Decatur Back & Neck Center

Confidential Health History

Name: _____ **Home Phone:** _____

Address: _____ **Cell Phone:** _____

City: _____ **State:** _____ **Date of Birth:** _____

Zip Code: _____ **Sex:** M or F

Soc Sec #: _____ **Marital Status:** M S W D

Employer: _____ **Work Location:** _____

Occupation: _____ **Work Phone:** _____

_____

Please describe your health problem: _____

_____

_____

List any other doctors seen for this problem:

_____

_____

List any diagnosis and/or treatments: _____

_____

_____

List any unusual diseases and year or occurrence/diagnosis:

_____

_____

Have you been treated for any health condition in the past year?

_____

_____

Have you received chiropractic treatment previously? If yes, explain:

_____

_____

We greatly appreciate referrals to our office. So we may thank them, who referred you to our office or how did you hear of our office?

_____

Please check the condition(s) you are now having and those you frequently have.

MUSCULO-SKELETAL SYSTEM
___ Low back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Ruptures
___ Broken Bones

GENITO-URINARY SYSTEM
___ Bladder trouble
___ Excessive urine
___ Scenty urination
___ Painful urination
___ Discolored urine

FEMALE
___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast

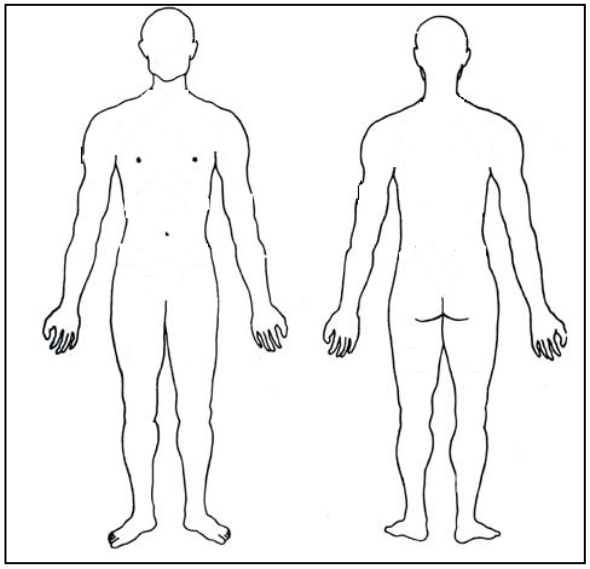
ARE YOU PREGNANT
___ Yes ___ No

GASTRO-INTESTINAL SYSTEM
___ Poor Appetite
___ Excessive hunger
___ Difficulty chewing
___ Difficulty swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Black stool
___ Bloody stool
___ Hemorrhoids
___ Liver trouble
___ Gall bladder problems
___ Weight trouble

NERVOUS SYSTEM
___ Numbness
___ Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

CARDIOVASCULAR-RESPITORY
___ Chest pain
___ Pain over heart
___ Difficulty breathing
___ Persistent cough
___ Coughing phlegm
___ Coughing blood
___ Rapid heartbeat
___ Blood pressure problems
___ Heart problems
___ Lung problems
___ Varicose veins

EYE, EAR, NOSE AND THROAT
___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Hearing loss
___ Ear discharge
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Difficulty breathing through nose
___ Sore gums
___ Dental problems
___ Sore mouth
___ Sore throat
___ Hoarseness
___ Difficulty with speech



Please mark your areas of pain on the figures to left.

In case of emergency, please notify:
Name:

Address:

Phone:

Signature: _____

Decatur Back & Neck Center

In accordance with the Patient Affordable Care Act of 2010, we are updating our records. Thank you for your cooperation.

Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip Code _____ Sex M or F

Occupation _____ Date of Birth _____

Employer _____ Right handed or Left handed (circle)

Family History	Diseases in the Family? (Arthritis, Heart Disease, Cancer, Diabetes, Multiple Sclerosis?)	Living or deceased?
Mother		
Father		
Brothers		
Sisters		
Grandmother(s)		
Grandfather(s)		

Please list ALL surgeries	Year of Surgery

Please any allergies to food, medication and other factors

Smoking Status:
Please check one:
____ Never a smoker

____ Current every day smoker _____ packs per day

____ Current periodic smoker. How often _____

____ Former Smoker. Quit in _____ year.

How many Children do you have? _____

Do you drink alcohol? _____ drinks per day/month (please circle)

Caffeine? How often? _____ How much? _____
What kind of caffeine (circle)? Coffee Soda Tea

Current Medications	**Dosage**

Signature _____

Date _____

Revised Oswestry Low/Mid Back Pain Disability Questionnaire

Instructions: This questionnaire is designed to enable us to understand how much your **lower and/or mid back** pain has affected your ability to manage your everyday activities. Please answer each section below utilizing the one best answer that most applies to you. We realize that that you may feel that more than one statement may relate to you, but **please just circle the one choice that closely describes your problem right now**.

Patient: _____

Date: _____

1. 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 severe.
5) The pain is severe and does not vary much.

2. Personal Care
0) I would 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 or dressing without help.

3. 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, but I can manage light to medium weights if they are conveniently positioned.
5) I can only lift very light weights, at the most.

