Bronson Clinic

PATIENT CONTACT INFORMATION

Today's Date _____

Name _____
FIRST Middle Initial LAST

What name would you prefer for us to call you? _____

Birth date: _____ Age _____ Male / Female

Social Security #: _____ Driver's License #: _____

Patient's Address _____

City _____ State _____ Zip _____

Cell Phone: _____ Other Phone: _____

e-mail: _____

Race _____ Ethnicity _____

Marital Status: M S D W Sep Spouse: _____

Occupation: _____

Employer _____

Name of person completing this form, if other than patient: _____

EMERGENCY CONTACT INFORMATION

Person's Name: _____

Your relationship to this person: _____

Phone: _____ e-mail: _____

REFERRAL INFORMATION

Referred by: (name of person or source)_____Relationship _____

PRIMARY CARE PHYSICIAN

Your medical doctor's name: _____ Phone: _____

Address _____ City _____ Zip _____

INSURANCE INFORMATION

Your insurance company _____

Bronson Clinic
HEALTH INFORMATION

PURPOSE OF THIS VISIT

Body part and symptoms: _____

_____

How long have you had this condition? _____

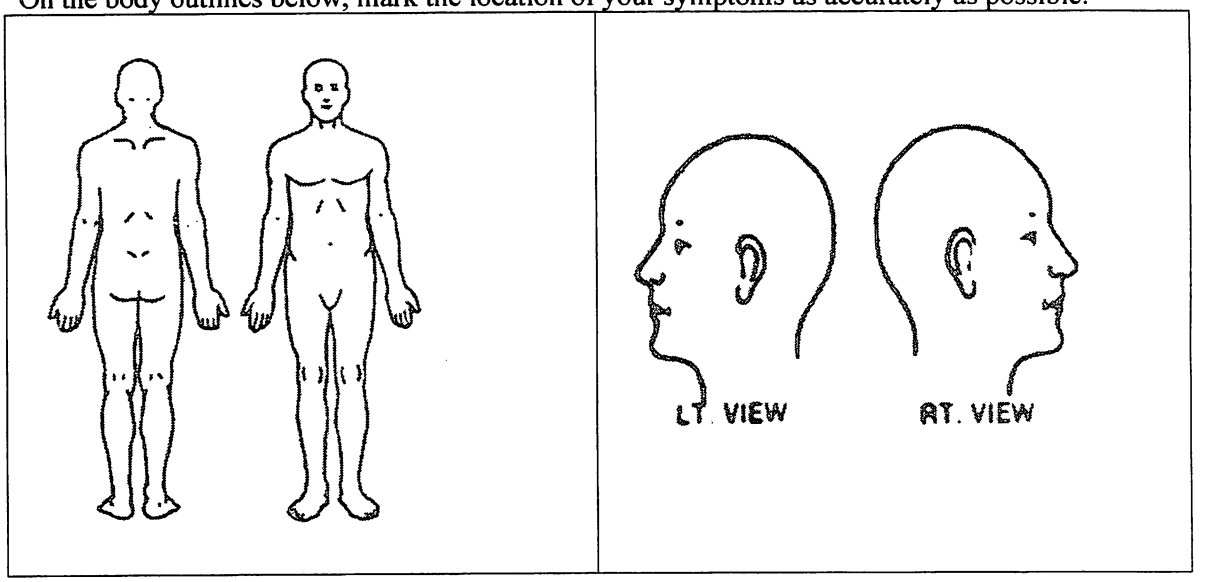
Did it start gradually or suddenly? □ Gradual Onset □ Sudden Onset

What do you think may have caused it?

_____

_____

On the body outlines below, mark the location of your symptoms as accurately as possible.



PAIN SCALE REFERENCE

0 = No pain at all. *1 = Almost no pain.* *2 = Mild discomfort.* *3 = Nagging mild pain.*	*4 = Bothersome pain.* *5 = Pain that limits activities.* *6 = Pain prevents some activities.* *7 = Pain causes face expressions.*	*8 = Pain causes moaning/crying.* *9 = Agonizing pain causes distress.* *10 = Worst pain imaginable.*

BELOW on the 0 to 10 scale, CIRCLE one or more numbers to indicate how much pain you have been feeling.

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

SEVERITY: What words describe the severity? (circle all that apply.) None. Good. Mild. Not Bad. Moderate. Discomfort. Severe. Distressing. Very Severe. Horrible. Worst Possible. Excruciating.

QUALITY: What words describe how it feels? Dull Ache. Sharp. Burning. Numbness. Tingling. _____

RADIATE: Do you have symptoms that travel remotely from the primary site of pain? _____

TIMING: When does it hurt? Constantly. Comes and goes. Morning. During the day. Night.

AGGRAVATED BY: What makes it hurt worse? Sitting. Standing. Lying. Walking. _____

RELIEVED BY: What makes it feel better? Sitting. Standing. Lying. Walking. _____

PAIN INTERFERES WITH: Work. Sleep. Daily routine. Recreation. _____

My pain is keeping me from: _____

_____

COURSE: Getting worse. Getting better. Staying the same.

