Sunrise CHIROPRACTIC
Chiropractic, Homeopathy, & Brain Integration

PATIENT INFORMATION

First Name:_____ Last Name:_____ MI:_____

Date of Birth:_____ Social Security #:_____ Sex: F M

Martial Status:_____ Are you a student? _____

Primary Address:_____

Primary Phone:_____ Email:_____

Employer:_____ Occupation:_____

Spouse's Name:_____ Occupation:_____ Primary Phone:_____

Emergency Contact:_____ Relationship:_____ Primary Phone:_____

Who were you referred by? _____

GUARDIAN OR RESPONSIBLE PARTY ACCOMPANYING PATIENT UNDER THE AGE OF 18

First Name:_____ Last Name:_____ Date of Birth:_____

Primary Address:_____

Primary Phone:_____ Employer:_____ Occupation:_____

Relationship to Patient:_____ Marital Status:_____

INSURANCE (PLEASE PRESENT MEDICAL CARDS FOR PHOTOCOPY)

Primary Company:_____ Company Address:_____

Group #_____ ID #:_____ Policy Holder:_____

Relationship to Patient:_____ Social Security #:_____ Date of Birth:_____

Primary Address:_____
Secondary Company:_____ Company Address:_____

Group #_____ ID #:_____ Policy Holder:_____

Relationship to Patient:_____ Social Security #:_____ Date of Birth:_____

Primary Address:_____

CERTIFICATION OF INFORMATION

By my signature below, I authorize Sunrise Chiropractic Center PC to release any information deemed appropriate to any doctor, insurance company, or attorney in the course of my treatment or in order to process any claim for reimbursement of charges. I hereby assign all the right, title and interest relative to insurance benefits to Sunrise Chiropractic Center PC. I clearly understand and agree that I am personally responsible for payment of all services rendered to me. Further, in the even that my account is turned over for collection, I understand that I will be responsible for any charges, attorney fees, collection costs and court costs incurred in collecting the balance

_____ _____

Patient Signature Date

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HEALTH HISTORY

Name:_____ DOB:_____ Age:_____ Height:_____
Weight:_____

Are you presently under a physician's care or have you been during the past five years? Y N Date of last exam:_____

Please list any and all medications that you are presently taking (antibiotics, pain meds, heart meds, anti coagulants, vitamins):

_____

Please circle if you've been affected by any of the following conditions:

AIDS/HIV	Diabetes	Liver Disease	Prostate Problems
Alcoholism	Emphysema	Measles	Psychiatric Care
Allergy Shots	Epilepsy	Migraine	Stroke
Anemia	Fractures	Miscarriage	Suicide Attempt
Appendicitis	Goiter	Mononucleosis	Thyroid Problem
Arthritis	Gout	Multiple Sclerosis	Tuberculosis
Asthma	Heart Disease	Mumps	Tumors
Bleeding Disorders	Hepatitis	Osteoporosis	Ulcers
Breast Lump	Hernia	Pacemaker	Whooping Cough
Cancer	Herniated Disk	Parkinson's Disease	Other:_____
Chemical Dependency	High Cholesterol	Pinched Nerve	_____
Chicken Pox	Kidney Disease	Pneumonia	_____

Exercise: None Moderate Daily Heavy

Work Activity: None Moderate Daily Heavy

Habits: Smoking (If yes, how many packs a day? _____) Alcohol Coffee High Stress Level

Injuries:_____

Falls:_____

Broken Bones:_____

Surgeries:_____

Motor Vehicle Accidents:_____

Please list any family history of heart disease, cancer, arthritis, etc:

_____

Please list all allergies:_____

Signature:_____ Date:_____

If minor, parent/guardian signature:_____ Date:_____

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PATIENT CONDITION

Reason for Visit:_____

When did your symptoms appear:_____

Is this condition getting progressively worse:_____

How often do you have this pain (Please circle): Constant Frequently (50-75% of the day)

Occasionally (25-50% of the day) Intermittently (less than 25% of the day)