4. Walking
0) Pain does not prevent me from walking any distance.
1) Pain prevents me from walking more than one mile.
2) Pain prevents me from walking more than one-half mile.
3) Pain prevents me from walking more than one-quarter mile.
4) I can only walk while using a cane or on crutches.
5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting
0) I can sit in a chair as long as I like without pain.
1) I can only sit in my favorite chair as long as I like.
2) Pain prevents me from sitting more than one hour.
3) Pain prevents me from sitting for more than one-half hour.
4) Pain prevents me from sitting for more than ten minutes.
5) Pain prevents me from sitting at all.

6. Standing
0) I can stand as long as I like without pain.
1) I have some pain while standing, but it does not increase without increasing pain.
2) I cannot stand for longer than one hour without increasing pain.
3) I cannot stand for more than one-half hour without increasing pain.
4) I cannot stand for longer than ten minutes without increasing pain.
5) I avoid standing, because it increases the pain straight away.

7. 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 my pain, my normal night's sleep is reduced by less than one-quarter (1/4).
3) Because of my pain, my normal night's sleep is reduced by less than one-half (1/2).
4) Because of my pain, my normal night's sleep is reduced by less than three-quarters (3/4).
5) Pain prevents me from sleeping at all.

8. Social Life
0) My social life is normal and gives me no pain.
1) My social life is normal but increased the degree of my pain.
2) Pain has no effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3) Pain has restricted by 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.

9. Traveling/Car Travel/Driving
0) I get no pain while traveling.
1) I get some pain while traveling, but none of my usual forms of travel make it any worse.
2) I get extra pain tram traveling, but it does not compel me to seek alternative forms of travel.
3) I get extra pain from traveling which compels me to seek alternative forms of travel.
4) Pain restricts all form of travel.
5) Pain prevents all forms of travel except that are done lying down.

10. 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 at present.
3) My pain is neither getting better or worse.
4) My pain is gradually worsening.
5) My pain is rapidly worsening.

Patient Signature:

_____

Score: _____

office use only

Neck Pain Disability Index Questionnaire

Instructions: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section below utilizing the **one** best answer that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just circle the one choice that closely describes your problem right now.**

Patient: _____

Date: _____

1. Pain Intensity

0) I have no pain at the moment.
1) The pain is very mild at the moment.
2) The pain is moderate at the moment.
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.

2. Personal Care

0) I can look after myself normally without causing extra pain.
1) I can look after myself, 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 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.

3. Lifting

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

4. Reading

0) I can read as much as I want to with no pain in my neck.
1) I can read as much as I want to with slight pain in my neck.
2) I can read as much as I want to with moderate pain in my neck.
4) I cannot read as much as I want to because of moderate pain in my neck.
5) I cannot read at all.

5. 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 with come frequently.
4) I have severe headaches which come frequently.
5) I have headaches almost all the time.

6. Concentration

0) I can concentrate fully when I want to with no difficulty.
1) I can concentrate fully when I want to with slight difficulty.
2) I have a fair degree of difficulty in concentrating when I want to.
3) I have a lot of difficulty in concentrating when I want to.
4) I have a great deal of difficulty in concentrating with I want to.
5) I cannot concentrate at all.

7. Work

0) I can do as much work as I want to.
1) I can only do my usual work, but no more.
2) I can do most of my usual work.
3) I cannot do my usual work.
4) I can hardly do any work at all.
5) I cannot do any work at all.

8. Driving

0) I can drive my car without any neck pain
1) I can drive my car as long as I want with slight pain in my neck.
2) I can drive my car as long as I want with moderate pain in my neck.
3) I cannot drive my car as long as I want because of moderate pain in my neck.
4) I can hardly drive at all because of severe pain in my neck.
5) I cannot drive my car at all.

9. 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).

10. Recreation

0) I am able to engage in all of my recreational activities with no neck pain at all.
1) I am able to engage in all of my recreational activities with some pain in my neck.
2) I am able to engage in most, but not all of my recreational activities because of pain in my neck.
3) I am able to engage in a few of my usual recreational activities because of pain in my neck.
4) I can hardly do any recreational activities because of pain in my neck.
5) I cannot do any recreational activities at all.

Patient Signature:

_____

Score: _____

office use only

RAPID Doc Documentation

LOWER EXTREMITY FUNCTIONAL SCALE

LAST NAME: _____ FIRST NAME: _____ MI: ____ Date: _____

We are interesting in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Today, do you or would you have any difficulty at all with any of the following activities?

Please provide an answer for each activity below as follows: 0 = no difficulty, 1 = a little bit of difficulty, 2 = moderate difficulty, 3 = quite a bit of difficulty, 4 = extreme difficulty or unable to perform activity.

1. Any of your usual work, household, or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your house	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Disabilities of the Arm, Shoulder and Hand

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

Disabilities of the Arm, Shoulder and Hand

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = $\left[\left(\frac{\text{sum of n responses}}{n}\right) - 1\right] \times 25$, where n is equal to the number of completed responses.