TREATMENT FOR THIS CONDITION

Have you seen **another doctor** for this? __yes ___no Name: _____

Have you had **X-rays** for this? __yes __no Have you had an **MRI** for this? __yes __no

What type of **treatment** did you receive? _____

What are you doing for yourself at home? _____

Are you taking any medicines for this condition? __yes __no List: _____

PAST MEDICAL HISTORY

Have you ever had a **similar** condition in the past? __yes __no If yes, please give date and brief explanation:

_____

Significant **accidents and illnesses** you have had with approximate dates: _____

_____

Significant **surgeries** you have had with approximate dates: _____

Do you have **allergies**? __yes __no

Please list any **other medical conditions** you have, and any medications that you take: _____

_____

_____

Do you have: [ ] Hepatitis [ ] Diabetes [ ] Heart Disease [ ] HIV [ ] None of these

Have you gained or lost **weight** recently? □ No □ Gained □ Lost Please explain: _____

_____

Any **other** significant health history not already mentioned: _____

_____

SOCIAL HISTORY

Do you smoke? □ No, never □ No, I quit _____ ago □ Yes How much? _____

Drink coffee or other caffeinated beverages? □ No □ Yes _____

Drink alcohol? □ No □ Yes How much? _____

What are your hobbies and activities? _____

How much do you exercise? _____

GOALS & EXPECTATIONS (for discussion purposes)

My **reasonable goal** is to reduce my pain level to (circle one number):

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

I think we can reach my goal in: [ ] one day [ ] one week [ ] one month [ ] two months [ ] six months

I may be interested in: [ ] Acupuncture [ ] Physical Therapy [ ] Exercise Instruction

[ ] Spinal Decompression Therapy [ ] Herbal and Homeopathic Medicines

[ ] a Diet Plan [ ] Nutritional Supplements

[ ] other _____

OUR PROMISE

We, the doctor and staff members of the Bronson Clinic, will do our best to find the cause or causes of your condition, and to do our best to explain our findings in terms that you will understand. We will tell you exactly what we feel that you need, and then cheerfully provide you with the finest care available.

Following your examination and case presentation by the doctor, you will choose a care plan that fits your schedule and your budget. We want you to be so satisfied with the Bronson Clinic and our services that you will eagerly refer others to us for chiropractic care.

Is there *anything else about your health* that you want to discuss with the doctor?

Please sign _____ Date _____

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** have 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

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____ _____

Signature **Date**

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SYSTEMS REVIEW AND FAMILY HISTORY

Date _____

Name _____

SYSTEMS REVIEW

If you have any of these conditions, please check one box to indicate OCCASIONAL, FREQUENT, or CONSTANT. If the item listed does not pertain to you, leave it blank.

O = Occasional F = Frequent C = Constant

O F C		O F C		O F C	
	GENERAL		MUSCULOSKELETAL		GASTROINTESTINAL
	Allergy		Arthritis (swollen joints)		Belching or gas
	Chills		Bursitis (swollen tissues)		Colon trouble
	Dizziness/ Fainting		Hernia (abdomen defect)		Constipation
	Fatigue		Neck pain/stiffness		Diarrhea
	Fever		Lower back pain/stiffness		Digestion difficulty
	Headache		Sciatica (pain in leg)		Excessive hunger
	Trouble sleeping		Shoulder pain/stiffness		Poor appetite
	Loss of weight		Elbow pain/stiffness		Hemorrhoids
	Nervousness / Depression		Wrist/hand pain/stiffness		Jaundice
	Panic attacks		Hip pain/stiffness		Liver trouble
	Sweats		Knee pain/stiffness		Gall bladder trouble
	Tremors		Ankle/foot pain/stiffness		Nausea or vomiting
O F C		O F C		O F C	
	CARDIOVASCULAR		RESPIRATORY		GENITO-URINARY
	High blood pressure		Chest pain		Bed-wetting
	Low blood pressure		Shortness of breath		Too frequent urination
	Pain over the heart		Chronic cough		Painful urination
	Poor circulation		Smoker's cough		Kidney infection/stones
	Rapid heart beats		Difficulty breathing		
	Slow heart beats		Spitting up blood		FOR WOMEN ONLY
	Skipped heart beats		Spitting up phlegm		Congested breasts
	Swelling of the ankles		Wheezing		Excessive menstrual flow
			Asthma		Painful menstruation
					Vaginal discharge
					Hot flashes
					Irregular cycle

FAMILY HISTORY

Please check any condition listed below that your family members have had, and add a letter using the following key:

Father = F Mother = M Brother = B Sister = S

Alcoholism	High Blood Pressure
Allergies	Kidney Disease
Anemia	Liver Disease
Arthritis	Anxiety or Depression
Asthma	Nervous Breakdown
Birth Defects	Obesity
Cancer	Suicide/Attempted
Diabetes	Tuberculosis
Heart Disease/Attack	Other _____

FINANCIAL, CONSENT, & AUTHORIZATION

Financial Policy
Payment in full is expected at the time of service unless prior *written* arrangements have been made. As a courtesy to our patients, we will file insurance claims to the insurance carriers with which we participate. Any deductible or co-payment your insurance company requires you to pay is due at the time of service. Please ask a staff member for additional information. Unless prohibited by law or contract, the patient is ultimately responsible for all account balances.

