

Fredrick Chiropractic Plus
3930 Washington St Suite B
Gurnee IL, 60031
847-662-1600
Fax: 847-662-1612

Consent to Contact

I, _____, hereby give my
Chiropractor, Dr Fredrick, D.C., permission to contact my medical facility
_____, regarding my health. My Medical is
Dr. _____, and I approve the contact and conversation about
my health.

Print

Sign

Date

Our office prides itself in confidentiality and following HIPAA compliance
Rules. By signing this release, you are giving authority for our office to
Share your health information with your primary care facility.

Initials

DIPLOMATE, AMERICAN BOARD OF CHIROPRACTIC ORTHOPEDISTS

DIPLOMATE, AMERICAN BOARD OF CHIROPRACTIC INTERNISTS

Mark Fredrick, D.C., D.A.B.C.O., D.A.B.C

2. ABOUT YOU

CELL PHONE CARRIER:

Today's Date: / /

Cell Phone:

e-mail:

Name:

What You Prefer To Be Called:

Male Female

Reason For Visit:

Home Phone:

Address:

Race:

Preferred Language:

Date of Birth: / /

S.S.#

Drivers License #

Address:

City

State

Zip

Employer:

How Long?

Employer Address:

City

State

Zip

Occupation:

Work Phone #:

Referred By:

Primary Doctor's Name & Phone #:

3. IN EVENT OF EMERGENCY CONTACT

Name:

Relation:

Work Phone #:

Home Phone #:

4. SPOUSE INFORMATION

Marital Status:

Single

Married

Divorced

Widowed

Separated

Name:

Home Phone #:

Date of Birth: / /

Employer:

Work Phone #:

SS #

D/L #:

6. AUTO ACCIDENT INFORMATION

Your Attorney:

Phone #:

Address:

City:

State:

Zip:

Name & Address of the vehicles owner:

Your Insurance Company:

Address:

City:

State:

Zip:

Agent/Adjuster:

Phone #:

Policy #:

Claim #:

Other Company:

Address:

City:

State:

Zip:

Agent/Adjuster:

Phone#:

Policy #:

Claim #:

5. ACCOUNT INFORMATION

Person ultimately responsible for account

Name:

Relation:

Billing Address:

Street

City

State

Zip

SS #:

Drivers License #:

Employer:

Work#:

Desired medical payment

Cash

Check

Credit Card

Card #

Exp. Date: / /

Name as it appears on card:

I hereby authorize Fredrick Chiropractic Plus to release to insurance companies, government agencies, or other third party payers and their agents (which may include your employer if your employer is self-insured) information concerning medical care, advice treatment supplies, itemized bills, or other information that may be necessary for the purpose of determining eligibility and available benefits and obtaining payment on my behalf for the health care services provided to me or to the patient covered by this authorization.

I understand that the care and services at Fredrick Chiropractic Plus is subject to review, both during and after treatments covered by this authorization, health care professionals, third party payers and review agencies.

I understand that I will be financially responsible for all charges incurred for the services provided if revocation or refusal to authorize the disclosure of my medical records results in a denial of payment for charges incurred.

I hereby authorize payment directly to Fredrick Chiropractic Plus of the insurance benefits herein specified and otherwise payable to me for this period of treatment. I understand that I am financially responsible to pay for my care, and that if my insurance plan does not pay the full amount due I will be responsible for the balance. This may include costs of collection and/or reasonable attorney's fees.

Signature of Responsible Person:

Date:

/ /

Patient Health Questionnaire – pag 2

Patient Name: _____ Date: _____

What type of regular exercise do you perform? 1. None 2. Light 3. Moderate 4. Strenuous

What is your height and weight?

