WellSpring Chiropractic
Dr. Shelia Payton

NEW PATIENT INFORMATION FORM

Please print all information. All blanks must be filled to allow us to serve you quickly and efficiently. If you already completed this form in the last 2 months, please fill out just the first 2 pages and only items on other pages that have changed since your initial visit. Thank you for your cooperation.

Date: ______________________ Date of Birth: ______________________

Patient Name: ____

Address: ____

____

Phone: Home: ( ) ______________________ Work: ( ) ______________________

Primary Doctor: ____

Address: ____

City: ____

Phone: ( ) ______________________ Fax: ( ) ______________________

Do you want your medical records sent to this physician? ☐ Yes ☐ No

Are there any other physicians to whom you would like your medical records sent?
(Please include name, address, and phone)

____

____

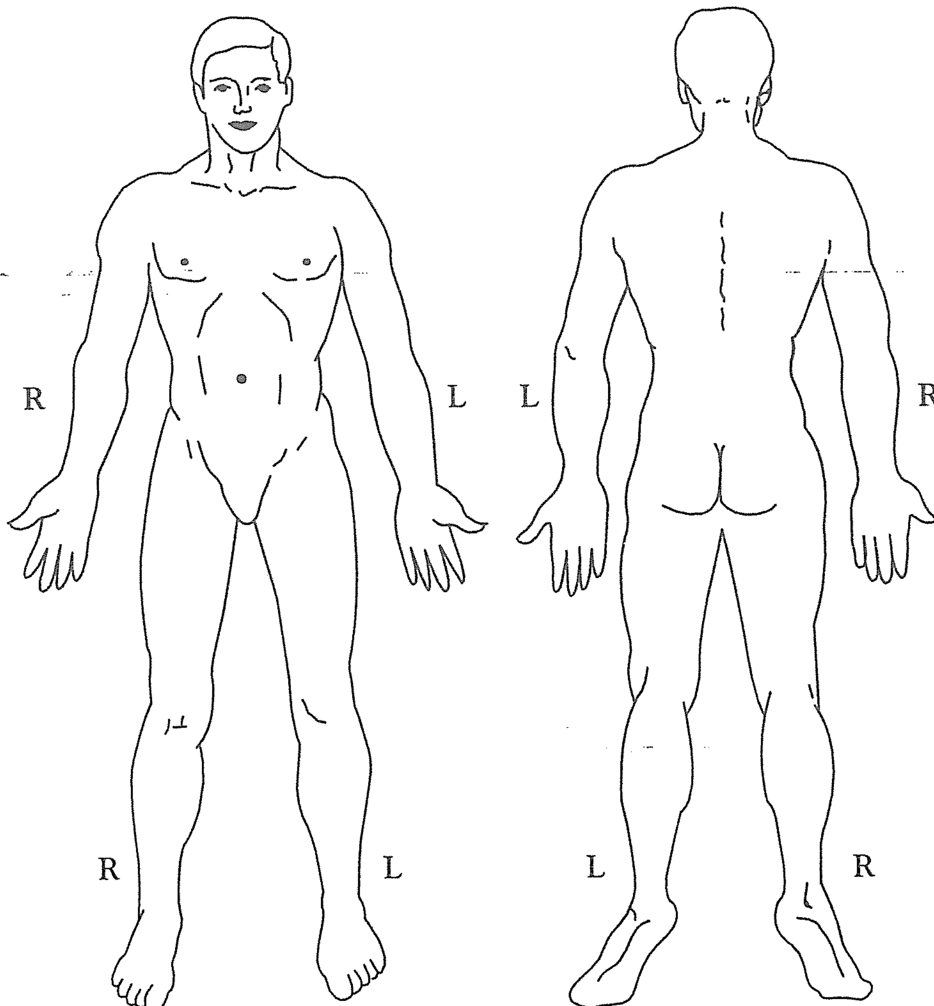
____

____

ORTHO PAIN CHART

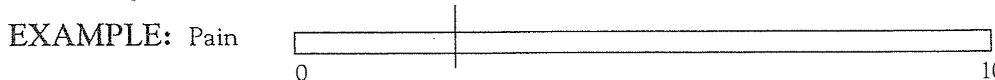
Mark the areas on your body where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas.

