ALL COUNTY CHIROPRACTIC CENTER
Mark Schneiderman, D.C.
4 Walter Foran Blvd., Suite 304
Flemington, NJ 08822
Tel. (908) 788-3624

ALIGNIS Clinical Records System

Patient Health Assessment

Please PRINT or WRITE Clearly

General Information

Patient Name:_____ Date:_____

Provider Name:_____

Primary Care Physician's Name:_____

Patient Sex: M_____ F_____ Date of Birth:_____ Social Security #:_____

Patient Address:_____

Home Phone:_____ Work Phone:_____

Patient Employer:_____ Patient Occupation:_____

Subscriber Name:_____ Relation to Patient:_____

Subscriber Employer:_____ Subscriber Social Security #:_____

Referred for Treatment by:_____

Health Insurance Plan:_____ Group #:_____ Member #:_____

Complaint History

1. Describe your current complaint and how the problem began: _____

How long have you had this condition?_____ **Date of onset:**_____

2. How would you describe pain?

☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness
☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting

ACTIVITIES OF DAILY LIVING PATIENT WOULD LIKE TO DO, BUT CAN'T

DAILY LIVING ACTIVITY
- ☐ FAMILY –RELATED
- ☐ SPORTS –RELATED
- ☐ WORK –RELATED
- ☐ OTHER

4. How often is the pain present?

☐ Constant (81-100%) ☐ Frequent (51-80%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

5. Since your problem began is the pain:

☐ Getting worse ☐ Getting better ☐ Staying the same

6. How did your problem begin?

☐ An auto accident ☐ Work related accident ☐ Other type of accident
☐ Gradual ☐ Sudden ☐ No specific reason

Explain: _____

7. What makes your problem better?

☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Moving around/exercise ☐ Lying down ☐ Inactivity

8. What makes your problem worse?

☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Moving around/exercise ☐ Lying down ☐ Inactivity

9. Are you currently taking any medications? ☐ Yes ☐ No

If yes, please describe _____

10. Were you previously treated for an earlier occurrence of this *same* condition? ☐ Yes ☐ No

If yes, by whom? ☐ MD ☐ Chiropractor ☐ Physical therapist ☐ Other_____

What were the approximate dates, type of treatment and the results? _____

11. What is your physical activity at work?

☐ Mostly sitting ☐ Light manual labor ☐ Moderate manual labor ☐ Heavy manual labor

ALIGNIS Clinical Records System

Patient Health Assessment (cont.)

12. Do you exercise?

☐ No regular exercise ☐ 1-2 times a week ☐ 3-4 times a week ☐ 5-7 times a week
☐ Cardiovascular ☐ Stretching ☐ Weight Machine ☐ Free Weights ☐ Sports _____ Type

13. What is your present general stress level:

☐ No stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

14. Is your problem affecting your ability to work or do other routine daily activities?

☐ No effect ☐ Have some limited physical restrictions, but can function
☐ Need some assistance with daily activities ☐ Cannot work
☐ Cannot function without assistance ☐ Totally disabled

Past Or Present Symptoms, Conditions Or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck pain	☐	☐	High blood pressure	☐	☐
Shoulder pain	☐	☐	Heart condition	☐	☐
Arm/elbow pain	☐	☐	Respiratory condition	☐	☐
Hand pain	☐	☐	Digestive problems	☐	☐
Upper back pain	☐	☐	Kidney/bladder problem	☐	☐
Lower back pain	☐	☐	Menstrual problems	☐	☐
Pain in upper leg or hip	☐	☐	Breast soreness/lump	☐	☐
Pain in lower leg or knee	☐	☐	Sinus conditions	☐	☐
Pain in ankle or foot	☐	☐	Allergies/asthma	☐	☐
Jaw pain	☐	☐	Cancer	☐	☐
Swelling/stiffness of joints	☐	☐	Stroke	☐	☐
Headaches	☐	☐	Excessive weight loss/gain	☐	☐
Dizziness	☐	☐	Skin condition	☐	☐
Fainting spells	☐	☐	Arthritis	☐	☐
Convulsions	☐	☐	Diabetes	☐	☐
General prolonged fatigue	☐	☐	Prostate condition	☐	☐
Condition of uterus/ovaries	☐	☐			

