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: ____________

Ethnicity: ____________ 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 Questionnarire – 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.

Past	Present	
O	O	Headaches
O	O	Neck Pain
O	O	Upper Back Pain
O	O	Mid Back Pain
O	O	Low Back Pain
O	O	Shoulder Pain
O	O	Elbow/ Upper Arm Pain
O	O	Wrist Pain
O	O	Hand Pain
O	O	Hip/ Upper Leg Pain
O	O	Knee/ Lower Leg Pain
O	O	Ankle/ Foot Pain
O	O	Jaw Pain
O	O	Joint Swelling/ Stiffness
O	O	Sleeping Problems
O	O	Arthritis
O	O	Rheumatoid Arthritis
O	O	General Fatigue
O	O	
O	O	Muscular Incoordination
O	O	Visual Disturbances
O	O	Dizziness

Past	Present	
O	O	High Blood Pressure
O	O	Heart Attack
O	O	Chest Pains
O	O	Stroke
O	O	Angina
O	O	Kidney Stones
O	O	Kidney Disorders
O	O	Bladder Infection
O	O	Painful Urination
O	O	Loss of Bladder Control
O	O	Prostate Problems
O	O	Abnormal Weight Gain/Loss
O	O	Loss of Appetite
O	O	Abdominal Pain
O	O	Ulcer
O	O	Hepatitis
O	O	Likes cold weather
O	O	Likes hot weather
O	O	Cancer
O	O	Tumor
O	O	Asthma
O	O	Chronic Sinusitis

Past	Present	
O	O	Diabetes
O	O	Excessive Thirst
O	O	Frequent Urination
O	O	Smoking/Tobacco Use
O	O	Drug /Alcohol Depend.

Allergies What & Severity(Mild, Mod. Sev.)___

Past	Present	
O	O	Systematic Lupus
O	O	Epilepsy
O	O	Dermatitis/Eczema/Rash
O	O	HIV/AIDS
O	O	Depression

Females Only

Past	Present	
O	O	Birth Control Pills
O	O	Hormonal Replacement
O	O	Pregnancy

Other Health Problems

Smoking status - ___never smoke ___former smoker

___ current everyday smoker ___ heavy smoker

___ unknown if ever smoked ___ smoker

___ current some day smoker

___ light tobacoo smoker

HX: Indicate if an immediate family member has had any of the following (mother, father or siblings):

O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus O ____________

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):______________

____

Ongoing medical problems: ______________________________

What are you doing as preventative care: ______________________________

Nutrition HX: ______________________ Developmental HX: ______________________

Patient Signature : ______________________________

Doctor's Signature: ______________________________ Date: ____________________

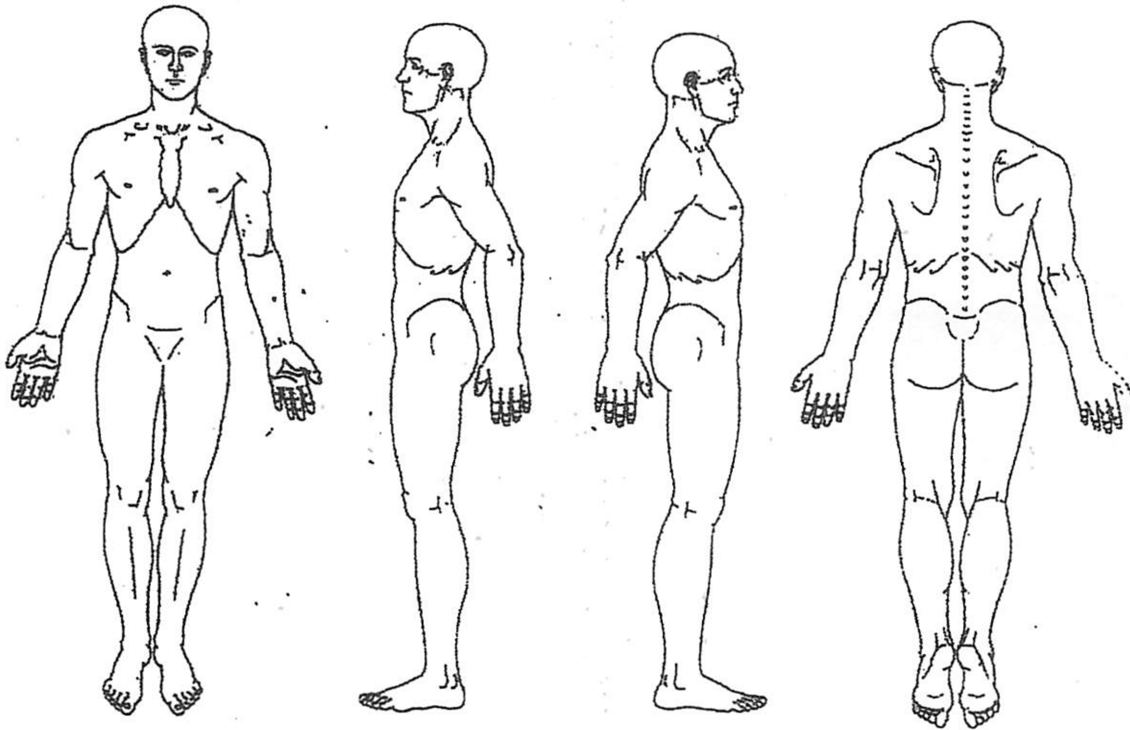
Office USE: Height___" Weight____lbs. B/P____/____
Temp.______ Pulse _____bpm Respirations____bpm
DX:________, ________, ________, ________, ________

Fredrick
Chiropractic
Plus
3930 West Washington
Suite B
Gurnee, IL 60031
847-662-1800
Fax 847-662-1812

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.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
^^^^^^^	————	00000000000	....	////////////////	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,____ request the following information:
(PATIENT'S NAME)

☐ 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. Washigton 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 1hour 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 diffilcuty.
2 I have a fair degree of difficulty concetrate when I want.
3 I have a lot of difficulty concentrating when I want.
4 I have a great deal of difficulty concetrating when I want.
5 I cannot concetrate 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 self 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

⓪ 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.

Personal Care

⓪ 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.

Sleeping

⓪ 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.

Lifting

⓪ 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.

Sitting

⓪ 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.

Traveling

⓪ 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.

Standing

⓪ 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.

Social Life

⓪ 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.

Walking

⓪ 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.

Changing degree of pain

⓪ 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.

Back Index Score ____

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

(847) 662-1600
Fax (847) 662-1612
3930 West Washington
Gurnee, Illinois 60031
www.echiroplus.com

WORKERS' COMPENSATION AUTHORIZATION

Please have your employer or other authorized personnel sign and return this authorization for treatment to our office with a copy of the completed EMPLOYER'S INJURY REPORT

DATE ____

EMPLOYER ____

____

SURPERVISOR ______________________ PHONE (   ) ______________

EMPLOYEE ____

DATE OF ACCIDENT ____

INSURANCE CARRIER ____

INSURANCE CARRIER ADDRESS ____

ADJUSTER / AGENT ______________________ PHONE (   ) ______________

AUTHORIZED BY TELEPHONE DATE ______________ SPOKE WITH ______________

SPECIFIC INSTRUCTIONS ____

____

____

I, ______________________ acknowledge that the above patient has reported to our office for injuries sustained while of the job.

Thank you for your assistance.

____

Supervisor or other authorized person's signature   Title   Date