Brannigan Chiropractic Center

Office use only: BP_____ HR_____Goals:_____Pt #:_____

Patient Data: EMAIL: **Date:**

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address Line _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____-_____ **Cell Phone** (_____) _____-_____

Date of Birth _____/_____/_____ **Sex:** Male Female

Marital Status: Single Married Other

Spouse Data

First Name _____ **Middle Initial** _____ **Last Name** _____

Home Phone (_____) _____-_____ **Work Phone** (_____) _____-_____

Children (age):_____

Employer Data

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Medical Doctor

Name_____ **Phone**_____

How did you hear about our office? _____

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke

Surgeries:

_____

Allergies:

_____

Social History: (Circle all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Tobacco:	occasional	often	never

Please list all current medications being taken _____

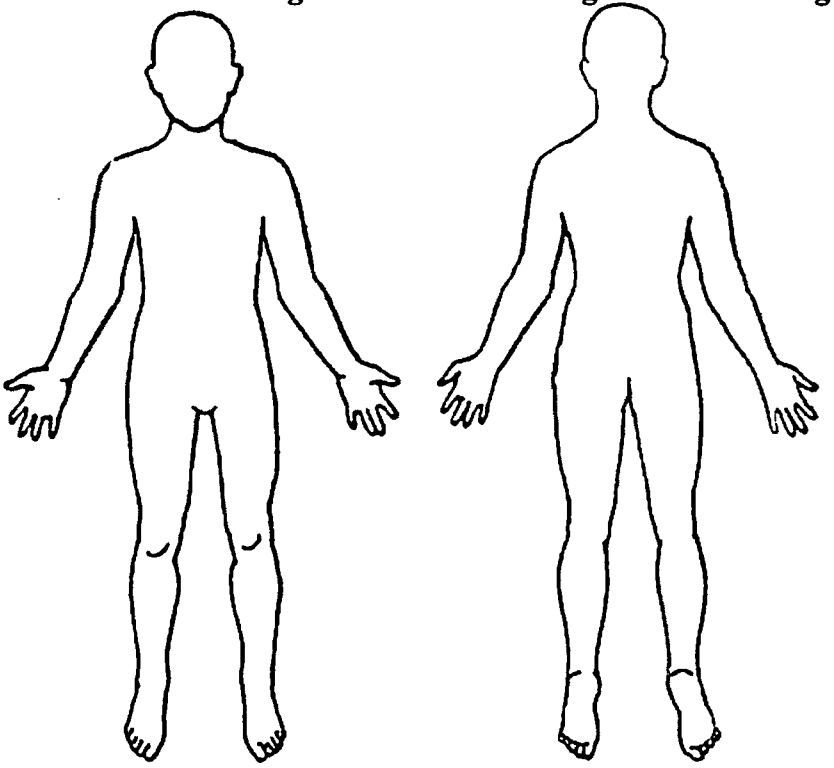
_____

_____

Are you pregnant? Yes_____ No _____N/A_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

When did your symptoms begin? Month_____ Day_____Year _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other___

How did your symptoms begin? _____

Brannigan Chiropractic Center

Circle ALL conditions that Apply

AIDS/HIV
Alcoholism
Allergy Shots
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Bleeding Disorders
Breast Lump
Bulimia
Cancer
Bronchitis
Cataracts
Chemical Dependency
Chicken Pox
Diabetes
Emphysema
Epilepsy
Fractures
Glaucoma
Hepatitis
Hernia
Herniated Disc
Herpes
High Cholesterol
Goiter
Gout
Heart Disease
Kidney Disease
Liver Disease
Measles
Migraine Headaches
Miscarriage
Mononucleosis
MS (Multiple Sclerosis)
Osteoporosis
Pacemaker
Parkinson's Disease
Pinched Nerve
Pneumonia
Polio
Prostate Problem
Prosthesis
Psychiatric Care
Rheumatoid Arthritis
Rheumatic Fever
Scarlet Fever
Stroke
Suicide Attempt
Thyroid Problems
Tonsillitis
Tuberculosis
Tumor Growth
Typhoid Fever
Ulcers
Vaginal Infections
Venereal Disease
Whooping Cough
Other _____

Brannigan Chiropractic Center

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require of payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. From time to time we may send you birthday cards or letters use your name on a birthday list or use your name on a referral board in our office. By your signature below you have given us permission to do so.
   I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient **Signature of Patient** **Date**

Brannigan Chiropractic Center

PAYMENT POLICY INFORMATION

PATIENT NAME: _____

Payment for Services will be by: Cash____ Check____ Credit Card____

Chiropractic Services provided in this office are payable the day's services are rendered unless other arrangements have been made prior to seeing the doctor.

