Loudon Chiropractic
806 Mulberry Street
Loudon, TN. 37774
P: 865-657-9941
F: 865-657-9942

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____
Gender: M F Date of Birth: ____/____/_____ Age: _____ SSN: _____ - _____ - _____
Home Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Work Phone: _____
Occupation: _____ Employer Name: _____
Employer Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____

SPOUSE OR GUARDIAN

Last Name: _____ First Name: _____ Middle: _____
Primary Phone: _____ Employer Name: _____
Date of Birth: ____/____/_____ SSN: _____ - _____ - _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____ Middle: _____
Primary Phone: _____ Relation to Patient: _____

MY PRIVACY

I have received or have seen a copy of the **Notice of Privacy Practices**. I understand that I have certain rights 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 care among the health providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payers; Conduct normal healthcare operations such as quality assessments and accreditation.

X _____ Date: _____
Signature of patient or persons acting on patient's behalf

MEDICAL HISTORY

Do you have, or have you had, any of the following?

If yes, please explain:

- ☐ Asthma/Breathing Problems_____
- ☐ Arthritis_____
- ☐ Bleeding/Clotting Disorder_____
- ☐ Blood Pressure Disorder_____
- ☐ Blood Transfusion
- ☐ Gastrointestinal Problems_____
- ☐ Cancer _____
- ☐ Cholesterol Disorder_____
- ☐ Diabetes_____
- ☐ Eye Disorder_____
  (i.e. Glaucoma, Cataracts, etc.)

If yes, please explain:

- ☐ Heart Disease/Disorder_____
- ☐ Lung Disorder_____
- ☐ Liver Disease
- ☐ Neurological Disorder_____
- ☐ Chronic Headaches
- ☐ Psychiatric Disorder_____
- ☐ Pulmonary Embolism/DVT
- ☐ Stroke
- ☐ Seizures or Epilepsy
- ☐ Thyroid Disorder_____
- ☐ Urinary/Kidney Disorder_____

Please list any other medical conditions: _____

Please list all past surgeries and hospitalizations with the approximate date: _____

Please list all current medications and doses: _____

Do you currently smoke? Y N Do you drink alcohol? Y N Do you use recreational drugs? Y N

I certify that the information that I have given thus far is true and accurate to the best of my knowledge.

Signed: _____ Date: _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

_____

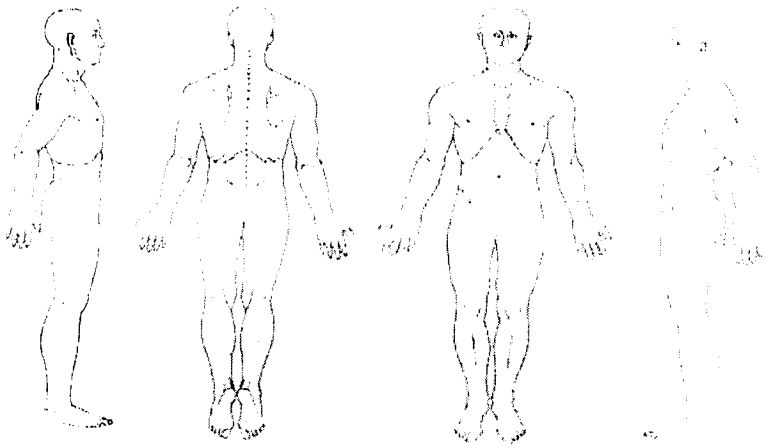
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past?

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

10. What is your occupation?

_____

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ **Date** _____

Functional Rating Index

For use with neck and/or back problems. For each item below, please **circle the number** which most closely describes your **condition right now**.

Patient Name: _____ Date: _____

1. **Pain Intensity**

0-No Pain	1-Mild Pain	2- Moderate Pain	3-Severe Pain	4-Worst Possible Pain

2. **Sleeping**

0-Perfect Sleep	1-Mildly Disturbed	2-Moderately Disturbed	3-Greatly Disturbed	4-Totally Disturbed Sleep

3. **Personal Care**

0-No Pain; No Restrictions	1-Mild Pain; No Restrictions	2-Moderate Pain; Go Slowly	3-Severe Pain; Some Assistance	4-Worst Possible Pain; 100% Assistance

4. **Travel (Driving, etc.)**

0- No Pain on Long Trips	1-Mild Pain on Long Trips	2-Moderate Pain on Long Trips	3-Moderate Pain on Short Trips	4-Severe Pain on Short Trips

5. **Work**

0-Usual Work + Extra	1-Usual Work, No Extra	2-50% of Usual Work	3-25% of Usual Work	4-Cannot Work

6. **Recreation**

0-All Activities	1-Most Activities	2-Some Activities	3-Few Activities	4-No Activities

7. **Frequency of Pain**

0-No Pain	1- Occasional (25%)	2-Intermittent (50%)	3-Frequent (75%)	4-Constant (100%)

8. **Lifting**

0-No Pain with Heavy Weight	1-Increased Pain with Heavy Weight	2-Increased Pain with Moderate Weight	3-Increased Pain with Light Weight	4-Increased Pain with Any Weight

9. **Walking**

0-No Pain with Any Distance	1- Increased Pain after 1 Mile	2-Increased Pain after ½ Mile	3-Increased Pain after ¼ Mile	4-Increased Pain after Any Distance

10. **Standing**

0-No Pain with Any Time	1- Increased Pain after Several Hours	2-Increased Pain after 1 Hour	3-Increased Pain after ½ Hour	4-Increased Pain after Any Time

Patient or Guardian Signature: _____ **Date:** _____

**********For Office Use Only**********

Total : _____(/4, x10) = **Functional Rating Score:** _____%

Treating Doctor Signature: _____ **Date:** _____

Loudon Chiropractic
Drs. Christopher & Stephanie Estes
806 Mulberry Street
Loudon, TN 37774
P: 865-657-9941

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Please CIRCLE the number that best describes the question being asked.
Indicate your pain level RIGHT NOW, your AVERAGE pain, and your pain at ITS BEST AND WORST.