How will you pay for today's visit?

__Cash __Check __Credit Card (circle one): MasterCard Visa Discover

Will you be using any of these plans? __Medicare __Medicaid __Work Comp __Attorney LOP

__PPO __EPO __HMO __POS __Discount Card *Please let us make a copy of your card.*

Consent to Examination
Your signature below gives your consent for the doctor and staff to examine you and perform diagnostic testing based upon your health history and presenting complaints. After your examinations, the doctor will report his findings to you. Following this "report-of-findings," you will be given a form titled, "Informed Consent for Treatment." Upon signing that form, you will attest that you have been adequately informed of the proposed treatment, reasonable alternative treatments, as well as the risks of treatment and non-treatment. In addition, we are happy to provide you with literature or resources, and spend additional time as necessary. We are always available to answer any questions you may have, and want you to be fully informed as you make decisions about your health care.

Authorization to release information
All of the information you have given is confidential and will not be shared with anyone without your authorization. Your signature below will allow us to provide information to other physicians, reviewers, adjusters, third party payers, or any other agency that may require a copy of medical records or additional reports from the doctor in order to process insurance claims. This may include any medical information pertaining to examination, treatment, work status, or any history events discussed during an office visit. This authorization also includes the release of pertinent medical information to any specialist or facility that Dr. Bronson may refer you to for evaluation or treatment. (See also the HIPAA Notice of Privacy Practices document along with the Consent and Authorization to Use, Disclose, or Release your private health information.)

Assignment of Benefits
Your signature below also authorizes the payment of medical benefits to Bronson Clinic, Inc. for services rendered.

Welcome to the Bronson Clinic! We are happy to be of service to you today. Thank you for completing this form. Your signature indicates that you agree to comply with the Financial Policy, Consent to Treat, Authorization to release information, and Assignment of Benefits as outlined above.

X _____ Date _____

Signature of patient or guardian

If this is an accident or work-related injury, please notify the receptionist.

Consent for Use of PHI for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information (PHI) by Bronson Clinic, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Bronson Clinic, Inc. I understand that diagnosis or treatment of me by Dr. Mark R. Bronson may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Bronson Clinic, Inc. is not required to agree to the restrictions that I may request. However, if Bronson Clinic agrees to a restriction that I request, the restriction is binding on the Bronson Clinic and Dr. Mark R. Bronson.

Please check one of the following and tell us how you would like for us to restrict your information if applicable:

□ No special restrictions.

□ I request a restriction of disclosure of my PHI as follows:

_____

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Bronson or Bronson Clinic, Inc. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Bronson Clinic, Inc.'s Notice of Privacy Practices prior to signing this document. The Bronson Clinic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Bronson Clinic. The Notice of Privacy Practices for Bronson Clinic, Inc. is also posted on the wall just outside the treatment rooms and on the Bronson Clinic's website at www.bronsonclinic.com. This Notice of Privacy Practices also describes my rights and Bronson Clinic's duties with respect to my protected health information.

Bronson Clinic, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Bronson Clinic's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority (if applicable)

Bronson Clinic, Inc.

CONSENT FOR EXAMINATION & TREATMENT

It is our mission in this clinic to provide our patients with the highest quality healthcare available. Our standard procedure prior to administering treatment is to inform you of our examination findings, discuss the various diagnostic possibilities that might be causing your symptoms, and then offer our treatment recommendations. This discussion may begin in the reception room, the examination room, or treatment room, and is ongoing. Anytime you have a question, please ask. To facilitate questions and answers, we provide you with a paper titled, "A Discussion of the Risks of Chiropractic Manipulation, Acupuncture, and Medical Alternatives," written by our clinic doctors and staff. Please read this and other materials in our *Informed Consent* notebook and at www.bronsonclinic.com. Then please print your name in the space below and sign at the bottom of this form in the space provided.

I _____ hereby request and consent to the performance of physical examination procedures, diagnostic x-ray, chiropractic adjustments and other therapeutic procedures, including acupuncture and various modes of physical therapy, on me (or on the patient named above, for whom I am legally responsible) by any of the licensed Doctors of Chiropractic or permanent or temporary staff in the Bronson Clinic.

I agree to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of this examination and recommended treatment procedures.

I understand that in the practice of chiropractic and physical medicine, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I have been presented with printed material regarding risks, and have had the opportunity to read the material. However, I do not expect the doctor to be able to anticipate and explain all risks and complications; and I wish to rely upon the doctor to exercise judgment during the course of each procedure which he/she feels is in my best interest at the time, based upon the facts then known to him or her. I also understand that results are not guaranteed.

I have read, or have had read to me, the above information, including the printed material in the notebook. I agree express any of my concerns and to ask questions about this information; and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment in the Bronson Clinic.

_____ _____

Patient or Guardian Signature Date

_____

Witness