Welcome to your new Chiropractic Family!

Name _____ Date of Birth _____

Address _____ City _____ State ___ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Address _____

Occupation _____ Work Phone _____ Ext _____

Social Security # (our use only) _____ Driver's License # _____

Spouse _____ Spouse Employer _____

Responsible Party _____

Referred By _____

Primary Insurance

Name _____ Insurance Company _____

Policy # _____ Group # _____

Secondary/Supplemental Insurance (circle one)

Name _____ Insurance Company _____

Policy # _____ Group # _____

Accident Information

Date of Injury _____ Auto/Work/Other (circle one) Explain _____

I certify the above information is correct.

Responsible Party if patient is a minor (print name here and sign below) _____

Signature _____ Date _____

Practice Member Initial Health Status

Name _____ Date _____

Primary area of concern: _____
When did it start? _____
How did it start? _____
Where does it travel (if applicable)? _____
Description: dull/sharp/ache/numb/tingle _____

Circle frequency:
constant/frequent/intermittent/occasional
Circle severity:
None 1 2 3 4 5 6 7 8 9 10 worst
Associated symptoms? _____

Secondary area of concern: _____
When did it start? _____
How did it start? _____
Where does it travel (if applicable)? _____
Description: dull/sharp/ache/numb/tingle _____

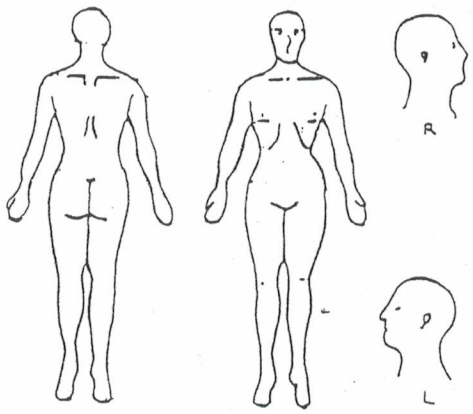
Circle frequency:
constant/frequent/intermittent/occasional
Circle severity:
None 1 2 3 4 5 6 7 8 9 10 worst
Associated symptoms? _____

Any x-rays/MRI/CT taken:
Of what? _____ Date _____
Where? _____
Prior accidents/injuries: _____

_____
Former chiropractic care? _____

_____
Surgeries: _____ Date _____
Hospitalizations: _____ Date _____
Vitamins/supplements: _____
Medication: _____

Please mark areas of concern.



Do you have a personal or family history of cancer, diabetes, cardiovascular problems/stroke, high blood pressure? Who? Age of diagnosis?:

_____

Outline your current exercise routine. _____
Which activities are you unable to perform and would like to resume? _____

Please list any other concerns you would like to discuss with the Doctor. _____

_____

I hereby authorize the associates of Amy B Friedman Chiropractic to examine, x-ray, and treat my condition as they deem appropriate through chiropractic, physiotherapy, and other supportive measures as explained to me.

Signature of person receiving care: _____ Date _____
Guardian's signature of person receiving care: _____ Date _____

AMY B. FRIEDMAN CHIROPRACTIC CORPORATION
OFFICE POLICY

You are ultimately responsible for any usual and customary charges incurred for any evaluations, treatment, or supply provided in your care regardless of expected payment by your insurance company or any other third party. Payment for the first visit is expected to be paid in full at the time of service unless other arrangements have been made. Our fee schedule is available for your review (Please ask our staff if you have any questions regarding our fees).

If you are covered for chiropractic under your health insurance plan we will verify your coverage and notify you of your responsibility. Billing your insurance is a service we provide through our billing company, Priority One Billing. You are responsible for payment of your co-pay on each date of service provided to you. You are responsible for any outstanding co-insurance percentage owed or deductible due as stated on your Explanation of Benefits processed by your insurance company.

If this is a work-related injury and we accept your case, we will obtain authorization for your care and complete the appropriate documentation as per the Labor code.

If this is an injury caused by a third party, arrangements must be made with the doctor. If you have health insurance or med-pay we will bill for you. If you have an attorney, they must sign a lien. Itemized statements will be sent regularly to update your attorney regarding your care received. In the case of a third party (See third party agreement) you are responsible for paying any outstanding balance on your account from the proceeds paid to you directly for your case. You are ultimately responsible for paying your balance in full.

All nutritional supplements and orthopedic supplies must be paid in full at the time received regardless of insurance coverage. (Most policies do not cover these items.)

We reserve the right to charge a full visit fee for any chiropractic or massage appointment missed or cancelled with less than 24 hour notice.

All accounts inactive over 60 days are considered overdue and are subject to collections.

INFORMED CONSENT
FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to receive chiropractic adjustments, physiotherapeutic procedures and chiropractic by Dr. Amy Friedman.

I understand that there are rare but possible risks to chiropractic treatment.