1. Patients are personally responsible for all charges. If the staff is unable to verify insurance benefits prior to the end of your first visit, **PAYMENT IS DUE IN FULL**.
2. There will be a $5.00 charge for paperwork above and beyond the normal claims information needed to process group or individual insurances or if more than 2(two) insurances are involved.
3. Payment Plan is available upon approval of credit extension by the office manager/Doctor. I authorize a credit check if credit is extended.
4. Assignment of Insurance benefits will be accepted upon proper verification of coverage and at the discretion of this office. There will be verification of coverage; however "benefits quoted are not a guarantee of payment." Benefits are determined at the time of processing.
5. Any balance remaining after 60 days with no action will be charged an 18% per annual service charge.
6. A collection fee equal to 40% of balance will be added to all delinquent accounts over 90 days past due that have to be sent to a collection agency.
7. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports at no charge to assist in collecting from my insurance company.
8. If mine is a regular insurance case, I agree to pay a percentage of services as they are rendered. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY:

PATIENT'S SIGANTURE: X_____**Date:**_____
(or Guardian/Guarantor)

WITNESS SIGNATURE: X_____**Date:**_____

Back: Activities of Daily Living

Make sure to turn over and complete the other side

NAME: _____

DATE: _____

This questionnaire has been designed to give the doctor information as to how your neck/back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- ❑ I can look after myself normally without pain.
- ❑ I can look after myself normally but it is very painful.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than ¼ of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

Section 6 – Standing

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ an hour.
- ❑ Pain prevents me from standing for more than 10 minutes.
- ❑ Pain prevents me from standing at all.

Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8– Social Life

- ❑ My social life is normal and causes me no extra pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

Section 9 – Traveling

- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over two hours.
- ❑ Pain restricts me to short necessary journeys less than 30 minutes.
- ❑ Pain prevents me from traveling except to receive treatment.

Section 10 – Changing degree of Pain

- ❑ My pain is rapidly getting better
- ❑ My pain fluctuates, but is definitely getting better
- ❑ My pain seems to be getting better, but improvement is slow
- ❑ My pain is neither getting better nor worse
- ❑ My pain is gradually worsening
- ❑ My pain is rapidly worsening

Neck: Activities of Daily Living

Section 1 – Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

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

Section 3 – Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Reading

- ❑ I can read as much as I want to with no pain in my neck.
- ❑ I can read as much as I want to with slight pain in my neck.
- ❑ I can read as much as I want with moderate pain in my neck.
- ❑ I cannot read as much as I want because of moderate pain in my neck.
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all.

Section 5 – Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

Section 6 – Concentration

- ❑ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want to with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to. have a great deal of difficulty in concentrating when I want to.
- ❑ I cannot concentrate at all.

Section 7 – Work

- ❑ I can do as much work as I want to.
- ❑ I can do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I cannot do any work at all.

Section 8 – Driving

- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight pain in my neck.
- ❑ I can drive my car as long as I want with moderate pain in my neck.
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe pain in my neck.
- ❑ I cannot drive my car at all.

Section 9 – Sleeping

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

Section 10 – Recreation

- ❑ I am able to engage in all my recreation activities with no neck pain at all.
- ❑ I am able to engage in all my recreation activities, with some pain in my neck.
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ❑ I can hardly do any recreation activities because of pain in my neck.
- ❑ I cannot do any recreation activities at all.

Neck D. Index, From Vernon H, Minor S.JMPT 1991; 14(7):409-415

Brannigan Chiropractic Center

RELEASE OF INFORMANTION AND ASSIGNMENT OF BENEFITS

Dr. Joseph Brannigan and Associates of Brannigan Chiropractic Center

I authorize Joseph T. Brannigan, D.C./Associates and/or their billing service to release any of the following information for the purpose of obtaining reimbursement/payment for the treatment and services provided to me or my dependents. The information may include the diagnosis, clinical records and procedure codes. This information may be released to any third-party payor having responsibility for payment.

I understand that I can revoke this consent at any time by written request to Brannigan Chiropractic Center and that I may inspect any and copy the information to be disclosed.

I understand that I am ultimately responsible for any and all charges not paid by my medical insurance. I understand that some fees may not be covered by my insurance and I would be responsible for those payments at the time of service. I certify that I am the patient and that I understand this consent. If I am not the patient, I certify that I am authorized as the patient's agent to accept these terms.

TERMS OF ACCEPTANCE

I understand that the therapy and consultation I will receive at Brannigan Chiropractic Center is for the purpose of musculoskeletal/myofacial tension, stress reduction and lifestyle modification. I understand that this therapy is not a substitute for medical treatment and that is recommended that I see a medical physician for any physical ailment I may have. I certify that I have truthfully stated all of my know medical conditions that will inform the doctor of any changes or new developments in my physical health.

PRIVACY POLICY

I understand and agree to allow this office to use my Patient Health Information (PHI), for the purpose of treatment, payment, healthcare operations, and coordination of care. I understand that my PHI is going to be used in the office. For your security and right to privacy, all staff has been trained in the area of patient privacy. We have taken all precautions to assure that your records are not readily available to anyone unauthorized. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the completed HIPPA notice that is available at the front desk before signing this consent. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

I have read and fully understand the above statements.

NAME OF PATIENT: _____ **DATE:**_____

PATIENT/PATIENT AGENT SIGNATURE:

_____ **DATE:**_____

INSURED SIGNATURE: _____ **DATE:**_____