Shelby County Chiropractic ~ 1713 Midland Trail ~ Shelbyville, KY 40065 ~ (502)633-1073

PATIENT INFORMATION

Full Name _____ Date of Birth _____ Gender: M F
First Middle Last

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell: _____

SS# _____ Are you a student? ☐Yes ☐No ☐Full-Time ☐Part-Time

E-Mail Address: _____

Your Employer (or School) _____ Your Occupation _____

Employer Address _____ City _____ State _____ Zip _____

☐Married ☐Single ☐Widow(er) ☐Divorced ☐Separated

If married: Spouse's Name _____ Spouse's Birth date _____

Spouse's Employer _____ Spouse's Occupation _____

Name and Address of Primary Care Physician _____

How did you hear about us? _____

INSURANCE INFORMATION

(please allow our staff to photocopy your current health insurance card(s) & a photo I.D.)

Do you have insurance? ☐Yes ☐No Primary Ins: _____ Secondary Ins: _____

Are you the policy holder? ☐Yes ☐No **If no:** Name of Policy Holder _____

Date of Birth of Policy Holder _____ Policy Holder's Relationship to Patient _____

I hereby instruct and direct any and all insurance companies, lawyers, or employers liable for my healthcare benefits to pay by check made out and mailed to: Shelby County Chiropractic ~ 1713 Midland Trail ~ Shelbyville, KY 40065 ~ (502)633-1073

Or: If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows: _____ **c/o Shelby County Chiropractic ~ 1713 Midland Trail ~ Shelbyville, KY 40065**

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I hereby authorize and direct you, my insurance carrier, to pay directly to Shelby County Chiropractic such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Worker's Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect Shelby County Chiropractic. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Shelby County Chiropractic. This is to act as an assignment of my rights and benefits to the extent of the office's services provided. I hereby give my permission for Dr. Stapleton d.b.a. Shelby County Chiropractic to contact my PCP and/or any other healthcare provider deemed necessary regarding my healthcare.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option. **A photocopy of this assignment shall be considered as effective and valid as the original.**

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case to facilitate collection under this Assignment, Lien and Authorization.

I understand I am ultimately responsible for payment to this office. If for any reason my insurance company should pay me for services received in this office instead of paying directly to Shelby County Chiropractic, I understand that payment is for services performed here, and I must bring the payment in immediately upon receipt.

I have read and understand the foregoing.

Patient's Signature _____ **Date** _____

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CASE HISTORY

Full Name: _____ Date of Birth: _____ Chart #: _____

History of Present Injury / Illness — List the complaints you are here to have treated, in order of importance & list how long you have had each:

1. _____ How Long? _____
2. _____ How Long? _____
3. _____ How Long? _____
4. _____ How Long? _____
5. _____ How Long? _____
6. _____ How Long? _____

Please fill out the following for the primary condition for which you are here to be treated:

Circle the number that best matches your level of pain at its worst. (0=no pain, 10=most severe) 0 1 2 3 4 5 6 7 8 9 10

1. Is your condition related to an accident? ☐Yes ☐No If yes: Date of Accident _____ ☐Work Related ☐Other
2. How did pain or condition start? _____ When did it start? _____
3. What words best describe your present condition? (example: sharp, burn) _____
4. When is your condition *most* severe? _____ least severe? _____
5. What makes your condition feel worse? _____ feel better? _____
6. What activities are difficult because of your condition? _____
7. Have you seen any other health care provider for your present condition? ☐Yes ☐No If yes, who? _____
8. Personal Habits: ☐Tobacco ☐Alcohol ☐Vitamins ☐Exercise ☐Recreational Drugs ☐Medications & Reasons _____
9. Family history related to present condition: _____
10. Any known allergies? _____

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time.

Female History: **Are you pregnant at this time?** ☐Yes ☐No ☐Unsure but could be

Date of last menstrual cycle _____ ☐regular ☐Irregular Using birth control pills: ☐Yes ☐No

Are you experiencing or do you have any of the following: (check all that apply)

- ☐A sore that won't heal
- ☐Any bleeding / discharge
- ☐Bladder / bowel problems
- ☐Difficulty swallowing
- ☐Lump / thickening anywhere
- ☐Night Pain
- ☐Persistent cough / hoarseness
- ☐Wart / mole changes
- ☐Weight loss without trying
- ☐None of the above

Review of Systems

In addition to the symptom(s) / dysfunction(s) listed above, are you experiencing any of the following?