Tobacco use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Alcohol use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Caffeine use: *(Coffee, tea, soft drinks)*
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Pregnancy: ☐ Past ☐ Present

Surgical Procedure:
☐ Past ☐ Present

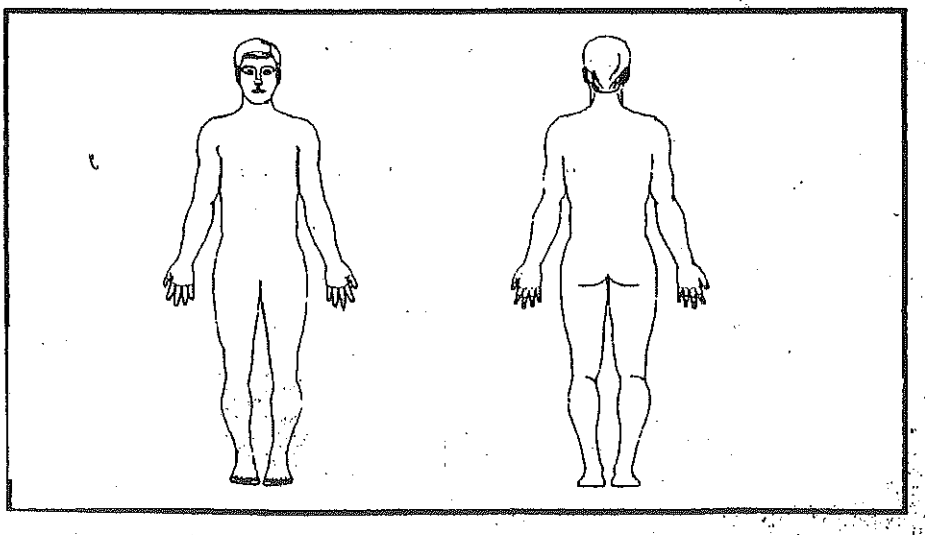
Please list: _____

_____

Comments: _____

_____

Please shade in the figures below where you have pain, or other symptoms:



I have reviewed the information contained on this form with the patient.

_____
Patient Name

_____
Provider Initials

_____
Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 **worst possible pain**

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1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

Other Comments: _____

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____

Score: Total all scores; divide by number of regions x 10 = _____ (< 50 LI / > 50 HI)

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, w/ permission from Elsevier Science

PATIENT INFORMATION FORM

NAME _____ HOME PHONE _____ WORK PHONE _____ x ____

HOME ADDRESS _____ CITY _____ ZIP CODE _____

SPOUSE'S NAME _____ WORK PHONE _____ x _____

NEAREST RELATIVE NOT LIVING WITH YOU _____ PHONE _____

NEAREST FRIEND NOT LIVING WITH YOU _____ PHONE _____

PHYSICIAN _____ PHONE _____

DENTIST _____ PHONE _____

LANDLORD _____ PHONE _____

WHOM MAY WE CONTACT IN THE CASE OF AN EMERGENCY? _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____ PHONE _____

SOC. SECURITY # _____ D.O.B. _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

I WILL BE PAYING TODAY BY CASH _____ CHECK _____

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ Date _____
Signature

_____ Date _____
Parent (if minor)

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ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been made in advance by our staff. For those patients being seen more then once per week we will be happy to extend payment due until the end of each week you are still under treatment. We accept cash, checks and credit/ debit cards with exception of American Express. For those patients with medical insurance, it is very important that you know and understand your policy. We will be happy to assist you by checking with you insurance company about your benefits. Please note, however, that we do not always get the correct information over the telephone with many customer service reps. Since the insurance company will not usually give us anything in writing, should they give us incorrect information, it is ultimately your responsibility as you have the written policy documentation in your possession. It has happened in the past that their computers are not always up to date and if you have changed policies recently we may be given obsolete or incorrect information or even incorrect information concerning precerts and referrals.

