Reilly Chiropractic, 4751 W. Park Ave, Chippewa Falls, WI 54729

Phone (715)723-2892 Fax (715)723-3540

PATIENT INFORMATION

Name: _____ (Age) _____ Gender: M F Date: _____

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

CHIROPRACTIC EXPERIENCE

Have you seen a chiropractor before? □ Yes □ No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

How frequently were you seen? _____

Did you receive maintenance or supportive care? □ Yes □ No □ Not Sure if yes @ what Frequency? _____

Did your previous chiropractor take x-rays? □ Yes □ No □ Not Sure

Are you aware of any of your poor posture habits? □ Yes □ No □ Not Sure

Explain: _____

Are you aware of any poor posture habits in your spouse or children? □ Yes □ No □ Not Sure

Explain: _____

GOALS FOR CARE

Indicate **one** of the following statements that apply to you:

□ I have a specific health concern. (I want ***short term relief only*** without a corrective or maintenance program)

□ I want to ensure that my health concerns do not become an ongoing problem. (I want ***relief and to maintain a pain free state*** of health)

□ I am interested in learning how to improve my quality of life. (I want ***relief and am motivated to correct the problem*** and change my lifestyle to support and maintain a pain free state of health)

Are you healthier now than you were 1 year ago? □ Yes □ No
How/Why? _____

Is it your goal to be healthier 1 year from now than you are today? □ Yes □ No
Do you have a plan on improving your health? _____
_____

Have you ever been advised on lifestyle choices for good health? □ Yes □ No

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee or caffeine? Yes No How many cups / day? Or what type? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

_____

REVIEW OF SYSTEMS

CERVICAL SPINE (NECK):

- ❑ Neck Pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Hearing disturbances
- ❑ Weakness in grip
- ❑ Recent weight loss
- ❑ Fever
- ❑ Chills
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Thyroid conditions
- ❑ Sinusitis
- ❑ Allergies/Hay fever
- ❑ Recurrent colds/Flu
- ❑ Low Energy/Fatigue
- ❑ TMJ/Pain/Clicking

THORACIC SPINE (UPPER BACK):

- ❑ Heart Palpitations or Arrythmia
- ❑ Heart Murmurs
- ❑ Tachycardia
- ❑ Heart Attacks/Angina
- ❑ Recurrent Lung Infections/Bronchitis
- ❑ Asthma/Wheezing
- ❑ Shortness of Breath
- ❑ Cough
- ❑ Pain On Deep Inspiration/Expiration
- ❑ Chest pain or pressure
- ❑ Shortness of breath
- ❑ Peripheral edema
- ❑ Blood clots
- ❑ Abnormal bleeding
- ❑ Bleeding
- ❑ Varicose Veins
- ❑ Cramping in thighs
- ❑ Nervousness, anxiety
- ❑ Depression
- ❑ Cancer

THOPRACIC SPINE (MID BACK):

- ❑ Mid Back Pain
- ❑ Pain Into Your Ribs/Chest
- ❑ Indigestion/Heartburn
- ❑ Reflux or Heartburn
- ❑ Nausea
- ❑ Ulcers/Gastritis
- ❑ Hypoglycemia
- ❑ Tired/Irritable after eating or when you haven't eaten for a while
- ❑ Rashes
- ❑ Sores
- ❑ Blisters
- ❑ Growths
- ❑ Heat or cold intolerance
- ❑ Excessive thirst
- ❑ Diabetes

LUMBAR SPINE (LOW BACK):

- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Constipation / Diarrhea
- ❑ Abdominal pain
- ❑ Bloody stool
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Menstrual irregularities/cramping (females)
- ❑ Sexual dysfunction
- ❑ Low back pain

Please list any health conditions not mentioned: _____

Please list any medications currently taking and their purpose: _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

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TERMINOLOGY for CHIROPRACTIC CARE

Adjustment is the ***specific application of forces*** to facilitate the body's correction of vertebral subluxation.

Health is a state of optimal physical, mental and social well being, ***not merely the absence of disease/symptoms***.

Subluxation is an immobility of one or more of the joints of the body. This ***may or may not cause pain***. Directly correlated with ***abnormal posture, muscle tension spasms, range of motion stiffness, joint tenderness, and organ dysfunction***. This also will result in alteration of nerve function and ***interference of the transmission of nerve*** impulses, lessening the body's innate ability to heal and achieve optimal health.

Maintenance/Supportive Care is defined as "services that seek to prevent disease, ***promote health*** and prolong and enhance the quality of life, or maintain or ***prevent deterioration of a chronic condition***. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective, the treatment is considered maintenance care."

AUTHORIZATION FOR CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

Dr. Broghan Reilly, Reilly Chiropractic LLC 4751 W. Park Ave. Lake Hallie, WI 54729

I have had an opportunity to discuss with the above named doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. 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 the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, 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.

