

# Complete Chiropractic, P.C.

1446 W. Patrick St- Unit 14

Frederick, MD 21702

<p>Date _____ SS# _____</p> <p>Name _____</p> <p>Address _____</p> <p>_____</p> <p>Home # _____ Cell# _____</p> <p>E-Mail Address _____</p> <p>Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age: _____ DOB: _____</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed</p> <p>Employer: _____</p> <p>Employer Address: _____</p> <p>_____</p> <p>Employer Phone: _____</p> <p>Occupation: _____</p> <p>Spouse's Name: _____</p> <p>Spouse DOB: _____ Spouse SS# _____</p> <p>Emergency Contact: _____</p> <p>Relationship to Patient: _____</p> <p>Home# _____ Cell# _____</p> <p>Children: _____</p> <p>Names and Ages</p> <p>Primary Care Dr: _____</p> <p>Dr's Address: _____</p> <p>Send a report to your Dr? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Whom may we thank for referring you?</p> <p>_____</p>	<div style="border: 1px solid black; padding: 5px; text-align: center;"><b>INSURANCE</b></div> <p>Insurance Co. Name: _____</p> <p>ID# _____ Group# _____</p> <p>Group Name: _____</p> <p>Policy Holder: _____</p> <p>DOB: _____ SS# _____</p> <p>Relationship to Patient _____</p> <p>Additional Insurance?      Yes      No</p> <p>Subscriber's Name _____</p> <p>DOB: _____ SS# _____</p> <p>Relationship to Patient _____</p> <p>Insurance Co. _____</p> <p>Group # _____</p> <p><b>Assignment of Benefits:</b> I, the undersigned, certify that I ( or my dependant) have insurance coverage with the above company and assign directly to Dr. Gary Schreiber/Complete Chiropractic, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.</p> <p>_____</p> <p>Responsible Party Signature</p> <p>_____      _____</p> <p>Relationship      Date</p>
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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_, have reviewed a copy of this office's Notice of Privacy Practices.

I understand that 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 healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

Signature

Please Print Name

Date

## **TERMS OF ACCEPTANCE**

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named below and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocation, muscle strain, Homers' 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 complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named below and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedure. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation and its resultant dysfunctions. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

**COMPLETE CHIROPRACTIC /GARY SCHREIBER, D.C.**

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition (s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE:

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Representative (if patient is minor or handicapped)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness to Patients' Signature

\_\_\_\_\_  
Date

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**Frederick, MD 21702**

**Financial Policy**

Our office is committed to providing you the best chiropractic health care services possible. We have established our financial policies to achieve that goal while providing affordable options so that you and your family may participate and experience the Chiropractic Advantage!

***Our office policy is that all new patients pay the initial exam fee for that date of service. Our staff will then work to verify benefits and eligibility and base future patient responsibility on information provided to us by your insurance carrier***

\_\_\_ **CASH:** Payment is due at time of service unless participating in a PCD Plan. Services provided will be charged per the Standard Fee Schedule on the reverse of this sheet, unless other arrangements have been made.

\_\_\_ **HEALTH INSURANCE:** Our office will gladly verify benefits, file insurances and provide limited follow up support. However, remember ultimately, the patient is responsible for the services rendered and the account status. Insurance benefits are an agreement between you and your insurance carrier. Our office is not responsible for any wrong information provided by the insurance carrier or for any wrongly processed claims. If payment is not received from the insurance carrier within 60 days, payment in full from you is expected and you will be issued a refund when/if the insurance pays. Deductibles and co-pays are to be paid as insurance plans dictate for services rendered.

\_\_\_ **MEDICARE:** The current Medicare program does include limited chiropractic benefits. These benefits cover the chiropractic adjustment; however, do not cover examination, therapies, rehab or nutritional services. All co-pays, payments and non- covered services will be due at the time of service. These benefits are explained in detail on the Medicare Authorization & Assignment Form.

