WELCOME

PATIENT INFORMATION

Date_____

Patient Name_____
Last Name

_____
First Name Middle Initial

Address_____

City_____

State_____Zip_____

E-mail_____

SS#_____

Sex □ M □ F Age_____

Birthdate_____

□ Married □ Widowed □ Single □ Minor

□ Other _____

Occupation_____

Patient Employer/School_____

Spouse's Name_____

Birthdate_____

Spouse's Employer_____

How did you hear about us? (mark all that apply) □ TV □ Gym
□ Drive-by □ Dr. Referral _____
□ Word-of-mouth_____ □ Internet_____
□ Other

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Home Phone (_____) _____

Work Phone (_____) _____

INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

ID #_____

Group #_____

Is patient covered by additional insurance? □ Yes □ No

Subscriber's Name_____

Birthdate_____SS#_____

Relationship to Patient_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to JERNIGAN CHIROPRACTIC CLINIC 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

ACCIDENT INFORMATION

Is condition due to an accident? □ Yes □ No

Date_____

Type of accident □ Auto □ Work □ Home □ Other

To whom have you made a report of your accident?

□ Auto Insurance □ Employer □ Worker Comp. □ Other

Attorney Name (if applicable)

_____

PATIENT CONDITION

Reason for visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? □ Yes □ No □ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

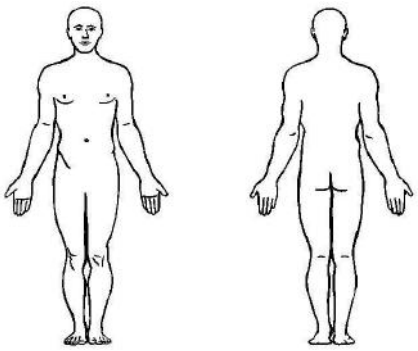
Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramp/spasm □ Stiffness □ Swelling □ Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful □ Sitting □ Standing □ Walking □ Bending □ Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? □ Medications □ Surgery □ Physical Therapy

□ Chiropractic Services □ None □ Other _____

Name and address of other doctor(s) who have treated you for your condition_____

Primary Care Physician_____Location_____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	□ Yes	□ No	Diabetes	□ Yes	□ No	Liver Disease	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No				
Alcoholism	□ Yes	□ No	Emphysema	□ Yes	□ No	Measles	□ Yes	□ No	Scarlet Fever	□ Yes	□ No				
Allergy Shots	□ Yes	□ No	Epilepsy	□ Yes	□ No	Migraines	□ Yes	□ No	Sexually						
Anemia	□ Yes	□ No	Fractures	□ Yes	□ No	Miscarriage	□ Yes	□ No	Transmitted						
Anorexia	□ Yes	□ No	Glaucoma	□ Yes	□ No	Mononucleosis	□ Yes	□ No	Disease	□ Yes	□ No				
Appendicitis	□ Yes	□ No	Goiter	□ Yes	□ No	Multiple Sclerosis	□ Yes	□ No	Stroke	□ Yes	□ No				
Arthritis	□ Yes	□ No	Gonorrhea	□ Yes	□ No	Mumps	□ Yes	□ No	Suicide Attempt	□ Yes	□ No				
Asthma	□ Yes	□ No	Gout	□ Yes	□ No	Osteoporosis	□ Yes	□ No	Tonsillitis	□ Yes	□ No				
Bleeding Disorders	□ Yes	□ No	Heart Disease	□ Yes	□ No	Pacemaker	□ Yes	□ No	Tuberculosis	□ Yes	□ No				
Breast Lump	□ Yes	□ No	Hepatitis	□ Yes	□ No	Parkinson's Disease	□ Yes	□ No	Tumors, Growths	□ Yes	□ No				
Bronchitis	□ Yes	□ No	Hernia	□ Yes	□ No	Pinched Nerve	□ Yes	□ No	Typhoid Fever	□ Yes	□ No				
Bulimia	□ Yes	□ No	Herniated Disk	□ Yes	□ No	Pneumonia	□ Yes	□ No	Ulcers	□ Yes	□ No				
Cancer	□ Yes	□ No	Herpes	□ Yes	□ No	Polio	□ Yes	□ No	Vaginal Infections	□ Yes	□ No				
Cataracts	□ Yes	□ No	High Blood			Prostate Problem	□ Yes	□ No	Whooping Cough	□ Yes	□ No				
Chemical			Pressure	□ Yes	□ No	Prosthesis	□ Yes	□ No	Other_____						
Dependency	□ Yes	□ No	High Choles.	□ Yes	□ No	Psychiatric Care	□ Yes	□ No	_____						
Chicken Pox	□ Yes	□ No	Kidney Disease	□ Yes	□ No	Rheumatoid Arthritis	□ Yes	□ No	_____						