Numbness =	= = = = = = = = =	Pin & Needles =	o o o o o o o o o	Burning Aching =	x x x x x x x x x	Stabbing =	//// //// ////

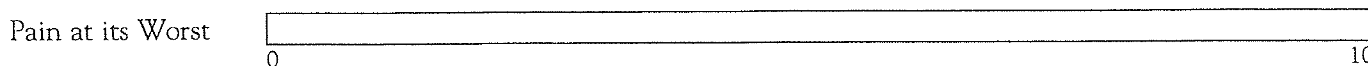


Please indicate your current pain level by placing a line below with "0" = no pain and "10" = worst pain imaginable.

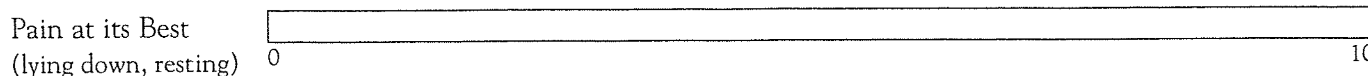
EXAMPLE: Pain



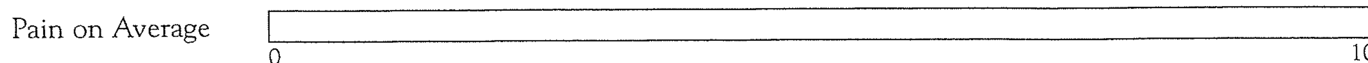
Pain at its Worst



Pain at its Best
(lying down, resting)



Pain on Average



HISTORY OF PRESENT COMPLAINT

1. Age: ________ ❑ Male ❑ Female Which side? ❑ Right ❑ Left
2. Where is your problem located? ❑ Neck ❑ Upper Back ❑ Arm ❑ Lower Back ❑ Hip ❑ Leg
3. How long have you had this problem? ________ Since? ____/____/____ (month / day / year)
4. Briefly, please give the details of how this problem originally started:

____

____

____

____

5. Was this from a work-related injury? ❑ No ❑ Yes – Is it under workers compensation? ❑ No ❑ Yes

   Have you missed any work because of this problem? ❑ No ❑ Yes, how much? ________
6. Please describe your present pain/problem now (what you feel, where, when, etc.):

____

____

____

7. Have you had spinal surgery in the past: (Check one) ❑ Yes ❑ No How many times? ____

   What type of surgery(s) was/were performed? ❑ Discectomy ❑ Laminectomy ❑ Fusion ❑ IDET

   ❑ Unknown ❑ Other ________ What spinal level? ________

   What was the date of your most recent spine surgery? ________

   Did you improve from your spine surgery procedure(s)? ❑ Yes ❑ No
8. Which of the following best describes your ratio for neck & arm or back & leg discomfort (if appropriate)

   A. 100% back pain and 0% leg pain
   B. 90% back pain and 10% leg pain
   C. 75% back pain and 25% leg pain
   D. 50% back pain and 50% leg pain
   E. 25% back pain and 75% leg pain
   F. 10% back pain and 90% leg pain
   G. 0% back pain and 100% leg pain

   A. 100% neck pain and 0% arm pain
   B. 90% neck pain and 10% arm pain
   C. 75% neck pain and 25% arm pain
   D. 50% neck pain and 50% arm pain
   E. 25% neck pain and 75% arm pain
   F. 10% neck pain and 90% arm pain
   G. 0% neck pain and 100% arm pain
9. For any pain/numbness in your arm(s) or leg(s), which side is worse? (Choose one if appropriate)

   Leg Symptoms

   A. 100% left leg and 0% right leg
   B. 75% left leg and 25% right leg
   C. 50% left leg and 50% right leg
   D. 25% left leg and 75% right leg
   E. 0% left leg and 100% right leg

   Arm Symptoms

   A. 100% left arm and 0% right arm
   B. 75% left arm and 25% right arm
   C. 50% left arm and 50% right arm
   D. 25% left arm and 75% right arm
   E. 0% left arm and 100% right arm

CURRENT PAIN PROFILE

10. Please choose letters A – F (in first column) to answer the questions in column two.

A. Unable to tolerate
B. About 15 minutes only
C. About 30 minutes only
D. About 45 minutes
E. About 1 hour
F. Indefinitely

How long can you sit? ______________________

How long can you stand? ______________________

How long can you walk? ______________________

11. Which of the following activities change the nature of your pain?

	Aggravates Pain	Relieves Pain	Neither
Sitting	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑
Leaning forward (brushing teeth)	❑	❑	❑
Bending forward	❑	❑	❑
Lying on your side	❑	❑	❑
Lying on your back	❑	❑	❑
Lying on your stomach	❑	❑	❑
Rising from sitting	❑	❑	❑
Changing positions	❑	❑	❑
Coughing / Sneezing	❑	❑	❑
Driving	❑	❑	❑

Now go back and CIRCLE the box to indicate <u>**the most aggravating activity**</u> and the <u>**most relieving activity**</u>.

