

Patient Registration

Patient: (This section refers to Patient only)

Name: _____ Sex: ___ Age: ___ D.O.B.: _____

Address: _____

City: _____ State: _____ Zip: _____ SSN: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Marital Status: () Single () Married () Divorced () Separated () Widowed

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Please Supply the Following Information:

Spouse's Name: _____ Phone: (____) _____

SSN: _____ Employer: _____

Employer Address: _____ City: _____

State: _____ Zip: _____ Phone: (____) _____

Please give us all pertinent information regarding your insurance coverage.

Carrier's Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Name of Insured: _____

Relationship to you: _____ Policy Holder: _____

Policy/Certificate #: _____ Group #: _____

Policy Statement

Patients who carry health insurance understand all health services furnished are charged directly to the patient and that he/she is responsible for payment of all physician services. This office will help prepare the patient's insurance forms to assist in making reimbursements from insurance companies. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

I have read the above and understand the office policy. I hereby authorize treatment.

Patient's Signature: _____ Date: _____

Signature of Guardian for patient's under 21: _____

For Women only: To the best of my knowledge I am not pregnant and authorize treatment.

Signature: _____ Date: _____

Privacy Policy

I do hereby affirm that I have received a copy of the privacy policy of Kauffman Chiropractic Clinic. If I have any questions or wish to exercise my rights regarding my personal health information I will contact the privacy officer.

Signature

Date

Confidential Health History

Please write **C** if you **currently** have any of the following or **P** if you have had any of the following in the **past**.

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficult Breathing |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Pleurisy/Pneumonia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eye problems | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Fractures/Dislocations | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Foot Trouble | <input type="checkbox"/> Abnormal Stools |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Lumps on Breast | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Menopausal Problems |

Other conditions: _____

Medications: _____

Vitamins: _____

List all surgeries and year: _____

Have you ever been hospitalized (Non-surgery)? _____

Do you have any metal implants?: () Yes () No Where?: _____

Do you have a pacemaker?: () Yes () No

Are you pregnant?: () Yes () No Date of last menstrual period: _____

Number of children: _____ Number of pregnancies: _____

Do you/Did you smoke?: _____

Family History

__ Cancer __ Diabetes __ Heart Disease __ Kidney Disease __ Other: _____

What is your area of complaint? (I.E. neck, low back, ETC.): _____

Have you had this or a similar problem in the past?: () Yes () No

If yes, explain: _____

Did the Accident/Injury occur at work: _____ Date: _____ Time: _____

Dates of work missed due to this condition: _____

Involved in Auto Accident: _____ Date: _____ Time: _____

Have you ever been treated by a chiropractic physician before: () Yes () No

His/Her name: _____

Other doctors seen for this condition: _____

Name: _____

Date: _____

Pain Chart

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols and include all affected areas. Mark all areas of radiation.

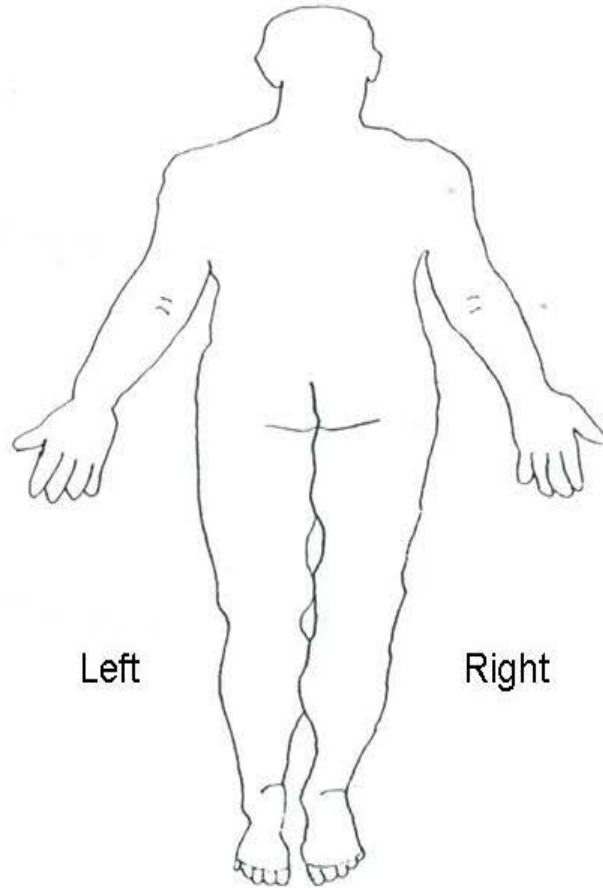
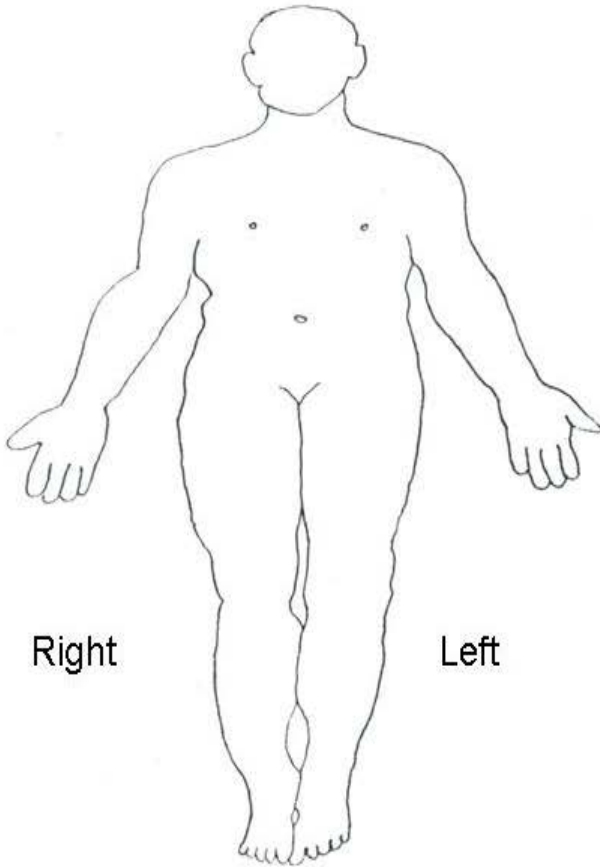
Numbness