If this is an automobile accident please let us know immediately as a separate precert requirement is needed.

At the present time we are not contracted with any insurance companies. Unfortunately it is not possible, at this time, to contract directly with the most popular ones, Aetna, Cigna, United, Oxford and Blue Shield NJ. The reason for this is that they either do not reimburse us, or reimburse us at such a low level for many of the procedures we utilize, that we would not be able to do them. In addition, many of them have recently lowered their fee schedule even further, to a level that we could not possibly even consider them. **WE WOULD JUST NOT BE ABLE TO GIVE YOU THE TIME AND ATTENTION YOU DESERVE AND NEED, AND WE WILL NOT COMPROMISE YOUR HEALTH.** As a result we feel that it is best for you to utilize any out of network benefits you may have. This will allow us to be committed to giving you the time and attention you need for your particular problem. Please also be aware that it is illegal for us to waive any co-pays or deductibles or to have a different fee schedule for patients with or without insurance. The only exception to this rule would be financial hardship. If you feel that this may apply to you please talk to us privately and we will tell you what documentation will be required to qualify for any reduced

fees.

We must emphasize that as a medical provider, our relationship is with you, not your insurance company. We will do our best to verify your benefits and follow whatever rules your managed plan requires. **PLEASE KNOW YOUR BENEFITS.** Any incorrect information we may be given will ultimately be your responsibility.

Please remember that we are always here to help you. We want us to have a good relationship with you and we want you to be comfortable with our treatment and office procedures. If you have any question or concerns, or if temporary financial problems occur please contact us promptly so that we can better assist you.

I have read **"ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE"** and a copy has been given to me if requested.

Signature of Patient

INFORMED CONSENT TO
CHIROPRACTIC TREATMENT

Based on your medical history, physical examination and diagnostic studies, All County Chiropractic Center is recommending a course of chiropractic therapy. This may include chiropractic manipulation, physical therapy, and traction treatment for your spinal or extremity pain.

While All County Chiropractic Center believes this recommended therapy to be reasonable and necessary and the anticipated benefits to far outweigh the risks, some patient understandably wonder what complications might occur. Thus, All County Chiropractic thinks that you should be made aware of these risks before you begin your treatment.

For the vast majority of patients, there are few, if any, risks; and most of the risks are minimal, such as spinal or extremity pain, rib or nose fractures. However, in some patients, more serious complications,such as a disc becoming larger by further rupture, paralysis of the legs or organs, or vascular accident, may occur. While none of these complications has ever occurred in our office, should they occur in your case, for your protection, you would be referred immediately to another physician for surgery or other treatment.

This consent is designed to inform rather than to frighten you. Thus, if you have any questions, All County Chiropractic Center will be glad to discuss them with you before beginning treatment.

Sincerely,

All County Chiropractic Center
Dr. Mark I. Schneiderman

I have read and understand the above consent form and understand the risks of the recommended treatment as the treatment and risks of treatment have also been verbally explained to me by my doctor I understand and consent to the treatment being delivered by Dr. Mark Schneiderman. I consent for All County chiropractic Center to provide the recommended chiropractic therapy. No guarantee or assurances of results has been made.

_____ Date

_____ Patient's Signature

HIPAA HAPPENINGS

ALL-COUNTY CHIROPRACTIC

Patient Authorization for contact regarding chiropractic care, related health services and/or related health products.

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, appointment related issues, advise you about health related meetings, workshops, and products.

The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care.
If you choose not to authorize this use of your information, your decision will have no adverse effect on your care from All-County Chiropractic or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____ _____
Name (printed) Signature Date

This authorization may be revoked by you 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 change in our system to be completed.

ALL COUNTY CHIROPRACTIC

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient, we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of your services.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Department of Health & Human Services – Office of the Patient Advocate.

If you would like further information about our privacy policies and practices please ask our staff.

This notice is effective as of April 14, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please) _____ Signature _____ Date _____

If you are a minor, or if you are being represented by another party

Personal Representative Printed _____ Personal Representative Signature _____ Date _____

Description of the authority to act on behalf of the patient. _____