Neuromusculoskeletal System (check all that apply)

- ☐Sensory changes
- ☐Atrophy
- ☐Joint deformity
- ☐Psychiatric disorders
- ☐Difficulty walking
- ☐Lack of coordination
- ☐Facial drooping
- ☐Vision trouble
- ☐Mood swings
- ☐Joint locking
- ☐Joint swelling
- ☐Popping noises
- ☐Loss of balance
- ☐Memory loss
- ☐Speech problems
- ☐Muscle weakness
- ☐Numbness
- ☐Extremity deformity
- ☐Seizures
- ☐Dizziness
- ☐Twitches
- ☐Stiffness
- ☐Tremors
- ☐None of the above
- ☐Headache
- ☐Anxiety
- ☐Limited range of motion
- ☐Depression
- ☐Concussion

Cardiovascular System (check all that apply)

- ☐Ankle swelling
- ☐Mitral valve prolapse
- ☐carotid blockage
- ☐Known vascular disease
- ☐Changes in skin color
- ☐Shortness of breath
- ☐Chest pain
- ☐Jaw pain
- ☐Previous stroke
- ☐Hypertension
- ☐Dizziness
- ☐Phlebitis
- ☐Varicose veins
- ☐None of the above
- ☐Fainting
- ☐Pin stroke
- ☐Blood clots

Past History List any surgeries you have had (including: appendix, tonsils, wisdom teeth, implanted devices including **pacemakers**, Etc.)

1. _____ When? _____
2. _____ When? _____
3. _____ When? _____
4. _____ When? _____

List any hospitalizations other than surgeries, when & for what: _____

List any diagnosed conditions: (examples: diabetes, cancer, etc.) _____

List any current Dr.'s & conditions not previously listed: _____

List any major or minor falls or accidents & when they occurred: _____

List any cracked or broken bones & when they occurred: _____

Patient's Signature _____ Date _____

Revised 1/2009

CONSENT TO TREAT

Patient Name: _____ Date: _____ Chart #: _____

I request and consent to the performance of chiropractic, examination, adjustment/manipulation and any and all other chiropractic procedures permitted by our State law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by any of the treating doctors of chiropractic on staff and/or any licensed chiropractor deemed appropriate by the office. I understand that results of treatment are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are risks associated with treatment, although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains, and worsening symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

I understand it is my responsibility to fill out my case history completely and to the best of my knowledge, and to inform the doctor of any information that is not listed on my case history. I also understand that it is my responsibility to inform the doctor of any changes that may occur once I have filled out that information. I authorize Shelby County Chiropractic to treat me.

I have read and understand the foregoing.

Patient's Signature: _____ **Date:** _____

CONSENT TO TREAT A MINOR

Patient Name: _____

I hereby request and authorize Shelby County Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to _____.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature: _____ Date: _____

_____ _____

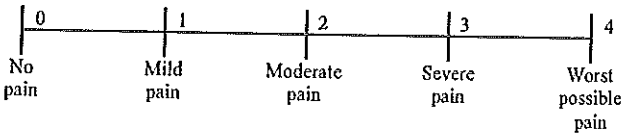
Printed Name Relationship to Patient

Functional Rating Index

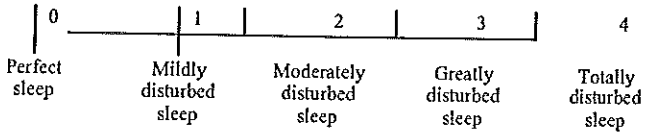
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

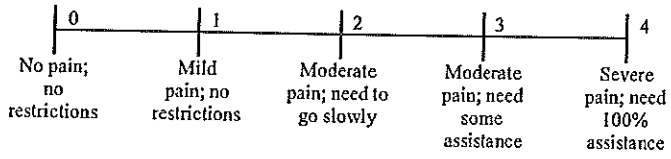
1. Pain Intensity



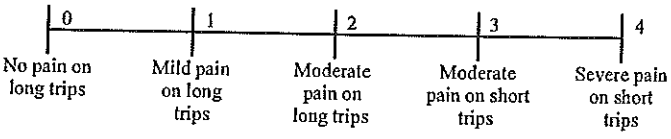
2. Sleeping



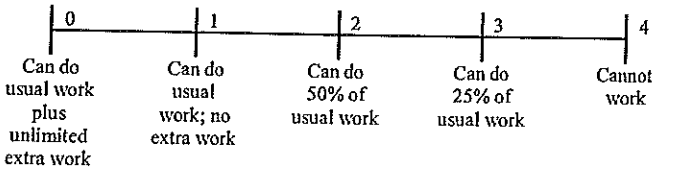
3. Personal Care (washing, dressing, etc.)