Pins/Needles
000000

Burning
xxxxx

Aching

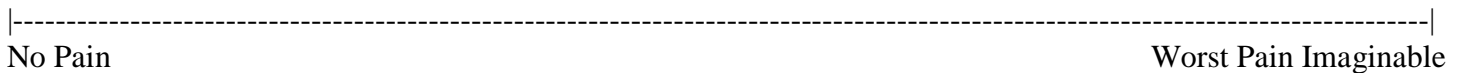
Stabbing
/////



Visual Analog Scale

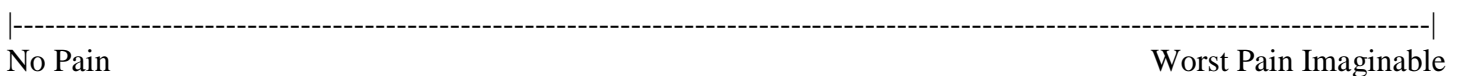
Low Back Pain

The line below represents the intensity of low back pain. Please mark an X at the position on the scale which indicates how much pain you feel in your low back **at this time**.



Pain Other Than Low Back Pain

The line below represents the intensity of your pain. Please mark an X at the position on the scale which indicates how much pain you feel **at this time**.



Name: _____

Date: _____

Oswestry Disability Questionnaire (LOWER BACK)

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box, which most closely describes your current condition.**

Pain Intensity

- I can tolerate the pain I have without having to use pain medication.
- The pain is bad but I can manage without having to take pain medication.
- Pain medication provides me complete relief from pain.
- Pain medication provides me with moderate relief from pain.
- Pain medication provides me with little relief from pain.
- Pain medication has no affect on my pain.

Personal Care (Washing, Dressing etc.)

- I can take care of myself normally without causing increased pain.
- I can take care of myself normally but it increases my pain.
- It is painful to take care of myself and I am slow and careful.
- I need help but I am able to manage most of my personal care
- I need help every day in most aspects of my care.
- I do not get dressed, wash with difficulty and stay in bed.

Lifting

- I can lift heavy weights without increased pain.
- I can lift heavy weights but it causes increased pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (ex. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I can not lift or carry anything at all.

Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than ½ mile
- Pain prevents me from walking more than ¼ mile.
- I can only walk with crutches or a cane.
- I am in bed most of the time and have to crawl to the toilet.

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 from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Standing

- I can stand as long as I want without increased pain.
- I can stand as long as I want but increases my pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than ½ hour.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using pain medication.
- Even when I take pain medication, I sleep less than 6 hours.
- Even when I take pain medication, I sleep less than 4 hours.
- Evens when I take pain medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

Social Life

- My social life is normal and does not increase my pain.
- My social life is normal, but it increases my level of pain.
- Pain prevents me from participating in more energetic activities (ex. sports, dancing etc.)
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

Traveling

- I can travel anywhere without increased pain.
- I can travel anywhere but it increases my pain.
- My pain restricts travel over 2 hours.
- My pain restricts my travel over 1 hour.
- My pain restricts my travel to short necessary journeys under ½ hour.
- My pain prevents all travel except for visits to the doctor/therapist or hospital.

Employment/Homemaking

- My normal homemaking/job activities do not cause pain.
- My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming)
- Pain prevents me from doing anything but light duties.
- Pan prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.

Score: _____

Name: _____

Date: _____

Neck Disability Index

This questionnaire has been designed to give your therapist information as to how your neck pain has affected you in your everyday activities. Please answer each section, marking only **ONE** box which best describes your status **today**.