12. If the symptoms of your present pain have changed, please indicate the most appropriate statement: (Circle one)

A. My symptoms have remained the same since the time of onset.
B. My symptoms are more severe since the time of onset.
C. My symptoms are less severe since the time of onset.

13. How have the symptoms of your present pain changed: (Circle one)

A. no change in symptoms
B. increased aggravation in one arm or leg
C. increased aggravation in both arms or legs
D. increased aggravation in the back or neck
E. increased aggravation in both arms/legs and back/neck

<u>For Office Use Only</u>

BB M/I
NP

PAST BACK HISTORY

14. Of the following list of treatments, please indicate the effect of those which have been used in an attempt to help your present injury: (Check one of each)

	Which type	Helpful	No Help	Not Used
Antiinflammatory	____________	❑	❑	❑
Muscle Relaxants	____________	❑	❑	❑
Narcotic Pain Medications	____________	❑	❑	❑
Hot Packs	____________	❑	❑	❑
Ice	____________	❑	❑	❑
Ultrasound	____________	❑	❑	❑
TENS Unit / Muscle Stim (Circle)	____________	❑	❑	❑
Physical Therapy Treatment	____________	❑	❑	❑
Back/Neck Exercises	____________	❑	❑	❑
Chiropractor	____________	❑	❑	❑
Epidural Block/Injection	____________	❑	❑	❑
Facet Block/Injection	____________	❑	❑	❑
SI Joint Block/Injection	____________	❑	❑	❑
Trigger Point Injection	____________	❑	❑	❑
Acupuncture	____________	❑	❑	❑
Traction / VAX-D (Circle)	____________	❑	❑	❑
Other: ____________	____________	❑	❑	❑

15. Please indicate whether you have had any of the following studies and write when/where the most recent was:

	YES	NO	WHEN/WHERE		YES	NO	WHEN/WHERE
Regular X-Ray of spine	❑	❑	____________	Myelogram	❑	❑	____________
CT Scan of spine	❑	❑	____________	Discogram	❑	❑	____________
EMG	❑	❑	____________	MRI of spine	❑	❑	____________
Bone Scan	❑	❑	____________	Bone Density	❑	❑	____________

16. Have you had any past episodes of similar pain or injury? ❑ Yes ❑ No (please describe)

____

____

____

17. List all other physicians with whom you have consulted in the past year for this problem.

____

____

____

MEDICAL / SURGICAL HISTORY

Please choose all current and past medical conditions

- ❑ No medical problem
- ❑ High blood pressure
- ❑ Heart attack/ ❑ Heart Disease
- ❑ Heart failure
- ❑ Abnormal heart rhythm
- ❑ Lung disease
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Liver disease
- ❑ Hepatitis
- ❑ Diabetes/ ❑ Type I ❑ Type II
- ❑ Thyroid disease
- ❑ Stomach ulcers/ ❑ Gastric Reflux
- ❑ Irritable bowel
- ❑ Stroke
- ❑ Seizures
- ❑ Cancer – where? ________________
- ❑ Kidney failure
- ❑ Kidney stones
- ❑ Osteoporosis/ ❑ Osteopenia
- ❑ Osteo-Arthritis
- ❑ Rheumatoid arthritis
- ❑ Bleeding disorders
- ❑ Anemia
- ❑ Blood clots in legs/lungs
- ❑ Endometriosis
- ❑ Ovarian cysts
- ❑ Anxiety
- ❑ Depression
- ❑ Schizophrenia
- ❑ Anorexia/bulemia
- ❑ Alcoholism
- ❑ Seen a psychiatrist
- ❑ HIV

Are you under a doctor's care for any other medical condition? ❑ Yes ❑ No If yes, please explain

