O'BRIEN FAMILY CHIROPRACTIC CENTER
1519 E. River Rd. Ste. B Muskegon, MI 49445
Phone: 231-744-6400•Fax: 231-744-6464

Case #: _____
Views: _____

1519 E. River Rd. Suite B, Muskegon, MI 49445
Phone: 231-744-6400 Fax: 231-744-6464

DATE: _____

PERSONAL HISTORY

Name: _____ Birth Date: _____ Age: _____

Address: _____ Sex: Male / Female

City: _____ State: _____ Zip: _____ Home Phone: _____

Race: Caucasian, African American, Hispanic, Asian, American Indian, Other

Cell Phone: _____

E -mail Address:_____

Business Employer: _____ Fax #: _____

Occupation: _____ Business Phone: _____

Name of Spouse: _____ Spouse's Employer: _____

Type of Work: _____ Names & Ages of Children under 18:_____

Referred To This Office By: _____ _____

Who is responsible for your bill? You and ☐Spouse ☐Worker's Comp ☐Auto Insurance ☐Medicare ☐Medicaid

Personal Health Insurance Carrier: _____ Health Card ID #: _____

Insured Person's Name: _____ Group #: _____

Insured Person's Date of Birth: _____ Have you had previous chiropractic care? ☐ Yes ☐ No

Insured Person's Social Security #: _____ Name of Previous Chiropractor: _____

Amount of time under chiropractic care: _____

Date of last Chiropractic visit: _____

CURRENT HEALTH CONDITION

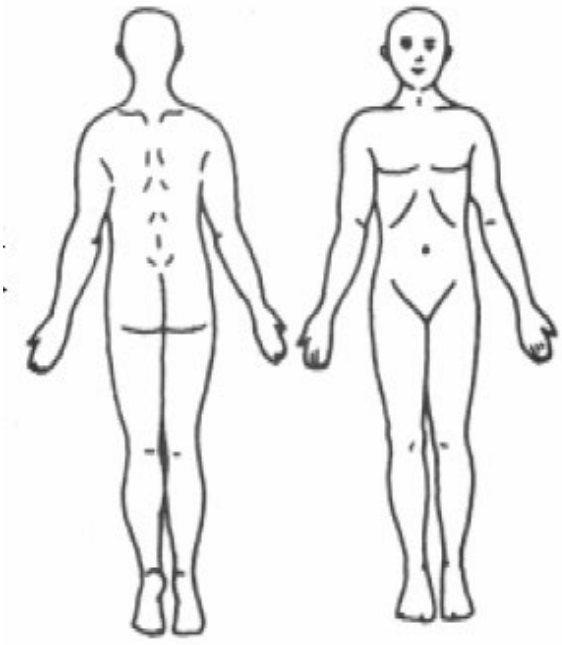
Height: _____Weight: _____

Chief Complaint (why you are here today):

_____

_____

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT



When did this condition begin? _____

Has it ever occurred before? ☐ Yes ☐ No

Please circle the number that best describes your pain today.

1 2 3 4 5 6 7 8 9 10

CHIEF COMPLAINT – HPI FORM

Is condition: ☐Auto related ☐Work related ☐Other ☐No injury

Explain: _____

Date of Accident: _____

Time of Accident: _____

Complaint / Pain Onset Date: _____

If work, have you filed an injury report with your employer?

☐Yes ☐ No Claim #: _____

SMOKING STATUS:

Have you ever used tobacco? YES NO

If Yes, Please Circle Which Status Applies to You:

Current Every day Smoker

Current Some Day Smoker

Former Smoker

MEDICATIONS: What medications are you currently taking and for what conditions?

_____

_____

_____

Medication Allergies: _____

_____

Additional Allergies: _____

_____

MECHANISM OF ONSET: Before you began to suffer with this problem, was there an earlier accident, injury, or condition that may or may have been directly related to this problem? (Example: fall, auto injury, sports trauma, repetitive motion on the job) _____

_____

SYMPTOMS: When this problem is at its worst, please explain in your words how exactly it feels? _____

_____

QUALITY:

☐ Burning ☐ Diffuse ☐ Dull / Aching ☐ Localized ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tingling

☐ Radiating ☐ Other: _____

Patient Name: _____ Date: _____

TIMING:

☐ Worse AM ☐ Worse PM ☐ Worse with activity ☐ Intermittent ☐ Constant ☐ Worse at night

How often do you find yourself suffering from this problem? _____

How long does the problem last? (Provide all details on timing) _____

DAILY ACTIVITIES:

Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

RECREATIONAL ACTIVITY:

_____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
_____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
_____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

On a scale of 1 to 10 with 10 being the highest, rate your commitment to getting rid of the problem? _____

_____

Please specify any concerns that could interfere with your commitment (example: time, transportation, other):

_____

Doctor Signature: _____ Date: _____

Blood Pressure: _____

ADDITIONAL PATIENT HISTORY ON SUBLUXATION

Our patients have had literally dozens of impacts that could cause subluxations. I want to discover several of yours.