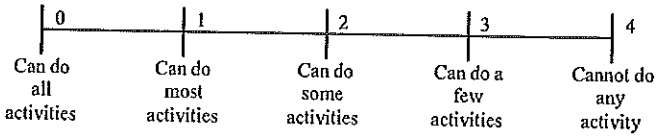
4. Travelling (driving, etc.)



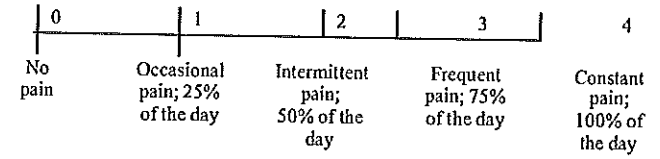
5. Work



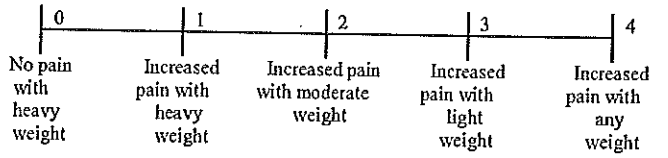
6. Recreation



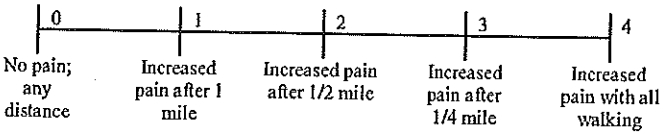
7. Frequency of Pain



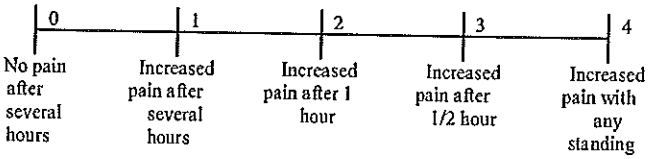
8. Lifting



9. Walking



10. Standing



_____

Patient's Signature

_____

Date

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: _____

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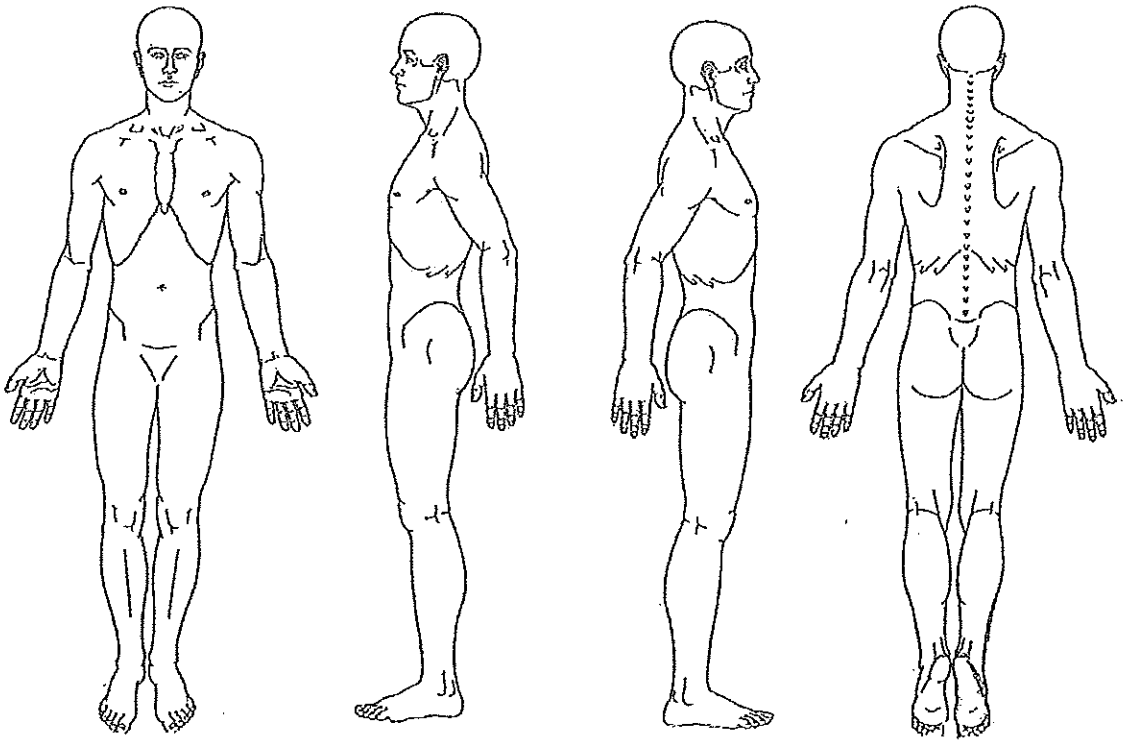
502-633-1073
Dr. James Stapleton, DC
Dr. William Yadon, DC