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 (washing, dressing, etc)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes me extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty, and I stay in bed.

Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are positioned conveniently.
- I can only lift very light weights.
- I cannot lift or carry anything at all.

Section 4 – Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I can't read as much as I want to because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

Section 5 – Headache

- I have no headache at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all of the time.

Section 6 – Concentration

- I can concentrate fully when I want to, with no difficulty.
- I can concentrate fully when I want to, with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 7 – Work

- I can do as much as I want.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

Section 8 – Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want to, with slight pain in my neck.
- I can drive my car as long as I want to, with moderate pain in my neck.
- I cannot drive my car as long as I want to because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I cannot drive my car at all.

Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleep loss).
- My sleep is mildly disturbed (1 – 2 hours sleep loss).
- My sleep is moderately disturbed (2 – 3 hours sleep loss).
- My sleep is greatly disturbed (3 – 5 hours sleep loss).
- My sleep is completely disturbed (5 – 7 hours sleep loss).

Section 10 – Recreation

- I am able to engage in all my recreational activities with no neck pain at all.
- I am able to engage in all my recreational activities with some pain in my neck.
- I am able to engage in most but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in only a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I cannot do any recreational activities at all.

Score: _____

Kauffman P.C.
1600 Converse Ave.
Cheyenne, WY 82001
307-632-5901

Privacy Policy

Our goal at Kauffman Chiropractic Clinic is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. We are required to:

1. Maintain the privacy of medical information provided to us.
2. Provide notice of our legal duties and privacy practices.
3. Abide by the terms of our Notice of Privacy Practices currently in effect.

Who Will Follow This Notice

This notice describes the practices of our employees and staff as well as:

All entities associated with Kauffman Chiropractic Clinic to include any additional individuals, affiliated entities, entities associated as organized health care arrangements, or any other individuals or entities, sites, and location will follow the terms of this notice. In addition these individuals, entities, sites, and locations may share medical information with each other for the treatment, payment or health care operation purposes described in this notice.

Information Collected About You

In the ordinary course of receiving treatment and health care services for you, you will be providing us with personal information such as:

- * Your name, address and phone number
- * Information relating to your medical history
- * Your insurance information and coverage
- * Information concerning your doctor, nurse, or other medical providers

In addition we will gather certain medical information about you and will create a record of the care that is provided for you. Some information may also be provided to us by other individuals and organizations that are part of your "circle of care," such as your primary care physician, your other doctors, your health care plan, and close friends or family members.

How We May Use and Disclose Information About You

We may use and disclose personal and identifiable health information about you in different ways. All of the ways in which we may use and disclose information will fall within one of the following categories, but not every use or disclosure in a category will be listed.

Treatment: We will use health information about you to furnish services and supplies to you, in accordance with our policies and procedures. For example, we will use your medical history, such as "history of trauma," to assess your health and perform the needed services.

Payment: We will use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your current medical conditions so that it will pay us for the treatment rendered to you. We need to inform your payer of the services in order to obtain prior approval or to determine whether the service is covered.

Health Care Operations: We may use and disclose information about you for the general operation of our business.

Public Policy Uses and Disclosures: There are 16 types of public-good uses and discloses that the HIPAA Privacy Rule permits provided applicable conditions are met. They are: required by law, judicial and administrative proceedings, public health authority, child abuse or neglect, victims of abuse, neglect, or domestic violence, law enforcement, FDA, cadaveric organ, eye, or tissue donation, coroners or funeral director, research, communicable diseases, health oversight activities, worker's compensation, employee workplace medical surveillance, specialized government functions, and to avert a serious and innumerable threat to health or safety.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment.

Treatment Alternatives: We may use and disclose your personal health information in order to tell you about or recommend possible treatment options.

Other Uses and Disclosures of Personal Health Information

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization. We will be unable to take back any disclosures already made based upon your original permission.

Individual Rights

You have the right to ask for restriction on the ways in which we use and disclose your medical information beyond those imposed by law. We will consider your request, but we are not required to accept it.

Except under certain circumstances, you have the right to inspect and copy medical billing records for yourself. If you ask for copies of this information, we may charge you a fee for copying and mailing.

If you believe the information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or correct the missing information. Under certain circumstances, we may deny your request.

You have a right to ask for a list of instances when we have used or disclosed your medical information for reasons other than your treatment, payment for services, our health care operations, or disclosures you have given us authorization to make. If you ask for this information from us more than once every twelve months, we may charge you a fee.

You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.

Changes to this Notice

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal health information we have about you as well as any information we receive in the future. In the event there is a material change to this Notice, the revised Notice will be posted. In addition, you may request a copy of the revised Notice at any time.

Complaints, Comments, and Exercising Your Rights:

If you have any complaints or wish to exercise your rights please contact us in writing.