--	--	--

 Feet Inches Weight

--	--	--

 lbs

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Diabetes
<input type="radio"/>	<input type="radio"/>	Neck Pain	<input type="radio"/>	<input type="radio"/>	Heart Attack	<input type="radio"/>	<input type="radio"/>	Excessive Thirst
<input type="radio"/>	<input type="radio"/>	Upper Back Pain	<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>	Frequent Urination
<input type="radio"/>	<input type="radio"/>	Mid Back Pain	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	Smoking/Tobacco Use
<input type="radio"/>	<input type="radio"/>	Low Back Pain	<input type="radio"/>	<input type="radio"/>	Angina	<input type="radio"/>	<input type="radio"/>	Drug /Alcohol Depend.
<input type="radio"/>	<input type="radio"/>	Shoulder Pain	<input type="radio"/>	<input type="radio"/>	Kidney Stones	Allergies What & Severity(Mild, Mod. Sev.) _____		
<input type="radio"/>	<input type="radio"/>	Elbow/ Upper Arm Pain	<input type="radio"/>	<input type="radio"/>	Kidney Disorders			
<input type="radio"/>	<input type="radio"/>	Wrist Pain	<input type="radio"/>	<input type="radio"/>	Bladder Infection	<input type="radio"/>	<input type="radio"/>	Systematic Lupus
<input type="radio"/>	<input type="radio"/>	Hand Pain	<input type="radio"/>	<input type="radio"/>	Painful Urination	<input type="radio"/>	<input type="radio"/>	Epilepsy
<input type="radio"/>	<input type="radio"/>	Hip/ Upper Leg Pain	<input type="radio"/>	<input type="radio"/>	Loss of Bladder Control	<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema/Rash
<input type="radio"/>	<input type="radio"/>	Knee/ Lower Leg Pain	<input type="radio"/>	<input type="radio"/>	Prostate Problems	<input type="radio"/>	<input type="radio"/>	HIV/AIDS
<input type="radio"/>	<input type="radio"/>	Ankle/ Foot Pain	<input type="radio"/>	<input type="radio"/>	Abnormal Weight Gain/Loss	<input type="radio"/>	<input type="radio"/>	Depression
<input type="radio"/>	<input type="radio"/>	Jaw Pain	<input type="radio"/>	<input type="radio"/>	Loss of Appetite	Females Only		
<input type="radio"/>	<input type="radio"/>	Joint Swelling/ Stiffness	<input type="radio"/>	<input type="radio"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Birth Control Pills
<input type="radio"/>	<input type="radio"/>	Sleeping Problems	<input type="radio"/>	<input type="radio"/>	Ulcer	<input type="radio"/>	<input type="radio"/>	Hormonal Replacement
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Pregnancy
<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	Likes cold weather	Other Health Problems		
<input type="radio"/>	<input type="radio"/>	General Fatigue	<input type="radio"/>	<input type="radio"/>	Likes hot weather	Smoking status - ___ never smoke ___ former smoker		
<input type="radio"/>	<input type="radio"/>	Muscular Incoordination	<input type="radio"/>	<input type="radio"/>	Cancer	___ current everyday smoker ___ heavy smoker		
<input type="radio"/>	<input type="radio"/>	Visual Disturbances	<input type="radio"/>	<input type="radio"/>	Tumor	___ unknown if ever smoked ___ smoker		
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Asthma	___ current some day smoker		
			<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis	___ light tobacco smoker		

HX: Indicate if an immediate family member has had any of the following (mother, father or siblings):
 Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus _____

List all prescription and over-the-counter medications (+ Dose Amount), and nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and times you have been hospitalized (What and Year):

On-going medical problems: _____
What are you doing as preventative care: _____
Nutrition HX: _____ **Developmental HX:** _____

Patient Signature : _____ Date: _____
 Doctor's Signature: _____

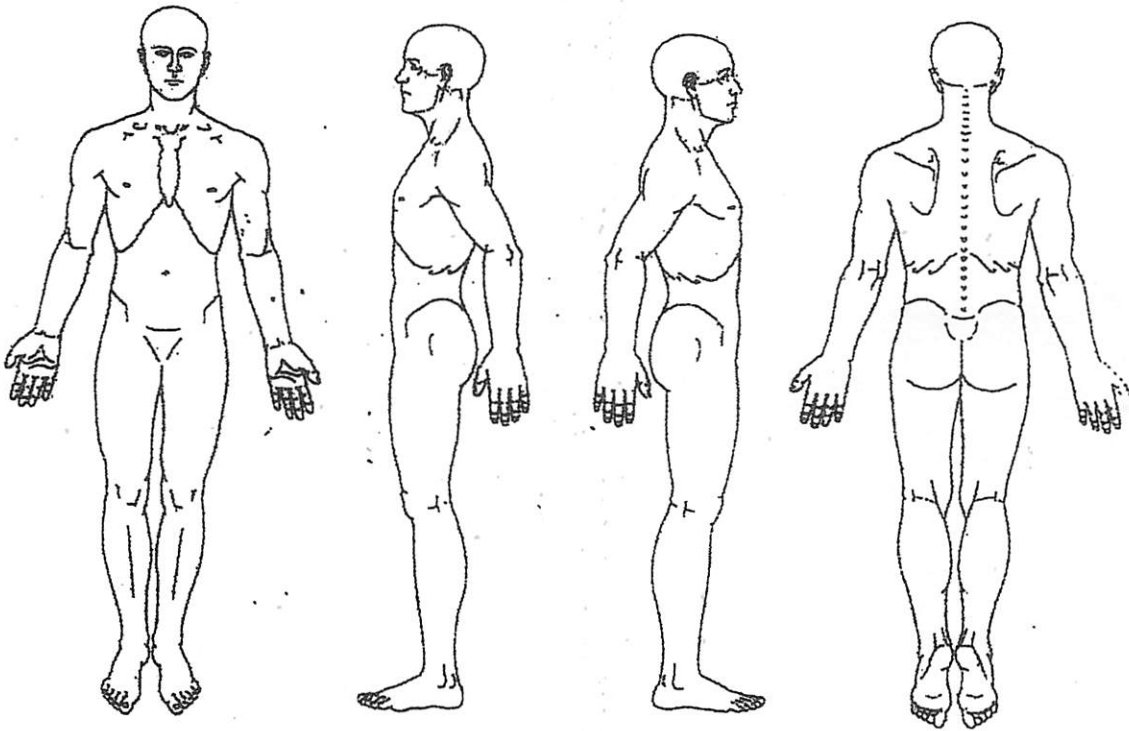
Office USE: Height _____" Weight _____ lbs. B/P _____ / _____
Temp. _____ Pulse _____ bpm Respirations _____ bpm
DX: _____, _____, _____, _____

**Fredrick
Chiropractic
Plus**
3930 West Washington
Suite B
Gurnee, IL 60031
847-862-1600
Fax 847-862-1612

Name _____ Date _____

Using the following descriptive symbols, draw the location of your pain on body outlines below.
In addition, mark the level of your pain on the pain line at the bottom of the page.

