LITTLE ROCK CHIROPRACTIC CLINIC, P.A.

Application for Chiropractic Treatment

Please print this form; fill out completely, and
Fax to us at 501-371-0810, or bring to our location in person.

Please print clearly:

Name (first)_____ (middle) _____(last)_____

Address_____

City_____ST_____Zip_____

Home Phone ( ) _____ - _____ Office Phone (____) _____- _____

Cell Phone ( ) _____ - _____

Date of Birth _____Referred to our office by_____

Number of Children _____

Please check or circle: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Email address_____ Please select: Male ☐ Female ☐

Where are you employed?_____

Address_____

City_____State_____Zip_____

How will payment be made? (Please indicate)

☐ Health Insurance ☐ Worker's Comp ☐ Auto Insurance ☐ Cash ☐ Check ☐ Credit Card

Your nearest relative NOT living with you:

Name_____

Address_____

Phone_____ Relationship_____

SPOUSE'S nearest relative NOT living with you: Name_____

Address_____

Phone_____ Relationship_____

Major complaint(s) Please describe your major complaints and describe the frequency and nature of your pain. For example: dull, sharp, constant, off and on, when standing, when sitting, etc.

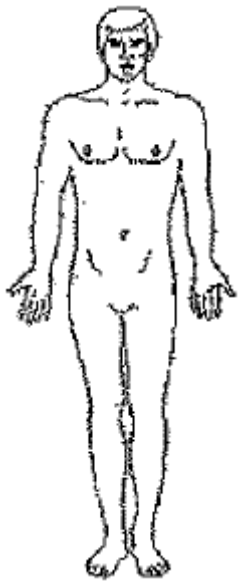
_____

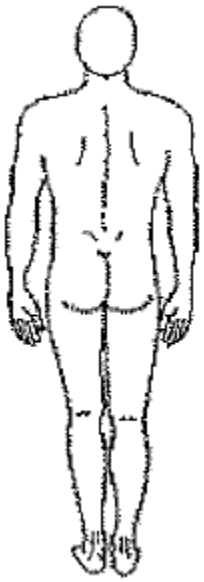
_____

_____

Patient Name:_____

Please mark the exact location of your pain or symptoms on the diagrams below:





When did your condition first begin?_____

How did your condition develop?_____

What caused it?_____

Have you ever had this problem or similar problem before? If yes, please explain:

_____

Have you seen another chiropractic physician for this complaint? If yes, who?_____

What was their diagnosis?_____

Have you seen another medical physician for this complaint? If yes, who?_____

What was their diagnosis?_____

Is your condition getting better, worse, or staying the same?_____

What makes your conditions worse?_____

What makes your conditions better?_____

Have you ever been involved in an automobile accident? If yes, when and where?

_____

What surgeries have you had? Include Date:

_____

_____

Please list drugs you now take:

_____

_____

Please list vitamins, minerals, supplements, and/or herbs you now take:

_____

_____

_____

Little Rock Chiropractic Clinic
1100 West Third Street
Little Rock, Arkansas 72201

Family and Social History

Patient's Name:_____Date:_____
(Please check the appropriate "Yes" or "No" responses to the following questions. If the answer is "Yes", please explain in the space provided. If more space is required, use the back side of the page.)

Your History:

	Yes	No	Explain
1. Any history of lung disease?	☐	☐	_____
2. Any history of bowel problems?	☐	☐	_____
3. Any history of genito/urinary problems?	☐	☐	_____
4. Any history of cardiovascular disease?	☐	☐	_____
5. Any history of neurological diseases?	☐	☐	_____
6. Any history of cancer? Where?	☐	☐	_____
7. Do you use tobacco products?	☐	☐	How much_____
8. Do you drink alcohol?	☐	☐	How much_____
9. Any history of accident other than automobile?	☐	☐	_____
10. Any drug, vitamin or herbal allergies?	☐	☐	_____

Family History:

	Yes	No	Explain
1. History of diabetes in your family?	☐	☐	_____
2. History of heart disease in your family?	☐	☐	_____
3. History of cancer in your family?	☐	☐	_____
4. History of arthritis in your family?	☐	☐	_____

System Review and Past Medical History

Name:_____

From the following list, please check any symptoms or conditions that apply to you.