These include, but are not limited to, fractures, disc injuries, dislocations, sprains/strains, burns or frostbite (physical therapy), and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications (although they would be more than happy to do so if requested). I wish to rely on the doctor's experience and expertise to exercise good judgment when choosing the most safe and effective course of care based upon my history, physical exam and x-ray findings.

I have read, or have had read to me, the above consent. I understand that I have the opportunity to ask any questions before receiving treatment. By signing below I consent to care for the entire course of treatment for my present condition and for any future conditions for which I seek consultation and treatment.

AUTHORIZATION AND ASSIGNMENT

I authorize Dr. Amy Friedman to release any information that she deems appropriate concerning my treatment and physical findings to any insurance company, attorney, doctor or insurance claims adjuster in order to process any outstanding claims for reimbursement of charges incurred or for obtaining authorization for care if necessary.

I authorize the direct payment to Dr. Amy Friedman for any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

This authorization and assignment is irrevocable and ongoing until all monies owed have been satisfied and paid in full. It will be in continual effect. A photocopy shall be as valid as the original document.

OFFICE POLICY

I acknowledge that I have read and understand the Amy B. Friedman Chiropractic Corporation Office Policy regarding my financial responsibility, insurance billing, worker's compensation or personal injury cases, massage therapy, and supplies.

_____
Printed name of practice member

_____ Date_____
Signature of practice member or guardian

_____
Name of parent or legal guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Amy B. Friedman Chiropractic Corp.

As required by the Privacy Regulations, I hereby acknowledge that I have read or received a current copy of Dr. Amy B. Friedman's "NOTICE OF PRIVACY PRACTICES."

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Dr. Amy B. Friedman with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

_____

Patient Name: Print

_____ _____

Patient's Signature Date

_____

Authorized Personnel Signature

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) | 2. Federal tax ID(TIN) of entity in box #1

3. Name and credentials of the individual performing the service(s)

[1] MD/DO [2] DC [3] PT [4] OT [5] Both PT and OT [6] Home Care [7] ATC [8] MT [9] Other ____

4. Alternate name (if any) of entity in box #1 | 5. NPI of entity in box #1 | 6. Phone number

7. Address of the billing provider or facility indicated in box #1 | 8. City | 9. State | 10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Cause of Current Episode

(1) Traumatic (2) Unspecified (3) Repetitive (4) Post-surgical (5) Work related (6) Motor vehicle

Date of Surgery

Type of Surgery

(1) ACL Reconstruction
(2) Rotator Cuff/Labral Repair
(3) Tendon Repair
(4) Spinal Fusion
(5) Joint Replacement
(6) Other _____

Diagnosis (ICD code)
Please ensure all digits are entered accurately

1° 2° 3° 4°

Patient Type

(1) New to your office
(2) Est'd, new injury
(3) Est'd, new episode
(4) Est'd, continuing care

Nature of Condition

(1) Initial onset (within last 3 months)
(2) Recurrent (multiple episodes of < 3 months)
(3) Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942 ○ 98941 ○ 98943

Current Functional Measure Score

Neck Index | DASH | (other)

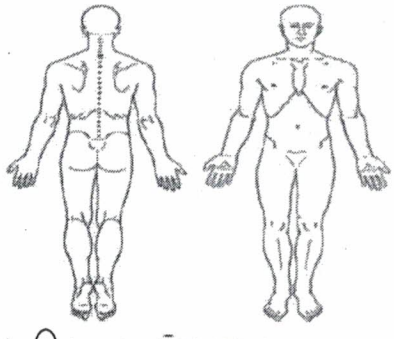
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

4. How often do you experience your symptoms?

(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?

(0) **N/A — This is the initial visit** (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Patient Signature: X _____ **Date:** _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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

Back Index Score _____

Neck Index

ACN Group, Inc. Form NI-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 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 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.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally 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 need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

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).

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

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.

Driving

⓪ I can drive my car without 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 neck 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.

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 concentrating 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.

Recreation

⓪ I am able to engage in all my recreation activities without 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.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no 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.

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

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

Neck Index Score _____

OPTUM

MN010-W120, PO Box 1459 | Minneapolis, MN 55440-1459 | Toll Free: (800) 873-4575 | Phone: (763)595-3200 | Fax (763) 595-3333

The STarT Back Musculoskeletal Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

		Disagree 0	**Agree** 1
1	My pain has **spread** at some time in the past 2 weeks	☐	☐
2	In addition to my main pain, I have had **pain elsewhere** in the last 2 weeks	☐	☐
3	In the last 2 weeks, I have only **walked short distances** because of my pain	☐	☐
4	In the last 2 weeks, I have **dressed more slowly** than usual because of my pain	☐	☐
5	It's really not safe for a person with a condition like mine to be physically active	☐	☐
6	**Worrying thoughts** have been going through my mind a lot of the time in the last 2 weeks	☐	☐
7	I feel that **my pain is terrible** and that **it's never going to get any better**	☐	☐
8	In general in the last 2 weeks, I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Funded by Arthritis Research UK