ORIGINAL

**APPLICATION FOR TREATMENT**
**INSURANCE OR SELF-PAY**

Date _____

Name _____ Age _____ Birthday _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security Number _____ Email _____

Whom should we thank for the referral? _____
Circle if you are: Married Single Widowed Divorced Separated
Employer _____ Occupation _____

Please describe the main reason(s) for which you came to this office: _____
_____

On a scale from 0-10, with 10 being unbearable pain, how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10

When and how did symptoms first occur? _____
_____
_____

List any other doctors seen for these problems. _____
_____

List diagnosis and types of treatment(s) _____
_____

Does this interfere with your normal living and work? Yes No If yes, in what way? _____
_____

Have you lost any days of work? Yes No Dates _____

Have you had similar symptoms or injuries before? Yes No If yes, explain. _____
_____

List the names of any relatives that have or have had a similar problem. _____
_____

Who is responsible for your bill (please circle)? Self Spouse Employer Insurance Other _____

**PAST HISTORY**

Has a physician treated you for any health condition in the last year? Yes No If yes, explain. _____
_____
Have you or any relative received chiropractic treatment previously? Yes No If yes, explain. _____
_____
List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones). _____
List all drugs or medications that you have used recently. _____
_____

**EMERGENCY CONTACT**

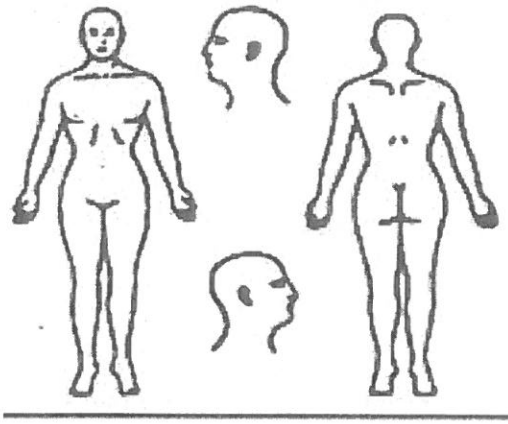
Name of emergency contact(s) _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Please mark your areas of pain on the figures below.



List the condition that you are most interested in getting corrected. List in order of importance:

1. _____
2. _____
3. _____
4. _____

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Exm: Sitting, walking, bending)

1. _____
2. _____
3. _____
4. _____

PATIENT NAME _____ DATE _____

# NECK PAIN DISABILITY INDEX (NPDI)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your activities daily living. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present - day situation.

## 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 worse imaginable at the moment.

## SECTION 2 - PERSONAL CARE

- ☐ 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 causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

## SECTION 4 – READING

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

## SECTION 5 – HEADACHES

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

## SECTION 6 – CONCENTRATION

- ☐ I can concentrate fully with no difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I can concentrate fully with moderate difficulty.
- ☐ I have a moderate degree of difficulty in concentrating fully.
- ☐ I have a great deal of difficulty in concentrating.
- ☐ I cannot concentrate at all.

## SECTION 7 – WORK

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

## SECTION 8 - DRIVING

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

## SECTION 9 - SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

## SECTION 10 – RECREATION

- ☐ I have no neck pain during all recreational activities.
- ☐ I have some neck pain with few recreational activities.
- ☐ I have neck pain with most recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain.

SCORE _____ [50]

PATIENT NAME _____ DATE _____

# OSWESTRY BACK PAIN INDEX QUESTIONNAIRE

This questionnaire is designed to help us better understand how your back pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation.

## SECTION 1 - PAIN INTENSITY

- ☐ My pain is mild to moderate. I do not need pain killers.
- ☐ The pain is bad, but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ ain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain.

## SECTION 2 - PERSONAL CARE

- ☐ 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 causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

## SECTION 4 – WALKING

- ☐ I can walk as far as I wish.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can walk only if I use a cane or crutches.
- ☐ I am in bed or in a chair for most of every day.