SKIN

- ☐ Rashes, psoriasis or dermatitis
- ☐ History of skin cancer
- ☐ New skin growth or mole

EYES

- ☐ Wear glasses
- ☐ Wear contact lenses
- ☐ Permanent blindness in either eye
- ☐ Cataracts
- ☐ Glaucoma

EARS / NOSE / THROAT

- ☐ Loss of hearing
  Hearing aids?
- ☐ Ringing in the ears
- ☐ Frequent ear aches
- ☐ Discharge from the ear
- ☐ Attacks of vertigo
- ☐ Frequent sinus infections
- ☐ Nasal blockage
- ☐ Frequent sneezing
- ☐ Frequent sore throat
- ☐ Loud snoring
- ☐ Recent change in voice quality
- ☐ Sleep apnea
- ☐ Difficulty in swallowing
- ☐ Frequent headache
- ☐ Nose bleeds
- ☐ Exposure to loud noise

RESPIRATORY

- ☐ Asthma or wheezing
- ☐ Recent bronchitis or chest cold
- ☐ Cough for over the past 2 months
- ☐ Coughing up blood
- ☐ Shortness of breath

HEART & CIRCULATION

- ☐ Heart attack
- ☐ Hypertension (high blood pressure)
- ☐ Heart murmur
- ☐ Chest discomfort (angina) with physical activity
- ☐ Heart failure or fluid on the lungs
- ☐ Palpitations, racing or pounding heart beat
- ☐ Stroke
- ☐ Blood clot in artery or vein
- ☐ "Mini-strokes" or TIA's
- ☐ "Black out spells"
- ☐ Aneurysm of any blood vessel
- ☐ Frequent ankle swelling at bedtime
- ☐ Heart surgery

STOMACH / INTESTINES

- ☐ Stomach ulcer of peptic ulcer
- ☐ Frequent heartburn or indigestion
- ☐ Hiatal hernia and or acid reflux
- ☐ Poor appetite
- ☐ Gall bladder attacks
- ☐ Frequent diarrhea
- ☐ Chronic constipation
- ☐ Bright blood from bowels or rectum
- ☐ Dark, tarry stools
- ☐ Liver disease or jaundice

ENDOCRINE / METABOLISM

- ☐ Thyroid disorder
- ☐ Recent weight gain or loss (More than 10 lbs.)
- ☐ Diabetes

KIDNEYS / URINARY TRACT

- ☐ Kidney disease or failure
- ☐ History of kidney dialysis
- ☐ Kidney stones or infection
- ☐ Pain or burning with urination
- ☐ Trouble starting urinary stream
- ☐ Dribbling or incontinence
- ☐ Multiple trips to the bathroom to urinate at night
- ☐ Bladder infections during past year
- ☐ Blood in urine during past year
- ☐ Prostate disease

MUSCLES / BONES / JOINTS

- ☐ Arthritis or other joint disease
- ☐ Chronic back trouble
- ☐ Bone or joint surgery in past year

NERVOUS SYSTEM

- ☐ Migraine headaches
- ☐ Epilepsy or seizures
  Date of last seizure:_____
- ☐ Depression
- ☐ Other nervous disorder
  Specify:_____

BLOOD

- ☐ Bleeding or bruising tendency
- ☐ Previous blood transfusion
- ☐ History of hepatitis

REPRODUCTIVE (Women only)

Are you or might you be pregnant?

☐ Yes ☐ No

Other conditions or additional comments:_____

_____

_____

_____

_____

_____

_____

CONFIDENTIAL CREDIT AND INSURANCE INFORMATION

Insurance Information: Name of Insured:_____

Insurance Company (primary):_____

Address_____

City_____ST_____Zip_____

Telephone (_____) _____ - _____

ID Number_____

List any Secondary Insurance_____

Spouse's Information:

Name:_____

Address_____

City_____ST_____Zip_____

Work Number (_____) _____- _____Home Number (_____) _____- _____

Employer
Name:_____

Employer Address:_____(City, State, and Zip) _____

Date of Birth_____

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand and agree that the health and accident insurance policies are an arrangement between an insurance company and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and insurance forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I also authorize the release of any needed information. I understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable within 30 days. I also understand that I am giving my consent to be treated.

