WILKINS
CHIROPRACTIC

Welcome to Wilkins Chiropractic. Please fill out the information below so we can know more about you and understand how we can best serve you.

Today's Date: / / **Signature of Patient:** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Mobile Phone _____ **Work Phone** _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Mobile Phone ❑ Work Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

Current medications, including frequency and dosage if known:

	Start Date		Start Date
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

List any known allergies:

1) _____ 3) _____

2) _____ 4) _____

Medical History (Past or current illnesses):

□ High blood pressure	□ Diabetes	□ Heart problems
□ Stroke	□ Osteoporosis	□ Cancer: _____
□ Blood clots	□ Hepatitis / HIV	□ Other: _____
□ 'Loose' joints	□ Arthritis	

Please briefly explain your current complaint(s): _____

_____

_____

Have you had an X-ray or CT scan or MRI of your spine in the past 6 months? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

WILKINS
CHIROPRACTIC

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I, _____, hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here Dr. Haley Wilkins and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Wilkins and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

Patient Signature:

_____

Patient's Representative Signature (If the patient is a minor or is physically or mentally incapacitated):

_____

Date:

_____

HIPPA PATIENT AUTHORIZATION FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose you PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so. This authorization for release of information covers the period of healthcare from _____, 20_____to _____, 20____. By signing this form, you authorize our use and disclosure to third parties, including but not limited to our billing and scheduling software provider, ChiroTouch, and our Clinic's franchisor, Wilkins Chiropractic, of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this authorization but later change your mind, you have the right to revoke this Authorization by delivering to us a written and dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization.

The patient understands and agrees that:

- The Clinic has a Notice of Privacy Practices. The patient has received and had the opportunity to review this Notice before signing this Authorization. The Clinic encourages all patients to review the Notice of Privacy Practices.
- The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.
- All my medical records and PHI may be disclosed or used for treatment, payment, or healthcare operations, and for certain marketing purposes. The Clinic will not receive any payment from a third party for marketing purposes in connection with the use or disclosure of your PHI.
- The Clinic or its business affiliates may use your PHI to contact you with appointment reminders, educational and promotional items in the future via email, phone, fax, and/or text messages. We WILL NOT ever sell or "SPAM" your personal contact information.
- The patient has the right to restrict the uses of his/her information, but the Clinic does not have to agree to all such restrictions.
- The patient may revoke this Authorization in writing at any time and all future disclosures that require the patient's prior written authorization will then cease. See the Notice of Privacy Practices for additional details.
- The Clinic may not condition your treatment or payment on whether you sign this Authorization.

Information used or disclosed pursuant to this Authorization may be re-disclosed by the patient and may no longer be protected by federal or state law.

The Authorization was signed by:

Patient Printed Name: _____

Patient Signature: _____ **Date:** _____

Witness Printed Name: _____

Witness Signature: _____ **Date:** _____

Authorization to Discuss Medical Information

I, _____, hereby authorize Wilkins Chiropractic to verbally discuss information about me with:

- Name:_____
- Home/Cell Phone:_____
- Relationship to patient: _____

Patient Name: _____

Patient Signature: _____

Date: _____

Emergency Contact Information:

- Name:_____
- Home/Cell Phone:_____
- Relationship to patient: _____

NECK PAIN AND DISABILITY INDEX

Patient Name:_____ Date:_____/_____/_____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and then mark the box that 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 worse than 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 objects without any extra pain.
- ☐ I can lift heavy objects, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ☐ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ☐ I can lift very light objects.
- ☐ 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 light pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I can't read as much as I want to 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 headache at all.
- ☐ I have slight headaches which 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.
- ☐ I 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.
- ☐ I can do only 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 work at all.
- ☐ I can't do any work at all.

SECTION 8 - DRIVING

- ☐ I can drive without any neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive at all.

SECTION 9 - SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 - RECREATION

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

NECK PAIN SCALE

Rate the severity of your **Neck Pain** by indicating on the following scale.

Absence I----------I **Extreme**

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____ Date: _____/_____/_____

Please read instructions carefully.
This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life.
Please read all statements in each section and mark the box which most closely describes your problem.

SECTION 1 - PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE

- ☐ I do not have to change my way of washing or dressing to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - LIFTING

- ☐ I can lift heavy objects without any extra pain.
- ☐ I can lift heavy objects, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy objects off the floor.
- ☐ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ☐ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ☐ I can only lift very light objects at the most.

SECTION 4 - WALKING

- ☐ I have no pain on walking.
- ☐ I have some pain but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half an hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain.

SECTION 6 - STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain.

SECTION 7 - SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Pain reduces my normal sleep by 1/4 each night.
- ☐ Pain reduces my normal sleep by 1/2 each night.
- ☐ Pain reduces my normal sleep by 3/4 each night.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ My social life is unaffected by pain apart form limiting more energetic interests.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - DRIVING / RIDING IN CAR, ETC.

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

Absence I----------I **Extreme**

X-Ray Consent Form

Patient Consent To X-Ray:

I hereby authorize the performance of diagnostic x-rays. The doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed:_____ Date:_____

Consent To X-Ray A Minor:

I am a parent or legal guardian of _____, who is a minor, _____years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed:_____ Date:_____

Females, Regarding Possibility of Pregnancy:

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed:_____ Date:_____