Patient Signature_____ Date _____

Witness Signature _____ Date_____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures
- You may inspect and receive copies of your records for a fee within 14 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and it's staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Patient Name (Print)_____

Patient or Guardian Signature_____ Date_____

Witness Signature_____ Date_____

FEES and BILLING POLICY

I clearly understand and agree that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. All services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable.

I have had ample opportunity to ask questions about my liability associated with the fees for a chiropractic adjustment and other procedures. The doctor of chiropractic and/or other office or clinic personnel has answered my questions to my satisfaction. I have reviewed a copy of the most recent fee schedule (next page) of services that may not be covered by my insurance regardless of insurance verification *Initial* _____. I have been provided my treatment plan and understand the fees associated with this plan *Initial* _____. I understand that I have the right to refuse this care and that by signing this form I will be fully responsible for the total billed charge(s) related to non-covered services. I have the right to request at any time a new copy of the fee schedule and/or an explanation of my treatment plan and the services I am receiving.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Reilly Chiropractic, LLC will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Reilly Chiropractic, LLC will be credited to my account on receipt. If my account becomes delinquent and must be sent to collections I will be responsible for collection costs up to **35%** applied as finance charges. I also understand that for every month that my account holds a balance, I will be charged an additional **1.5%** cost applied as interest charges.

Staff Signature_____ Date_____

Patient or Guardian Signature_____ Date_____

PRIMARY CONCERN FOR THIS VISIT

Reason for this visit – Main Concern: _____

Is this concern related to an auto accident / work injury? □ Yes □ No If so, when: _____

When did this condition begin? _____/_____/_____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? □ Yes □ No Describe: _____

Type of pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the pain radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? □ Yes □ No

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with activity

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

Have you experienced this condition before? □ Yes □ No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

SECONDARY CONCERN FOR THIS VISIT

Reason for this visit – Main Concern: _____

Is this concern related to an auto accident / work injury? □ Yes □ No If so, when: _____

When did this condition begin? _____/_____/_____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? □ Yes □ No Describe: _____

Type of pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the pain radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? □ Yes □ No

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with activity

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

Have you experienced this condition before? □ Yes □ No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

ADDITIONAL NOTES / COMMENTS: (onset, intensity, duration, frequency)

_____

_____

_____

_____

_____

_____

_____

Chronic Musculoskeletal Complaints:

- ❑ Low back pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Pain into hips/legs/feet
- ❑ Headaches
- ❑ Pain into shoulders/arms/hands

Name (Please Print) _____

INITIAL REPORT

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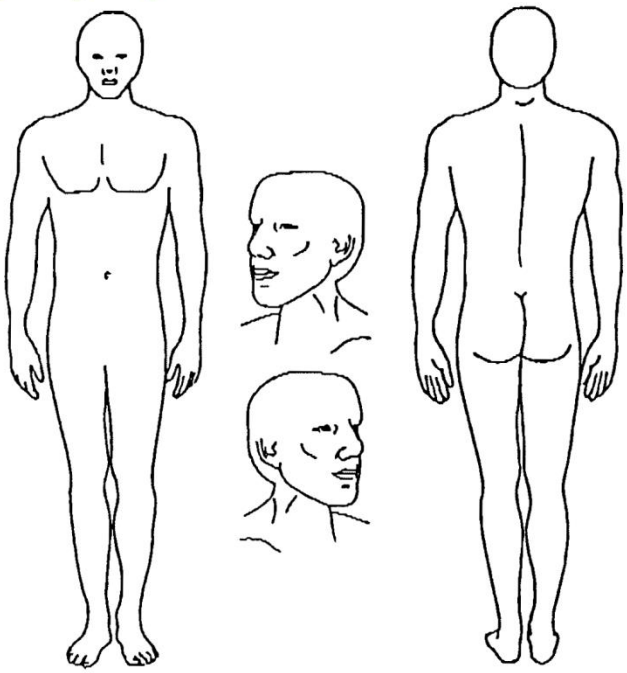

PLEASE MARK YOUR AREAS OF PAIN ON THESE FIGURES, INDICATING WHICH TYPE OF PAIN YOU ARE EXPERIENCING.

A = ACHE/DULL PAIN
B = BURNING PAIN
S = STABBING/SHARP PAIN
N = NUMBNESS
P = PINS & NEEDLES/TINGLING
T = TENDER/TIGHT

Please mark the intensity of pain you are experiencing on the pain scale.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild		Discomforting		Distressing		Horrible			Excruciating

Daily Activities: Effects of Current Condition on Performance

1. Bending:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
2. Carrying Groceries:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
3. Change Posn–Sit-Stand:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
4. Climb Stairs:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
5. Driving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
6. Ext Computer Use:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
7. Household Chores:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
8. Kneeling:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
9. Lift Children:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
10. Lifting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
11. Reading (Concentration):	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
12. Self Care–Bathing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
13. Self Care–Dressing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
14. Self Care–Shaving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
15. Sexual Activities:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
16. Sleep:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
17. Sitting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
18. Standing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
19. Walking:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
20. Yard Work:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
21. Other_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
22. Other_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform

Date:_____ Patient's Signature:_____