Signature_____Date_____

Patient Consent for Use and Disclosure
Of Protected Health Information

LITTLE ROCK CHIROPRACTIC CLINIC, P.A.

I hereby give my consent for Little Rock Chiropractic Clinic, P.A. (hereinafter referred to as "LRCC") to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

LRCC's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. A copy of this Notice is available upon request to Dr. Richard L. Riley or Denise Moix, our Privacy Officers, or any other LRCC staff member.

LRCC reserves the right to revise its Notice of Privacy Practices at any time and agrees to provide me a revised copy upon my request to LRCC.

With this consent, the LRCC may call (or text message) my home or other designated phone number on file and leave a message on voice mail or in person in reference to any items that assist LRCC in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, LRCC may mail to my home or other designated location on file any items that assist LRCC in carrying out TPO, such as patient statements.

With this consent, LRCC may e-mail to my home or other designated location on file any items that assist LRCC in carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that LRCC restrict how it uses or discloses my PHI to carry out TPO. However, LRCC is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to LRCC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that LRCC has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, LRCC may decline to provide treatment to me as permitted by Section 164.506 of the Code of Federal Regulations.

_____
Print Patient's Name

_____ _____
Print Name of Legal Guardian, if applicable Date

_____
Signature of Patient or Legal Guardian

☐ I have been given and am in receipt of LRCC's Notice of Privacy Practices. _____***(please initial)***
☐ I do not wish to receive a copy of LRCC's Notice of Privacy Practices. _____***(please initial)***

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just check the box that indicates the statement **which most clearly 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 the worst imaginable at the moment

Section 2: Personal Care (e.g.washing,dressing)

- ☐ 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 can manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed,e.g.on a table
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Walking

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 ¼ miles
- ☐ Pain prevents me from walking more than 2/3 mile
- ☐ Pain prevents me from walking more than 1/3 mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

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 sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

Patient Signature_____ **Date**_____

Little Rock Chiropractic Clinic
Financial Policy

Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any question you may have concerning an account statement.

Our staff checks your insurance benefits and takes that information into consideration when collecting for the appointment. However, the sum we request at checkout is only an ***estimate*** of your out-of-pocket responsibility based on our understanding of your insurance benefits. You may owe more than collected, or you may have paid more than required by your plan. You will receive a statement of account showing your balance due, or we will send you a check for an account credit balance.

Cancellation and Missed Appointment Policy
We understand that, on occasion, appointments must be changed or cancelled. You may call our office at any time, night or day, to cancel or reschedule an appointment by leaving a message on our answering machine. Failure to do so, will result in a $10.00 fee.

Auto accidents/workers compensation
Motor Vehicle Accidents (MVAs) will be filed to your auto insurance as a courtesy to you. Failure to receive payment within 30 days of the date of service may result in you becoming responsible to pay the balance.

Our office will send appropriate workers compensation claim forms for services rendered on your behalf as a courtesy. If a claim is denied, we will expect payment in full from you within 30 days of receipt of our statement.

Collections and Outstanding Balances
We do our best to work with patients on collection of account balances. We ask that a patient pay a minimum of $25 per month to satisfy their account balance. If a patient has an account balance over 60 days old with no payment made by the patient in the last 60 days, the account will be referred to an outside collection agency. Accounts referred to an outside collection agency will be subject to a collection fee of 30%, which will be added to the total balance due. If your account is sent to court for collection, a total of 40% will be added to the balance due.

Returned Check Fee
There will be a fee of $25.00 for any returned checks to our office.

Signing below acknowledges that you have read and understand the above-stated policies.

_____ _____

Signature of Patient or Patient Representative Date