Wieging Family Chiropractic, LLC.
3435 Farm Bank Way Grove City, Ohio 43123
Phone (614) 539-0405 ~ Fax (614) 539-0554

Acct#_____

Confidential Patient Information

Patients Name: _____ Sex [ ] M [ ] F Age: _____

Address: _____ Marital Status: Married [ ] Single [ ] Divorced [ ]

City: _____ Zip:_____ Widowed [ ] Separated [ ]

Home Phone: _____ Date of Birth: _____

Cell Phone: _____ Social Security #:_____

Email: _____

Occupation: _____ Employer/School:_____

How did you hear about our office?_____Referred By?_____

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder Birth date: _____

Policy Holder Employer: _____ Policy Holder SS#:_____

Patients relationship to the policy holder: [ ] Self [ ] Child [ ] Spouse

Secondary Ins. Company:_____ Ins. Phone #_____

ID#:_____ Group #: _____

Name of Policy Holder:_____ Policy Holder Birth date: _____

Policy Holder Employer:_____ Policy Holder SS#: _____

Family Physician: _____ Physician's Phone: _____

Physician's address _____

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? (Y / N) If so, Who? _____

What is your goal in our office? _____

What is/are your Chief Complaint(s)?_____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Wieging Family Chiropractic, LLC.** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other health care providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

I may be billed $25 for missed/cancelled massage appointments when I do not provide 24 hour notice of cancellation.

I have read and fully understand this agreement.

_____ _____

Signature of Insured / Patient / Guardian Date

WIEGING CHIROPRACTIC REGISTRATION AND HISTORY

ACCIDENT INFORMATION

Is condition due to an accident? [ ] Yes [ ] No Date _____ Type? [ ] Auto [ ] Work [ ] Home [ ] Other

To whom have you made a report ? [ ] Auto Ins [ ] Employer [ ] Workers Comp [ ] Other

Claim Number _____ Ins Phone Number _____ Attorney Name

_____

HEALTH HISTORY

Have you received any of the following treatments for your condition?

[ ]Medication [ ]Surgery [ ]Physical Therapy [ ]Chiropractic [ ]None [ ]Other:_____

Name and address of other doctor(s) who have treated your condition _____

_____

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 _____

Please write a **"Y"** to indicate if you have had any of the following :

AIDS/HIV		Hepatitis		Pinched Nerve	
Appendicitis		Hernia		Pneumonia	
Arthritis		Herniated Disc		Polio	
Asthma		Herpes		Prosthesis	
Bleeding Disorders		High Cholesterol		Psychiatric Care	
Bronchitis		Kidney Disease		Rheumatoid Arthritis	
Cancer		Liver Disease		Stroke	
Diabetes		Migraines		Thyroid Problems	
Emphysema		Miscarriage		Tonsillitis	
Epilepsy		Multiple Sclerosis		Tuberculosis	
Fractures		Osteoporosis		Tumors, Growths	
Gout		Pacemaker		Typhoid Fever	
Heart Disease		Parkinson's		Ulcers	
				Metal,Mechanical,Electrical Implants	
				Other:	

Exercise

[ ]None [ ]Moderate

[ ]Light [ ]Heavy

Work Activity

[ ]Sitting [ ]Standing

[ ]Light Labor [ ]Heavy Labor

Habits

[ ]Smoking Packs/Day ____ [ ]Coffee/Caffeine Cups/Day ____

[ ]Alcohol Drinks/Week ____

Are you pregnant? [ ] Yes [ ]No Due Date _____

Head Injuries _____

Broken Bones/ Dislocations _____

Illness/Disease _____

Surgeries _____

Other _____

Medications	Allergies	Vitamins/Herbs/Minerals

Pharmacy Name _____ Pharmacy Phone _____

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

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.

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.

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 al

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.

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

Wieging Family Chiropractic, LLC

Acct:_____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will help clarify those issues. Please read below and if you have any questions, feel free to ask our staff members.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to Wieging Family Chiropractic, LLC, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures, whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The Doctor of Chiropractic provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime. I understand that if I am accepted as a patient by a doctor at Wieging Family Chiropractic, LLC, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request. Our clinic has a common therapy area and open reception area, where people can overhear conversations. Some of your care maybe provided in these areas, but there are private consulting areas available upon request.

Patient Signature:_____ Date:_____

Women only:

To the best of my knowledge **I am/ am NOT pregnant and give/ don't give** permission to x-ray me for diagnostic purposes.

Missed Massage Appointments

Any massage appointment that is not canceled 24 hours prior to schedule appointment will be subject to a charge of $15-$25

Consent to Evaluate and Treat a Minor:

I, _____being the parent or legal guardian of _____, have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

If you wish to allow our office staff to speak to someone other than you regarding your treatment and/or financial information, we ask that you list that person(s) below.

Name:_____Relationship: _____

As a courtesy, our office may provide reminder calls, which only disclose the date and time of your next appointment. This information may be left on your answering machine or voicemail. You agree, in order for us to provide services to you and/or collect any amounts you may owe, in addition to regular mail, we may contact you by telephone, at any telephone number associated with your account, or by any email address associated with your account. Method of contact may include pre-recorded and/or the used of an automated dialing device.

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request, I will be given a copy.

Print Name:_____

Signature:_____Date:_____

Acct: _____

Advantage Radiology Service
419-269-2424 / 844-283-4163

Patient Name:_____ DOB:_____

Clinic: **Wieging Family Chiropractic, LLC.**
3435 Farm Bank Way, Grove City, OH 43123
Phone: 614-539-0405 / Fax: 614-539-0554

X-ray Assignment Agreement

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury. I agree to remit any patient responsibility, such as co-payments, deductibles, and/or co-insurance charges directly to Advantage Radiology Service for this service. I also understand that **Wieging Family Chiropractic LLC**. cannot guarantee that Advantage Radiology Service is in-network with my insurance plan.

In the event that I receive payment for these services from my insurance carrier, Workers' Compensation carrier, or State Bureau, and/or my attorney, I agree to promptly remit payment to Advantage Radiology Service (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

Print name_____

Patient/Guardian Signature _____ Date_____

If Guardian, please indicate relationship to patient_____