1. When was your most recent auto accident? _____
    a. Speed: _____
    b. Front, side, or rear-end collision? _____
    c. Was treatment received? YES / NO
    d. If yes, where? _____

2. When was your most recent stress or strain at work? _____
    a. Was any treatment needed? YES / NO
    b. When was the one before that? _____
    c. What type of jobs have you done? _____

3. Previous Surgeries or Hospitalizations? YES / NO
    If Yes, Please Explain:_____

4. What sport or recreational activities do you do? _____
    a. When was your most recent stress or strain during your activity?
    _____
    b. Was any treatment received? YES / NO
    c. When was the one before that? _____

5. Is there any other injury to your spine, minor or major, that the doctor should know about?

VERTEBRAL SUBLUXATIONS CAN CAUSE PAIN

FAMILY HEALTH HISTORY

Patient Name_____ Date_____

Please review the below listed symptoms and conditions and indicate those that are **current** health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a **past** problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

	Father Age____	**Mother** Age____	**Spouse** Age____	**Brother**(s) Age____ Age____		**Sister**(s) Age____ Age____		**Children** Age____ Age____ Age____		
First Name										
Condition										
Allergies										
Anxiety										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Epilepsy										
Frequent Colds/Flus										
Gassy/Bloating										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Low Energy										
Migraine										
Neck Pain										
Nervousness										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Sleeping Problems										
Other:										
Other:										
Other:										

O’Brien Family Chiropractic Center

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Patient Name: _____

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to O’Brien Family Chiropractic Center, of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to O’Brien Family Chiropractic Center.

Authorization To Release Medical Record Information

O’Brien Family Chiropractic Center is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by O’Brien Family Chiropractic Center. This authorization I give with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said O’Brien Family Chiropractic Center.

The undersigned certifies that he / she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of Witness: _____

Signature of Patient or Responsible Party: _____

Name of Primary Insurance Company:

_____

Please sign here to confirm you have No other health insurance coverage.

_____
Signature Date

Policies

1. All 1st adjustment charges are payable when services are rendered.
2. X-ray film is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand O'Brien Family Chiropractic Center will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to O'Brien Family Chiropractic Center and will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered to me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount. I authorize O'Brien Family Chiropractic Center to obtain a credit report if deemed necessary.

Patient Signature_____ Date_____

Guardian Signature Authorizing Care _____ Date_____

In Case of Emergency Notify_____

Relationship_____ Address_____

Phone#_____

Pregnancy Release: This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Signature: _____Date: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____Signature: _____ Date:_____

Parent or Guardian: _____Signature:_____ Date:_____

Witness Name: _____Signature:_____Date:_____

O'Brien Family Chiropractic **1519 E. River Rd., Suite B, Muskegon MI** **231-744-6400**

Patient Name: **Identification Number:**

Medicare Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for 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 Services below.

Services:	Estimated Cost:	Reason Insurance May Not Pay
Manual Manipulation of the Spine Exam X-Rays Massage Therapy Ice Pack Traction	$38.00-$65.00 $88.00-$116.00 $35.00-$245.00 $45.00-$90.00 $10.00-$18.00 $11.00-$22.00	• NOT A COVERED BENEFIT • NOT A COVERED BENEFIT • NOT A COVERED BENEFIT • NOT A COVERED BENEFIT • NOT A COVERED BENEFIT • NOT A COVERED BENEFIT

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 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.

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

☐ **OPTION 1.** I want the services listed above. You may ask me to pay now, but I also want Medicare billed for an official decision on payment, which will be 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 be refunded any payments you made, less co-pays or deductibles.

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

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

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.

Signature:	Date:

O'Brien Family Chiropractic 1519 E. River Rd., Suite B, Muskegon MI 231-744-6400

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: *If your insurance (including Medicaid) does not pay for any of the services below, you may have to pay. Some insurances (including Medicaid) may not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect some insurances (including Medicaid) may not pay for some or all of the Services below.*

Services:	Estimated Cost:	Reason Insurance May Not Pay
Manual Manipulation of the Spine Exam X-Rays Massage Therapy Ice Pack Traction	$38.00-$65.00 $88.00-$116.00 $35.00-$245.00 $45.00-$90.00 $10.00-$18.00 $11.00-$22.00	• NOT A COVERED BENEFIT • NOT A COVERED BENEFIT • NOT A COVERED BENEFIT • NOT A COVERED BENEFIT • NOT A COVERED BENEFIT • NOT A COVERED BENEFIT

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.**

☐ **I want the services listed above. Please bill my insurance. I understand that if insurance (including Medicaid) does not pay, I am responsible for payment.**

☐ **OPTION 2.** I want the services listed above, but do not bill Medicare. I may be asked to pay now as I am responsible for payment.

We advise that you check with your insurance before scheduling your appointment to find out your chiropractic benefits to help you make an informed decision.

Signing below means that you understand this notice.

Print Name: _____ Date: _____

Signature: _____