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

Decatur Back & Neck Center

Physical Activity Readiness Questionnaire (PAR-Q)

Patient Name (Print) _____ **Signature _____**

Date _____

1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
   _____Yes
   _____No

2. Do you feel pain in your chest when you do physical activity?
   _____Yes
   _____No

3. In the past month, have you had chest pain when you were not doing physical activity?
   _____Yes
   _____No

4. Do you lose your balance because of dizziness or do you ever lose consciousness?
   _____Yes
   _____No

5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
   _____Yes
   _____No

6. Is your medical doctor currently prescribing drugs (for example water pills) for your blood pressure or heart condition?
   _____Yes
   _____No

7. Do you know of any other reason why you should not do physical activity?
   _____Yes
   _____No

HIPAA Acknowledgement of Receipt of Decatur Back and Neck Center's Notice of Privacy Practices

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq. and regulations there under, as amended from time to time (collectively referred to as "HIPAA"). This authorization affects your rights in the privacy of your personal healthcare information.

By signing this authorization, you acknowledge and agree that Decatur Back and Neck Center ("Practice") or its Business Associates may use or disclose your Protective Health Information (PHI) for the purpose of providing treatment, for purposes of relating to the payment of services rendered, and for the Practice's healthcare operations purposes.

Further, by signing this authorization, you acknowledge that you have been provided a copy of and have read and understand Decatur Back and Neck Center's Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Decatur Back and Neck Center has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available and can be received by sending a written request with return address to the center where you were seen.

By signing below, you are acknowledging that you have received, reviewed, understand and agree to the Notice of Privacy Practices of Decatur Back and Neck Center, which describes the Practice's policies and procedures regarding the use and disclosure of any of your Personal Health Information created, received, or maintained by the Practice.

Acknowledged and agreed to by:

Patient

By: _____ Date: _____

Print Name _____

OR, ON BEHALF OF PATIENT

By: _____ Date: _____

Print Name _____

Information about you, your appointment time or your examination results cannot be disclosed to persons other than you, unless you authorize us to do so. If you wish for use to disclose information to persons other than you, please indicate who they are below.

NAME	Relationship	Telephone Number

Signature: _____

Date: _____

Decatur Back & Neck Center

OFFICE FINANCIAL POLICY

It is our policy that following a preliminary exam, any services which are rendered by this office on the initial visit shall be paid for at that time, unless other arrangements have been made in writing. Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. However, it must be fully understood that the contract is between you and your insurance company, and you are fully responsible for any and all amounts not paid by your insurance.

Our office policy is as follows:

1. Since by taking your insurance assignment, we have to await payment, this courtesy may be withdrawn if warranted.
2. The deductible amount must be paid in full prior to billing.
3. Insurance payments should be made every 30 days. the maximum time limit we extend is 60 days, then fees must be paid in full by the patient.
4. You are required to sign "Authorization to Pay Physician" form and any other documents required by your insurance company.
5. Our office **will not** guarantee that your insurance company will pay. At the beginning of your healthcare, we will make every attempt to receive verification of your policy coverage. However, if for any reason your claim is denied, you are responsible for the total amount due this office.
6. This office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. We will, however, assist you in any way that we can.
7. You the patient must keep current with your insurance co-payment.
8. A 1.5% finance charge will be added to all accounts over 90 days old.
9. In the event that your account is past due, it may be turned over to a collection agency. If our account is not paid in full and this account is turned over to a collection agency and/or attorney, then you agree to be responsible for all reasonable fees necessary for the collection agency fees of 50% of the balance due and costs and reasonable attorney's fees of 33% of the balance.
10. If the insurance company sends you payment for our services, it is your responsibility and obligation to bring to us payment in full.

I have fully read, and agree to this financial policy as written:

Signed: _____

Date: _____

Witness: _____

Decatur Back & Neck Center Employee Signature

DECATUR BACK & NECK CENTER
Mario Fucinari DC, CCSP, DAAPM, MCS-P
Elizabeth Paunicka, DC, MS, ATC
3350 North Water Street, Suite A
Decatur, IL 62526
217-877-2404

We are currently an in-network PPO Provider for Blue Cross Blue Shield of Illinois (BCBSIL). As of July 14, 2014, BCBSIL requires us to notify you in writing prior to services being performed, and for you, the patient, to acknowledge in writing that you received such notification, that certain services may not be covered. If your BCBSIL policy determines that certain services are not medically necessary, investigational or experimental, please be advised that you will be financially responsible for payment of such services. These may include the following, depending on what the doctor orders and the provisions of your policy. We make every possible effort to determine your policy coverage and limitations, but the coverage is ultimately up to Blue Cross determination.

Service	Cost
Spinal and/or Extremity Manipulation for maintenance	1-2 regions $42, Extremity $40 3-4 regions $52
Interferential Electric Stimulation Therapy	$20
Foot Orthotics	$256 and up
Pillows	$36 and up
Nutritional Supplements	

I, _____ have been notified before services were rendered, that the above services may not be covered. In the event that Blue Cross denies coverage, I acknowledge that I am responsible for payment of such services.

Signature _____

Date _____

Witness _____