____

Please choose all surgeries you have had

- ❑ Spine-Neck
- ❑ Spine-Lower back
- ❑ Brain
- ❑ Heart / ❑ Pacemaker / ❑ IV Filter
- ❑ Angioplasty / ❑ Stent/ ❑ Bypass
- ❑ Lung
- ❑ Gallbladder / ❑ Stomach
- ❑ Appendix / ❑ Intestine
- ❑ Hernia / ❑ Colon / ❑ Rectum
- ❑ Hysterectomy / ❑ C-section / ❑ Female
- ❑ Kidneys / ❑ Bladder / ❑ Urinary
- ❑ Prostate
- ❑ Shoulders / ❑ Arms / ❑ Hands
- ❑ Hips / ❑ Knees / ❑ Legs / ❑ Feet
- ❑ Eyes
- ❑ Ears
- ❑ Nose
- ❑ Throat / ❑ Tonsils
- ❑ Other ____________
  ____
  ____

Allergies	
Substance	Reaction

All Current Medications	
Name	Dose

SOCIAL HISTORY

18. Current work status: ❑ Working regular duty ❑ Working restricted duty (Since ________) ❑ Retired
    ❑ Disabled (Since ________) ❑ Student ❑ Homemaker ❑ Unemployed
    Company: ________________ Occupation: ________________ Title: ________________
    How long have you worked for this company? ________________________________

19. Marital status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

20. Number of Children: ________________

21. I live: ❑ Alone ❑ With: ________________________________

22. I live in a: ❑ House ❑ Apartment ❑ Assisted living ❑ Nursing home

23. Are you a cigarette smoker? ❑ Yes, now ❑ Never ❑ Quit - How long ago did you quit? ________
    If you answered "yes" or "quit", how much do or did you smoke per day?
    ❑ Less than 1/2 pack ❑ 1/2 pack ❑ 3/4 pack ❑ 1 pack ❑ More (How many?) ________
    How old were you when you started smoking? ________

24. Do you drink any alcoholic beverages? (Check one) ❑ None ❑ Occasional
    ❑ 1 to 3 drinks per month ❑ 1 to 2 drinks per week ❑ 1 to 2 drinks per day ❑ 3 to 5 drinks per day
    ❑ More than 5 drinks per day How many? ______ Alcoholic in past? ❑ Yes ❑ No

25. Have you ever had a problem with drug dependence? ❑ Yes ❑ No

26. Are there any law suits pending or contemplated related to your problem? ❑ Yes ❑ No
    If yes, please give your attorney's name and phone number: ________________________

27. Please write any additional information that you feel is important for us to know.

____

____

____

____

FAMILY HISTORY

What illnesses run in your close family (other than yourself)?

- ❑ Scoliosis
- ❑ Spine disease
- ❑ Arthritis
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Diabetes
- ❑ Cancer
- ❑ Bleeding disorder
- ❑ Mental illness
- ❑ Alcoholism
- ❑ Kidney disease
- ❑ Other: ____________________

____

____

____

REVIEW OF SYSTEMS

Please check off any current or recent problems you have

GENERAL
- ❑ Unexplained weight loss
- ❑ Appetite change
- ❑ Fevers or chills
- ❑ Night sweats
- ❑ Marked fatigue
- ❑ Difficulty sleeping

EAR, NOSE, THROAT
- ❑ Difficulty swallowing
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Ear pain
- ❑ Nosebleeds
- ❑ Gum trouble

EYES
- ❑ Glasses
- ❑ Change of vision

CARDIOVASCULAR
- ❑ Heart or chest pain
- ❑ Abnormal heartbeat
- ❑ Poor heart function

LUNG
- ❑ Morning cough
- ❑ Shortness of breath
- ❑ Productive cough or sputum

DIGESTIVE
- ❑ Nausea or vomiting
- ❑ Stomach pain or ulcers
- ❑ Heartburn/acid stomach
- ❑ Frequent diarrhea
- ❑ Frequent constipation
- ❑ Uncontrolled loss of stool
- ❑ Blood in stool
- ❑ Hemorrhoids

SKIN
- ❑ Frequent rashes
- ❑ Frequent itchiness
- ❑ Easy bruising
- ❑ Swollen ankles

NEUROLOGICAL
- ❑ Seizures
- ❑ Blackouts/fainting
- ❑ Tremor
- ❑ Headaches/migraines

MUSCULOSKELETAL
- ❑ Joint Pains / Swelling
- ❑ Back Pain
- ❑ Neck Pain
- ❑ Muscle Aches

GENITOURINARY
- ❑ Burning on urination
- ❑ Difficulty starting urination
- ❑ Incontinence
- ❑ Pelvic pain
- ❑ Urinate at night more than once
- ❑ Unable to completely empty bladder

PSYCHIATRIC
- ❑ Depression
- ❑ Nervous exhaustion
- ❑ Anxiety
- ❑ Paranoia
- ❑ Obsessive/compulsive behavior

HEALTH CARE AUTHORIZATION FORM

Patient's Name ____

Patients SS# ______________________________ Date of Birth ____________

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **Dr. Shelia T.PaytonPC** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to **Dr Shelia T. Payton PC** to use my address and /or phone number and clinical records to contact me with birthday cards, holiday related cards, newsletters, appointment reminders and information about treatment alternatives or other health related information. (circle any objection)

I give **Dr. Shelia T. Payton PC** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private ,with prior notice, the doctor will provide a room for these conversations.