<u>ACHE</u> ~~~~~	<u>BURNING</u> _____	<u>NUMBNESS</u> 0000000000	<u>PINS & NEEDLES</u>	<u>STABBING</u> //////////	<u>OTHER</u> XXXX
----------------------	-------------------------	-------------------------------	------------------------------------	-------------------------------	----------------------



0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

No Pain

Worst Possible Pain

Please circle through this pain scale the level of your pain.

Patient Signature

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Would you like to have access to your personal health information electronically? Yes No

Name of Patient

Date

Signature

CHIROPRACTIC PLUS
3930 Washington St. Suite B
Gurnee, IL 60031
Phone (847) 662-1600
Fax (847) 662-1612

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: (Provider) _____
(NAME OF DOCTOR, CLINIC, HOSPITAL, ETC.)

Address: _____

I, _____ (PATIENT'S NAME) request the following information:

X-rays History Records Diagnosis Treatment Reports Billings Blood works results Other _____

concerning my: Accident Injury Illness Other _____

D.O.B.

To be released to: **FREDRICK CHIROPRACTIC PLUS**

Address: 3930 W. Washington st. Suite B. Gurnee, IL 60031

For the purpose of: **Review and Treatment**

According to Section 25252 of the California Health and Safety Code, these records must be provided within 15 days of receipt of this notice.

Signed _____ Date _____

Patient Spouse Parent Guardian

Exp. Date _____

Compare your quality of life before and after the injury

1. Do you need the help of others?

2. Any change at work or home?

3. Has your energy, fatigue, or stress levels changed?

4. Any change in your social life?

5. Any change in your family life?

6. Any feelings of fear, anger, frustration, irritation, isolation or sadness?

7. Any change in appetite, sleeping pattern, or sexual activity?

Name _____ **Date** _____

Neck Index

ACN Group, Inc Form N1-100

ACN Group, Inc Use Only rev 3/27/2003

Patient Name _____

Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by **circling** the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- 0 I have no pain at the moment.
- 1 The pain is very mild at the moment.
- 2 The pain comes and goes and is moderate.
- 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.

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).

Reading

- 0 I can read as much as I want with no neck pain.
- 1 I can read as much as I want with slight neck pain.
- 2 I can read as much as I want with moderate neck pain.
- 3 I cannot read as much as I want because of moderate neck pain.
- 4 I can hardly read at all because of severe neck pain.
- 5 I cannot read at all because of neck pain.

Concentration

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

Work

- 0 I can do as much work as I want.
- 1 I can only do my usual work but not more.
- 2 I can only do most of my usual work but not more.
- 3 I cannot do my usual work.
- 4 I can hardly do any work at all.
- 5 I cannot do any work at all.

Personal Care

- 0 I can look after myself normally with out 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 I manage most of my personal care.
- 4 I ned help everyday in most aspects of seif care.
- 5 I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- 0 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, but I can manage if the are conveniently positioned (e.g. on the table).
- 3 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if the are conveniently positioned.
- 4 I can only lift very light weights.
- 5 I cannot lift or carry anything at all.

Driving

- 0 I can drive my car with out any neck pain.
- 1 I can drive my car as long as I want with slight neck pain.
- 2 I can drive my car as long as I want with moderate neck pain.
- 3 I cannot drive my car as long as I want because of moderate pain.
- 4 I can hardly drive at all because of severe neck pain.
- 5 I cannot drive my car at all because of neck pain.

Recreation

- 0 I am able to engage in all my recreation activities with out neck pain.
- 1 I am able to engage in all my usual recreation activities with some neck pain.
- 2 I am able to engage in most but not all my usual recreation activities because of neck pain.
- 3 I am only able to engage in a few of my usual recreation activities because of neck pain.
- 4 I can hardly do any recreation activities because of neck pain.
- 5 I cannot do any recreation activities at all.

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 which come frequent.
- 4 I have severe headaches which come frequently.
- 5 I have headaches almost all the time.

Patient's signature _____

Neck
Index
Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ 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 very severe.
- ⑤ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do 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 and dressing without help.

Lifting

- Ⓐ 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 off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my 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.

Changing degree of pain

- Ⓐ 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.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

Index Score = $\left[\frac{\text{Sum of all statements selected}}{\text{\# of sections with a statement selected} \times 5} \right] \times 100$

Back
Index
Score