\_\_\_ **PERSONAL INJURY:** Although at fault parties or law suit settlements may eventually pay this office in full for services rendered, standard policy is to first utilize the patient's own Personal Injury Protection (PIP) coverage. Once PIP coverage is exhausted we will hold on account any remainder owed until the case has settled. However, regardless of payments and/or settlements the patient is ultimately responsible for the services rendered and the account status.

\_\_\_ **PREFERRED CHIROPRACTIC DOCTOR:** We have structured our PCD plans to maintain affordability by reducing office costs while providing our practice members the ability to participate in care, thus experiencing maximum health benefits.

\* PCD plans are non-transferable.

\* Family members are defined as spouse and legally dependent children within the same household, under 21 or enrolled in school.

***Any account credits will be determined after the practice member's re-exam.***

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**Projected Fees per Visit:**

**Projected Health Insurance Benefits:**

**Projected PCD Plan Benefits:**

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**I have read and I understand the above policies. I have initialed the one that applies to me.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Patient Signature

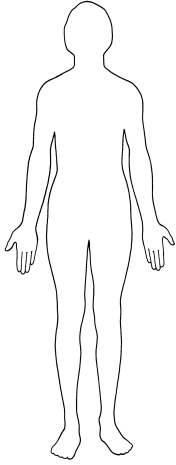
\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Initials

**Patient Initial Evaluation Data**

Name: \_\_\_\_\_

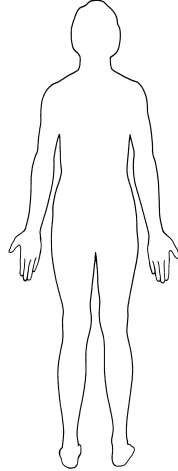
**PROBLEM DIAGRAM:**



FRONT



RIGHT SIDE



BACK



LEFT SIDE

**Place an "x" on the drawing below on areas causing you pain and a letter describing the pain using the following key:**

- |   |
|---|
| <p>A = ACHE<br/>         B = BURNING<br/>         S = STABBING<br/>         N = NUMBNESS<br/>         P = PINS &amp; NEEDLES<br/>         M = MUSCLE SPASM/ TIGHTNESS</p> |
|---|

**Complaint/Problem: In relation to your primary complaint:**

What is your primary complaint and the date it started? \_\_\_\_\_

How did you develop the complaint/became injured? \_\_\_\_\_

When did you first seek treatment for this problem and with whom: \_\_\_\_\_

What type of treatment was provided: \_\_\_\_\_

Did treatment help? \_\_\_ Y \_\_\_ N Describe: \_\_\_\_\_

What aggravates the problem: \_\_\_\_\_

What relieves the problem: \_\_\_\_\_

Is pain: \_\_\_ Deep \_\_\_ Superficial \_\_\_ Sharp \_\_\_ Dull \_\_\_ Burning \_\_\_ Tingling \_\_\_ Aching \_\_\_ Throbbing \_\_\_ Numb

Does the pain radiate and to where? \_\_\_\_\_

What is your pain RIGHT NOW?

No Pain 

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

 Unbearable Pain

What is your TYPICAL/AVERAGE pain prior to injury?

No Pain 

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

 Unbearable Pain

What is your pain level AT ITS BEST?

No Pain 

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

 Unbearable Pain

What is your pain level AT ITS WORST?

No Pain 

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

 Unbearable Pain

What percent of the time AWAKE is this pain a problem?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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How long have you had this problem:

\_\_\_ Less than 6 weeks \_\_\_ 6 weeks to 3 months \_\_\_ 3 months to 12 months \_\_\_ greater than 12 months

How many times in the past have you had the same or a similar pain/problem? \_\_\_ 0 \_\_\_ 1-2 \_\_\_ 3-4 \_\_\_ 5 or more

Which of the following statements best describe your pain?

- I have no pain
- Dull achy nagging pain
- Dull achy nagging pain that is occasionally sharp or stabbing
- Mostly sharp or stabbing
- Mostly sensations of burning, numbness or pins and needles

Which of the following statements best describe the location of your pain?