By signing this form you are giving **Dr. Shelia T. Payton PC** permission to use and disclose your protected health information in accordance with the directives listed in accordance with Notice of Privacy Practices.

EXPIRATION

The Authorization shall expire on the following date:

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.
You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **Dr. Shelia T. Payton PC.** The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

OUR FINANCIAL POLICY

The following is a statement of Our Financial Policy which we require you read, agree to, and sign prior to any treatment.

PAYMENT POLICY

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMEX, AND DISCOVER.
WE ACCEPT AN EXTENDED PAYMENT PLAN WITH A CREDIT CARD IMPRINT.
WE OFFER A PRE-PAYMENT PLAN WITH SPECIAL INCENTIVES.
WE CHARGE $25 FOR ALL RETURNED CHECKS.
WE CHARGE $50 FOR ALL BROKEN APPOINTMENTS WITHOUT 24 HOURS NOTICE.
We offer special arrangements for wellness care and financial hardships. If you have questions or are interested in special arrangements, please speak to the office staff.

REGARDING UNINSURED PATIENTS

Payments for your care may be paid at the time of service or on the first visit of the week. Weekly payments require credit card imprints. Any payments not received within thirty (30) days are considered past due, and you will receive a statement at that time. You may submit payment to bring your account into a "current" status, or any past due amount will be automatically charged to your designated card below.

REGARDING INSURANCE

The following applies to patients who are interested in filing insurance. If you are not going to file insurance, continue on to "CONSENT FOR CARE AND TREATMENT".

FULL PAYMENT OF ESTIMATED DEDUCTIBLE AND/OR CO-PAYMENTS IS DUE AT TIME OF SERVICE.

We require: A copy of your insurance card
A credit card imprint
The following form completed

Once we have received the necessary information from you, we will file your insurance for you and accept direct assignment of benefits. Any amount not paid by your insurance carrier within 60 days is considered past due and payable by you. You will receive a statement at that time. You may submit payment to bring your account into a "current" status, or any past due amount will be automatically charged to your designated card below.

Your insurance policy is a contract between you and your insurance carrier. Therefore, should your insurance carrier pay less than you expected, or not at all, it is your responsibility to confer with them if you wish to dispute your claim. Such dispute will not effect your financial obligation to make timely payments toward your balance. You are ultimately financially responsible for the services you receive and payment to our office is neither contingent nor dependent upon your insurance company.

I/ We authorize, assign, and direct payment of any medical/chiropractic benefits arising from insurance policies or other coverage through which the patient nsured or covered, and all other proceeds from .. .y insurance and/or settlement or judgment arising out of a claim or lawsuit, directly to Dr. Shelia T. Payton PC

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent to Dr. Shelia T. Payton PC and associates, partners, assistants and designees, to furnish chiropractic/medical care and treatment to the patient for the purposes of diagnosing or treating the patient's physical condition.

In the event that it becomes necessary to collect this bill through an attorney or collection agency, I agree to pay all reasonable and customary attorneys' fees or any collection fees. All bills not paid within thirty (30) days of request are delinquent, and shall bear interest at the highest rate allowable by law. If the account goes into a delinquent status, I will pay any finance charges.

I have read the financial policy, the consent for care and treatment and I certify that I understand its contents and acknowledge that no guarantees have been made to me as to the results of the treatment or examination done by Dr. Shelia T. Payton PC.

____

Patient Signature Date

* * * ** ** * * ** * * * ** *** * * * * * * * **** * * * * * * * * * **

CREDIT CARD: VISA MASTERCARD AMEX DISCOVER

CARDHOLDER NAME:______________________________________

CARD NUMBER: ______________________ EXP DATE __________

I have read and understand the financial policy. I agree to the terms, and I hereby authorize Shelia T. Payton PC's office staff to charge any outstanding balance due this clinic to the above credit card.

____

Patient Signature Date