EXERCISE

- □ None
- □ Moderate
- □ Daily
- □ Heavy

WORK ACTIVITY

- □ Sitting
- □ Standing
- □ Light Labor
- □ Heavy Labor

HABITS

- □ Smoking
- □ Moderate
- □ Daily
- □ Heavy

Packs/Day_____
Drinks/Week_____
Cups/Day_____
Reason_____

Are you pregnant? □ Yes □ No Due Date_____ Doctor _____

Injuries/Surgeries you have had	Description	Date
□ Falls		
□ Head Injuries		
□ Broken Bones		
□ Dislocations		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name_____		
Pharmacy Phone (___)_____		

Neck Index

ACN Group, Inc. Form NI-100

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

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

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

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

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 more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Jernigan Chiropractic Clinic
229 DeBuys Road
Gulfport, MS 39507

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

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 / Other / 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 as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

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

PRACTICE'S REQUIREMENTS

1. The Practice:

   a. Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

   b. Is required by state law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law.

   c. Is required to abide by the terms of this Privacy Notice.

   d. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

   e. Will distribute any revised Privacy Notice to you prior to implementation.

   f. Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of ____/_____/_____.

By signing below, I acknowledge that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language that I can understand.

_____	_____
Name of Individual (Printed)	Signature of Individual
_____	_____
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor)	Relationship

Informed Consent

It is our responsibility to fully inform you of all aspects of your treatment. Part of this includes a discussion of any potential side effects or complications. All treatments potentially can cause these reactions, and chiropractic manipulation is no different. It however, has one of the safest records of the wide range of treatments that can be used for spinal disorders.

Possible adverse effects of spinal manipulation can include soreness in the area of treatment, reactive muscle spasm, injury to the disc causing pressure on the nerve tissue, fractures in weakened bone such as ribs, and injury to arteries in the neck resulting in stroke. Soreness or reactive muscle spasms or tightening are common but usually brief reactions to treatment. The other potential complications versus the relative frequency of the complication for other typical treatments are listed below.

Disc injury from manipulation causing spinal cord pressure	Neurological complication from neck surgery	back surgery
1 per 100 million	1 per 64	1 per 33

Artery injury from manipulation causing stroke	Death rate from neck surgery
1 per 1 million	1 per 145

Perhaps the most common alternative to spinal manipulation is the use of anti-inflammatory drugs. These drugs cause fairly common and potentially serious complications.

Complication associated with anti-inflammatory drug use:

Serious stomach or intestinal bleeding	1-4 per 1000 users
Hospitalizations from complications	20,000 per year
Death from complications	2,600 per year

I have read the above and understand the risk of complication that many occur from spinal manipulation. With this understanding, I consent to treatment with spinal manipulation by Jernigan Chiropractic Clinic.

_____ _____

Signature Date

Jernigan Chiropractic Clinic-HIPPA

Patient Authorization regarding chiropractic care being provided in an "open adjusting" environment: It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" means that while you are the only patient in an exam room, the door is usually open during your adjustment. Periodically patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care, NOT for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kind of matters related in an "open adjusting" environment are incidental matters. In the event you or someone else would not agree with us, we are providing this disclosure. The use of this format is intended to make your experience with our office more efficient and productive as well as enhance your access to quality health care and health information. If you choose not to be adjusted in an open adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from **Jernigan Chiropractic Clinic** or on your relationship with our staff. Your signature indicates your authorization of this activity.

It is our desire for our staff to use your name, address and/or telephone number for the purposes of contacting you to remind or advise you about: Appointment related issues, insurance correspondence and billing, and mailings from our office. The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this decision will have no adverse effect on your care from **Jernigan Chiropractic Clinic** or on your relationship with our staff.

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the changes in our system to be completed.

Expiration Date: _____

_____ _____

Signature Date