1) What is your pain level **RIGHT NOW**?

No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

2) What is your **TYPICAL** or **AVERAGE** pain?

No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

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

No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

4) What is your pain level **AT ITS WORST** (How close to "1-" does your pain get at its worst)?

No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____
_____
_____

Consent for Treatment
And
Authorization to Perform X-rays

In the chance that diagnostic x-rays are advisable, please read and sign the consent below.

Date: _____ Time: _____ am/pm

I have been informed, by Dr. Estes, that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem or illness. I authorize Dr. Estes to perform such a radiographic examination. To the best of my knowledge, I am not pregnant as this procedure could cause harm to an un-born child.

Signed: _____

Witness/Staff: _____

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(865) 657-9941

Authorization to Release Information, Notice of Assignment, and Financial Policy

Consent for Treatment: I hereby consent to the performance of any examinations, procedures, or treatments deemed necessary by the attending health care provider.

Financial Policy Regarding Health Insurance Claims:

- Loudon Chiropractic offers direct billing to your insurance company for chiropractic treatments and services.
- As a courtesy, Loudon Chiropractic will verify insurance on your first visit. We highly recommend that you verify your coverage as well because information we receive over the phone is not guarantee of payment.
- Co-payments and estimated Co. Insurance amounts are due at the time of service. Additionally, full visit payment may be required until any deductible amount that may apply is satisfied.
- Loudon Chiropractic is acting as agent for the patient in filling claims for payment of the patient's services. However, Loudon Chiropractic assumes no responsibility for guaranteeing that billed charges will be covered.
- All services rendered by this office are charged directly to you, and you ultimately, will be personally responsible for payment, regardless of your insurance coverage.
- If payment of patient responsibility is not received upon request, service charges/interest/collection fees may be applied.
- There is a $25.00 service charge for all returned checks.
- It can take approximately 30-60 days or more for an insurance claim to be processed and paid to this office. This can cause a delay in billing to your account for disallowed services.
- We urge you to keep us informed of any changes made to your health insurance coverage to ultimately save you and Loudon Chiropractic time and money.

Authorization to Release Information: I authorize Loudon Chiropractic to release my information as necessary to my insurance provider, attorney, or adjuster in order to process claims for reimbursement of charges incurred by me as a result of professional services.

Notice of Assignment: I authorize Loudon Chiropractic to receive direct payment of any expense benefits allowable as payment toward the total charges for professional services rendered to me. This payment will not exceed my indebtedness to the assignee. I agree that a photo static copy of this agreement shall serve as the original.

Signature _____ Date _____

Witness _____ Date _____

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Informed Consent

This disclosure is not meant to frighten or alarm you. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent. Please feel free to ask any questions you may have.

Adjustments are made by chiropractors in order to correct spinal and extremity joint subluxations. This condition is one of the most common disturbances to the nervous system and involves one or vertebrae in the spine that have misaligned sufficiently enough to cause interference and or irritation to the nervous system. The primary goal in chiropractic health care is the removal of nerve interference caused by subluxation.

A chiropractic exam will be undergone which may include spinal and physical examinations, orthopedic and neurological testing, palpation, radiological examination, and laboratory testing.

The chiropractic adjustment is the application of precise, high velocity movement of the spine over a very short distance. There are a number of different methods or techniques by which the chiropractic adjustment is delivered. Chiropractic adjustments are typically delivered by hand, but some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included to manage a case properly.

In addition, to the benefits of chiropractic care, one should be aware of the existence of some risks and limitations of this care. These risks are seldom high enough to contraindicate care but should still be considered. All health care procedures have some risk associated with them. Risks associated with chiropractic care may include musculoskeletal soreness/sprain/strain, neurological injury, fracture, vertebral artery syndrome (VAS) including stroke and perhaps death through complicating factors. No research to date provides a direct link to chiropractic care and VAS. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain.

Consent for Chiropractic Care

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me regarding the results of chiropractic care. I have read the above paragraphs. I understand the information provided and all questions I have about this information have been answered to my satisfaction. Having this information, I knowingly authorize Loudon Chiropractic to proceed with care and treatment.

_____ Signature _____ Date

_____ Staff _____ Date

No Show / Late Cancellation Policy

Effective 1/5/23, Loudon Chiropractic/Kingston Chiropractic will implement the following policy regarding no show/late cancellation appointments.

Our policy is no different than most other medical offices' policies and is now a requirement to begin/continue care with us. For most, this will not affect anything regarding your appointments but sadly the abuse of a few patients has made this policy necessary.

A no show/late cancellation appointment is defined as a patient appointment that has not been attended with no communication or rescheduled with a notice of at least 24 hours of the original appointment time. We make every attempt to notify you of upcoming appointments via appointment cards, and/or automated reminders via email, text, or phone. If you do not get the reminders, please check with us regarding your preferences to ensure you receive the notifications. We are aware things happen unexpectedly and therefore will offer a free forgiveness on one appointment that is missed or rescheduled with less than a 24 hour notice. Any future no show/late cancellations will incur a non-billable $25 fee that must be paid before receiving your next service.

Patient Signature _____

Date ___/___/___