- I have no pain
- The pain is localized to the neck, head (if headache) or back
- The pain is localized to the neck, head (if headache) or back, but occasionally:
  - Radiates or travels into my shoulder, upper back or upper arm, but not below my elbow; or
  - Radiates or travels into my buttock, hip or leg, but not below my knee
- The pain radiates or travels most of the time:
  - Into my shoulder, upper back or upper arm, but not below my elbow; or
  - Into my buttock, hip or leg, but not below my knee
- The pain radiates or travels below my elbow or knee

Which of the following statements best describe the frequency of your pain?

- I have no pain.
- Intermittent: The pain occurs less than one fourth of the time when I am awake
- Occasional: The pain occurs between one fourth and one half of the time that I am awake
- Frequent: The pain occurs between one half and three fourths of the time that I am awake
- Constant: The pain occurs between three fourths and all of the time that I am awake

## Health Status Questionnaire

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

1. In general, would you say your health is:  
(circle one number)

- Excellent 1
- Very Good 2
- Good 3
- Fair 4
- Poor 5

2. Compared to one year ago, how would you rate your health in general now?  
(circle one number)

- Much better now than one year ago 1
- Somewhat better now than one year ago 2
- About the same 3
- Somewhat worse now than one year ago 4
- Much worse now than one year ago 5

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If yes, how much: (circle one number on each line)

	Yes, limited a lot	Yes, limited a little	No, not limited at all
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.	1	2	3
4. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf.	1	2	3
5. Lifting or carrying groceries.	1	2	3
6. Climbing several flights of stairs.	1	2	3
7. Climbing one flight of stairs.	1	2	3
8. Bending, kneeling, or stooping.	1	2	3
9. Walking more than a mile.	1	2	3
10. Walking several blocks.	1	2	3
11. Walking one block.	1	2	3
12. Bathing or dressing yourself.	1	2	3

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (circle one number on each line)

	Yes	No
13. Cut down the amount of time you spent on work or other activities.	1	2
14. Accomplished less than you would like.	1	2
15. Were limited in the kind of work or other activities.	1	2
16. Had difficulty performing the work or other activities. (for example, it took extra effort)	1	2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
17. Cut down the amount of time you spent on work or other activities.	1	2
18. Accomplished less than you would like.	1	2
19. Didn't do work or other activities as carefully as usual.	1	2
20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (circle one number)		
Not at all	1	
Slightly	2	
Moderately	3	
Quite a bit	4	
Extremely	5	

21. How much bodily pain have you had during the past 4 weeks? (circle one number)

- None 1
- Very mild 2
- Mild 3
- Moderate 4
- Severe 5
- Very Severe 6

22. During the past 4 weeks, how much did pain interfere with your normal work (including work outside the home and housework)?  
(circle one number)

- None at all 1
- A little bit 2
- Moderately 3
- Quite a bit 4
- Extremely 5

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

(circle one number on each line)

	All of the time	Most of the time	A good bit of the time	Some of the time	Little of the time	None of the time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. During the past 4 weeks, how much of the time has your physical health or emotional health problems interfered with your social activities? (like visiting with friends, relatives, etc.) (circle one number)

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

How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people.	1	2	3	4	5
34. I am as healthy as anybody I know.	1	2	3	4	5
35. I expect my health to get worse.	1	2	3	4	5
36. My health is excellent.	1	2	3	4	5

### **SYMPTOM HISTORY:**

**Please check  symptoms you currently have:**

Balance Impairment     Headaches     Loss of Memory     Loss of concentration     Vertigo     Ringing in Ears  
 Burning Eyes     Lightheadedness     Nausea     Depression     Visual/Sensory Disturbance

Medications/Supplements: \_\_\_\_\_

Allergies: \_\_\_\_\_

Accidents/Injuries/Falls: \_\_\_\_\_

Surgeries/Broken Bones: \_\_\_\_\_

I certify that this information is correct to the best of my knowledge. Patient Signature \_\_\_\_\_ Date \_\_\_\_\_