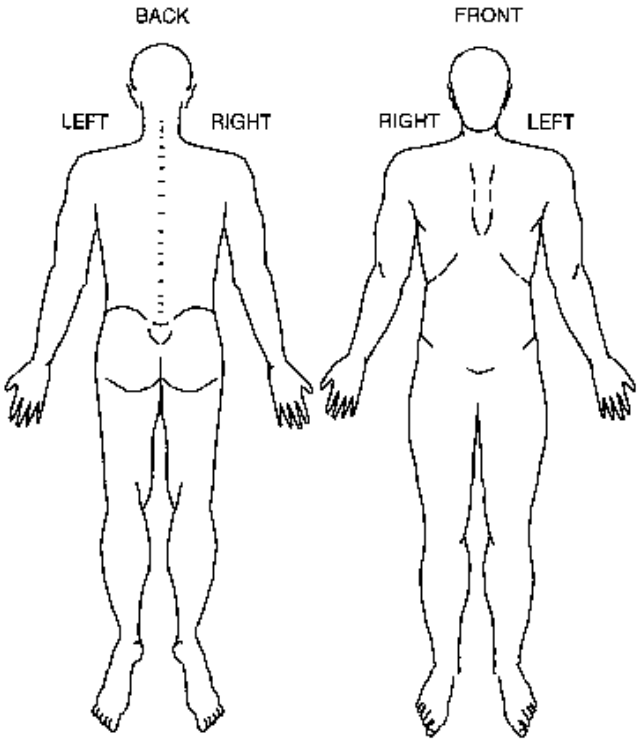
Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

In general would you say that your overall health is: Excellent Very Good Good Fair Poor

Mark the area of your body where you feel the described sensations. Use the appropriate symbols, mark areas of radiating pain and include all affected areas. You may draw in the face as well.

Numbness: -------- Pins & Needles: oooooo Burning Pain: xxxxxx Stabbing Pain: //////// Aching Pain: ((((((



Please mark on the line the pain level that most accurately represents your pain:

NO PAIN	0 1 2 3 4 5 6 7 8 9 10	UNBEARABLE PAIN
Pain Right Now	0 1 2 3 4 5 6 7 8 9 10	_____
Average Pain	0 1 2 3 4 5 6 7 8 9 10	_____
Pain at Best	0 1 2 3 4 5 6 7 8 9 10	_____

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NOTICE OF PRIVACY PRACTICES

The privacy and protection of your patient information is of the utmost importance to SCC. As required by the Federal Health Insurance Portability and Accountability Act (HIPPA) Regulations, a Notice of Privacy Practices must be provided by all health care providers to their patients. At SCC a copy is clipped to the new patient paperwork clipboard and a copy will be provided upon request. SCC reserves the right to modify the privacy practices outlined in the notice.

I authorize SCC to release my protected health information to (Please circle):
Yes_____
(Name of person to whom information may be released other than self, dentist and or physician, i.e. parent, grandparent, spouse)
No
(Self, dentist and or physician)
I have read and understand the Notice of Privacy Practices for SCC and by signing below, acknowledge the same.

_____ _____ _____
Signature of Patient/Legal Guardian Date Relationship to patient if applicable

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment and any alternatives to the treatment. There are some risks that may be associated with treatment. In particular you should note:

1. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.
2. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused or may be caused by spinal or soft tissue manipulation or treatment.
3. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation had been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms.

Musculoskeletal care contributes to your overall well being. The risk of injuries or complications from treatment is substantially lower than that associated with many medical treatments, medications and procedures given for the same symptoms.

I acknowledge that I have discussed the following with my health care provider:

1. The condition that the treatment is to address
2. The nature of the treatment
3. The risk and benefits of that treatment
4. Any alternative treatments

I have had the opportunity to ask questions and receive answers regarding the treatment. I consent to the treatments offered or recommended to me by my health care provider, including osseous and soft tissue manipulation. I authorize Dr. Schiller to diagnose and treat my condition as deemed appropriate. I intend this consent to apply to all my present and future care with Sunrise Chiropractic Center PC and Dr. Gwen Schiller, DC.

_____ _____
Patient Name (Please print) Date

_____
Patient Signature

Notifier: Sunrise Chiropractic Center, PC
7610 Union Blvd, Suite 125, Colorado Springs, CO 80920
Patient Name: **Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for Chiropractic services below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the Chiropractic Services below.

Chiropractic Services	E. Reason Medicare May Not Pay:	F. Estimated Cost
◦Electric Muscle Stimulation	Medicare does not pay for this service	$25
◦Therapeutic Ultrasound	Medicare does not pay for this service	$25
◦Chiropractic manipulation	Medicare will not cover manipulation that is preventative or maintenance	$50
◦ Supplements, supplies or homeopathic remedies	Medicare does not pay for this service	$25-$40

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **Chiropractic services** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **Chiropractic services** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **Chiropractic services** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **Chiropractic services** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. 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											**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**	

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1 – What is your pain RIGHT NOW?

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

2 – What is your TYPICAL or AVERAGE pain?

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

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

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

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

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

OTHER COMMENTS:

_____

_____

_____

Examiner

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, with permission from Elsevier Science.

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date