Name _____ Date_____ File _____

Pain Diagram

Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.
DO NOT SIMPLY CIRCLE THE AREA OF INVOLVEMENT PLEASE.

Numbness ---- Pins & Needles oooo Burning xxxx Aching **** Stabbing ////



Please place a vertical mark on the line below to indicate the severity of your complaint.

Headache No Pain _____ Worse Pain Experienced

Neck Pain No Pain _____ Worse Pain Experienced

Middle Back Pain No Pain _____ Worse Pain Experienced

Low Back Pain No Pain _____ Worse Pain Experienced

Other _____ No Pain _____ Worse Pain Experienced

Shelby County Chiropractic
Dr James Stapleton D.C.
Dr William Yadon D.C.
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Patient Authorization for the Use and Disclosure of Protected Health Information

1. I have been presented a copy, read and fully understand the Shelby County Chiropractic Notice of Privacy Policy.
2. I am aware I can contact the Privacy Officer at any time regarding any questions I may have concerning the Shelby County Chiropractic Notice of Privacy Policy.
3. I understand I can request a limitation to the disclosure of my protected health information at any time in writing.
4. I expressly acknowledge that this authorization is voluntary and, I also understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.
5. I understand I may get a copy of this form by request after I sign it.
6. I understand that the information used or disclosed pursuant to this authorization, may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
7. I hereby authorize Shelby County Chiropractic to use and / or disclose my protected health information in accordance with the procedures outlined in the Shelby County Chiropractic Notice of
8. I understand the Practice treats in an open adjusting area, where privacy is limited. I understand that I can meet with the doctor privately in a closed room upon my request. Unless a request is made, it is understood that I will be treated in the open adjusting room.
9. I understand that at some point in the future that if I refer someone to the Practice, that my name and image may appear on a thank you board or other notation(s) throughout the Practice, that is in plain view of other individuals that are in the Practice.
10. I understand x-rays taken at this office are considered part of a patient's **original health care record** and like all other records having originated at this practice, they are the **absolute sole and legal property of Shelby County Chiropractic.** We are required by Kentucky State Law to retain patient records for a period of no less than (10) ten years. Therefore, it is the policy of Shelby County Chiropractic to **NOT** release original x-rays to patients , other facilities or health care provider, unless issued a court order to do so. We are however, happy to provide our patients with a copy of their written x-ray report upon request, **ONE TIME**, at no charge, A minimum of **(48) HOURS WRITTEN** notice is required for production of this report and or any other records requested. If an imaging center in our community has the equipment necessary to copy your films, we will cooperate in facilitating this process, however, a fee will be charged for this service.
11. I hereby authorize this office to use my name, picture (still or video), patient testimonial in any in office publication and also in any publication for advertising such as newspaper, newsletter, website, etc.

Name of Patient: _____
(please print)

Signature: _____
of patient or legal guardian if patient is under 18 or otherwise unable to sign for himself / herself.

Date of authorization: _____

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:

First name: _____

Last name: _____

Date of birth: _____ / _____ / _____

Email address: _____

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Women's Health Issues
- ❑ Wellness Topics
- ❑ Diet and Nutrition
- ❑ Exercise and Fitness
- ❑ Stress Management

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:

Chiropractor: