hygiene

- Bathing
- Drying hair
- Brushing teeth
- Putting on shoes
- Showering
- Combing hair
- Tying shoes
- Eating
- Doing laundry
- Washing hair
- Washing face
- Putting on pants
- Cooking meals
- Doing dishes
- Going to the bathroom
- Family care
- Child care
- Sleeping

Physical Activities

- Standing
- Standing a long time
- Walking
- Walking distances
- Bending back
- Bending forward
- Twisting left
- Twisting right
- Sitting
- Kneeling down
- Reaching
- Climbing

Functional Activities

- Carrying small items
- Carrying large items
- Exercising
- Lifting off table
- Lifting off floor
- Carrying briefcase
- Carrying purse
- Work related functions

Social and Recreational Activities

- Bowling
- Jogging
- Swimming
- Skating
- Competitive sports
- Riding bike
- Golfing
- Dancing
- Skiing
- Hobbies
- Dining out
- Dating

Traveling

- Driving Car
- Riding in car
- Riding in a train
- Driving for long periods
- Riding in an airplane
- Riding a motorcycle

Use this scale for the following question.

- 1 = This area is not affected by my condition.
- 2 = This area is slightly affected by my condition.
- 3 = My condition moderately restricts my ability in this area.
- 4 = My condition severely limits my ability in this area.
- 5 = My condition prevents me from using this ability.

Communication

- Concentrating
- Hearing
- Listening
- Speaking
- Reading
- Writing
- Typing
- Computers
- Cell phones

Sense

- Seeing
- Hearing
- Touch
- Taste
- Smell

Hand Function

- Grasping
- Holding
- Pinching
- Sensory discrimination

Sleep and Sexual Function

- Able to have normal, restful sleep
- Able to participate in sexual activity

Back Pain Questionnaire

Please check only the sentences that describe you today.

- I stay at home most of the time because of my back.
- I change position frequently to try to get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back, I am not doing any jobs that I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back, I lie down to rest more often.
- Because of my back, I have to hold on to something to get out of man easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly than usual because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel down.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back.
- I have trouble putting on my socks (or stockings) because of the pain in my back.
- I can only walk short distance because of my back pain.
- I sleep less well because of my back.
- Because of my back pain, I get dressed with the help of someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of my back pain, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

Signature: _____ Date: _____