## SECTION 5 – SITTING

- ☐ I can sit in any chair for as long as I like.
- ☐ I can sit in my favorite chair only, but for 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 for more than 1 hour.
- ☐ Pain prevents me from standing more than 1/2 hour.
- ☐ 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 sleep well but only when taking medication.
- ☐ Even when I take medication, I sleep less than 6 hours.
- ☐ Even when I take medication, I sleep less than 4 hours.
- ☐ Even when I take medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

## SECTION 8 - SOCIAL LIFE

- ☐ Social life is normal and causes me no extra pain.
- ☐ Social life is normal, but increases the degree of pain.
- ☐ Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- ☐ 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 - SEXUAL ACTIVITY

- ☐ Sexual activity is normal and causes no extra pain.
- ☐ Sexual activity is normal, but causes some extra pain.
- ☐ Sexual activity is nearly normal, but is very painful.
- ☐ Sexual activity is severely restricted by pain.
- ☐ Sexual activity is nearly absent because of pain.
- ☐ Pain prevents any sexual activity at all.

## SECTION 10 – 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 restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to necessary journeys under ½ hr.
- ☐ Pain prevents traveling except to the doctor/hospital.

SCORE _____ [50]

BOUTWELL CHIROPRACTIC GROUP, P.C.

# AUTHORIZATION FORM

## CONSENT TO RECEIVE TREATMENT

FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS AND TREATMENTS ARE RECEIVED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC. I HEREBY GIVE PERMISSION FOR TREATMENT.

**Signature of Patient** _____ Social Security Number _____ Date _____

## RELEASE OF INFORMATION

**Patient's or Authorized Person's Signature:** I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card. I authorize payment of medical benefits to Boutwell Chiropractic Group for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.

**Signature**_____ Date_____

## INSURANCE DISCLAIMER

**The following policies with regards to insurance assignment are currently being enforced:**

1. Insurance companies will only pay what is covered in each individual's insurance policy. If your insurance policy does not cover any services rendered or supplies given to the patient, then the patient is responsible for all of these non-covered services, supplies, and treatment.
2. The deductibles must be met in full before assignment is accepted.
3. All accounts must be kept current on a weekly basis. There will be a missed appointment fee of $25.00 charged for all missed or cancelled appointments without 24 hours prior notice. All past due accounts will be charged interest and all other charges associated with collecting delinquent accounts.

I have been notified by Boutwell Chiropractic Group that if my insurance does not cover the services rendered, I am to be personally and fully responsible for the payment to Boutwell Chiropractic Group.

**Signature**_____ Date_____

Darrell T. Boutwell, D.C. • J. Randall Boutwell, D.C.
Beau E. Thigpen, D.C. • Robert B. Mall, D.C.
Chip Fischofer, B.S., P.S.E.

3665 Wheeler Road • Augusta, Georgia 30909 • Office: 706/860-8717 • Fax: 706/860-1341

Boutwell Chiropractic Group
3665 Wheeler Road, Suite 2A
Augusta, GA 30909

# Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

**First Name:**_____ **Last Name:**_____

**Email address:** _____@_____

**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail

**DOB:** __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

**Smoking Start Date (Optional):** _____

*CMS requires providers to report both race and ethnicity*

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Do you have any medication allergies?**

| Medication Name | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

***For office use only***

Height: _____ Weight:_____ Blood Pressure:_____/_____

# MEDICARE PATIENTS

MEDICARE does not pay Doctors of Chiropractic the same as they do the Doctors of Medicine

MEDICARE in the Chiropractic office ONLY PAYS FOR A MANUAL MANIPULATION (AFTER your deductible has been satisfied)

MEDICARE requires that the manual manipulation be made for a condition found on an x-ray, but Medicare DOES NOT PAY FOR THE X-RAY

MEDICARE DOES NOT PAY FOR EXAMINATIONS, THERAPIES, OR SUPPLIES. However, examinations are needed to find your health problem. Hot/cold packs, braces, pillows, and other orthopedic supports may also be deemed necessary for treatment, but at your expense.

MEDICARE only pays for manipulations that they determine to be medically NECESSARY. This is approximately 12 to 15 visits for acute conditions. Most supplemental policies to Medicare follow Medicare guidelines, and therefore also do not pay for non-covered charges. Please understand that it is your responsibility as a patient to inform your Doctor of any new conditions or injuries related to falls or accidents. It is critical that we are able to inform Medicare when this occurs.

MEDICARE requires that we give you this advance notice. Your signature acknowledges that you have been given this notice and that you agree to pay for services and supplies not covered by Medicare.

| DATE | SIGNATURE |
| --- | --- |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
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| _____ | _____ |
| _____ | _____ |