Aspinwall Chiropractic Clinic, L.L.C.
302 S. Greenwood Street
LaGrange, GA 30240
Ph. (706) 884-8360; Fax (706) 884-0265

Patient History *(an answer MUST be given in ALL spaces)*

Today's Date [/ /] Signature of Patient _____

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

Date of Birth [/ /] Age _____ Gender *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other SSN _____

Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ Cell/Mobile Phone _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed ❑ Disabled

Employer _____ Work Phone _____

Home email _____ Work Email _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check all that apply)*

❑ Primary Phone ❑ Work Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Spouse: _____ Phone _____

*Patient's Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑ Samoan	❑ Guamanian or Chamorro	❑ Other_____	❑ I choose not to specify

*Multi-Racial *(check one)* ❑ Yes ❑ No ❑ Unknown

*Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

*Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

***Verification Question** *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

***Verification Answer to the Chosen question: (must be 6 characters)** _____

***Do you currently smoke tobacco of any kind?** ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

***Current medications, including frequency and dosage if known. If there are no current medications, check here:** ❑

		Start Date			Start Date
1)			5)		
2)			6)		
3)			7)		
4)			8)		

***List any known allergies you have had to any medications and/or food.**
If no allergies are known, check here: ❑

1) _____ 3) _____

2) _____ 4) _____

***Briefly list your main health problems:** _____

_____

***Has any doctor diagnosed you with Hypertension (high blood pressure) presently?** ❑ Yes ❑ No

If yes, describe: _____

***Has any doctor diagnosed you with Diabetes presently?** ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, do you know your A1c number/result: _____

***Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?** ❑ Yes ❑ No

***Emergency Contact** _____ **Relationship:** _____ **Phone** _____

To be performed by clinic staff: Pulse: _____ **Temp:** _____ **Verified:** _____

Height: ____ **inches Weight:** _____ **pounds BP:** _____ / _____

HEALTH HISTORY

WHAT BRINGS YOU TO OUR OFFICE?

Today's Complaint(s):

_____

- Date when symptom first appeared/started: _____
- Did it begin: _____Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase/worse?

_____

- Type of Pain: _____ Sharp _____ Dull _____ Ache _____Burn _____Throb
- Does the Pain Radiate into your: _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____ Y_____ N
- How often do you experience theses symptoms? _____ 100% _____ 75% _____ 50% _____ 25% _____ 10%

PAIN INTENSITY: Please circle the number on the scale describing the intensity of your pain.

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

Please circle the treatment you have already had for your condition: **Medications** **Surgery** **Physical Therapy** **Chiropractic Services** **None** **Other:** _____

Name and address of other doctor(s) who have treated you for your condition: _____

DATE OF LAST: Physical Exam _____ Spinal X-Ray _____ MRI, CT-SCAN, Bone Scan:_____

Please circle "yes" or "no" to indicate if you presently or have had any of the following:

AIDS/HIV	YES	NO	Epilepsy	YES	NO	Multiple Sclerosis	YES	NO	**OTHER:**
Alcoholism	YES	NO	Fractures	YES	NO	Osteoporosis	YES	NO	
Allergy Shots	YES	NO	Gout	YES	NO	Pacemaker	YES	NO	
Anemia	YES	NO	Heart Attack	YES	NO	Parkinson=s	YES	NO	
Arthritis	YES	NO	Heart Disease	YES	NO	Pinched Nerve	YES	NO	
Asthma	YES	NO	Hepatitis	YES	NO	Pneumonia	YES	NO	
Bleeding Disorder	YES	NO	Hernia	YES	NO	Prostate Problems	YES	NO	
Bronchitis	YES	NO	Herniated Disk	YES	NO	Prosthesis	YES	NO	
Cancer	YES	NO	High Cholesterol	YES	NO	Psychiatric Care	YES	NO	
Chemical Dependency	YES	NO	Ice Allergies	YES	NO	Rheumatoid Arthritis	YES	NO	
Diabetes	YES	NO	Kidney Disease	YES	NO	Stroke	YES	NO	
Dizziness	YES	NO	Liver Disease	YES	NO	Thyroid Problems	YES	NO	
Emphysema	YES	NO	Metal Implants	YES	NO	Tuberculosis	YES	NO	
			Migraines	YES	NO	Tumors, Growths	YES	NO	

Please circle all that apply in the following:

EXERCISE
None
Moderate
Daily
Heavy

WORK ACTIVITY
Sitting
Standing
Light Labor
Heavy Labor

HABITS
Alcohol
Coffee/Caffeine Drinks
High Stress Level

Females Only:
ARE YOU PREGNANT? YES / NO
DUE DATE: _____

INJURIES/SURGERIES YOU HAVE HAD	DESCRIPTION	DATE
FALLS:		
HEAD INJURIES:		
BROKEN BONES:		
SURGERIES:		
Primary Physician:		

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Certified Rehab of Georgia

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

The right to inspect and copy your information; the right to request corrections to your information; the right to request that your information be restricted; the right to request confidential communications; the right to a report of disclosures of your information; the right to a paper copy of this Notice; the right to file a complaint if you feel your privacy has been violated.

As a provider of medical services we may on occasion mail you a card, call you on the telephone at the phone number(s) you have provided and/or leave a message for you to call our office.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

Please list the name of any person(s) with proper identification you would like to have access to medical information:

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge ***Aspinwall Chiropractic Clinic and/or Certified Rehab of Georgia*** **will** make available to me a copy of the NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights, that I may contact *Rhonda Alford, Privacy Officer*. I further understand that ***Aspinwall Chiropractic Clinic and/or Certified Rehab of Georgia*** *will* offer me updates to this NOTICE OF PRIVACY PRACTICES, should it be amended, modified or changed in any way.

Patient's Name: _____ **D/O/B:** _____

Social Security Number: _____ **Address:** _____

_____ **DATE:** _____
Signature of **Patient** or **Representative**

_____
Relationship to patient if other than patient

_____ Patient Refused to Sign _____ Patient was unable to sign because _____

Documented by: _____ **DATE:** _____
NEW 11/2010

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FINANCIAL POLICY AND AUTHORIZATIONS

Thank you for choosing Aspinwall Chiropractic Clinic and/or Certified Rehab of Georgia as your Chiropractic and/or Physical Therapy specialty healthcare provider. We are committed to providing you and your family with the best available care. In our ongoing process to make sure that all your needs are met, our staff will be available to discuss our fees and this policy with you. The services you have elected to participate in imply a financial responsibility on your part. ***We ask that all responsible parties read and sign our financial policy as well as complete all patient information forms prior to seeing the provider.***

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, and American Express. As a courtesy to you, we will verify your coverage and bill your insurance carrier on your behalf; however, you are ultimately responsible for the entire bill. As the responsible party, please understand:

(PLEASE READ AND INITIAL THE FOLLOWING)

_____ 1. Your insurance policy is a contract between you, your employer (if applicable), and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charge. As your provider, we will only supply factual information to facilitate claim processing. Furthermore, I understand that his office will prepare any necessary reports and forms to assist me making collection from the insurance company and that amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittance to the conveyance to credit my account. I understand if I have a balance outstanding over 30 days interest will be added on a monthly basis for each month the balance is outstanding at a rate of 1.5%. **However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT, I FURTHER UNDERSTAND IF ANY UNPAID/OUTSTANDING BALANCE ON MY ACCOUNT IS TURNED OVER/TRANSFERRED TO A COLLECTION AGENCY AND/OR ATTORNEY, I WILL BE RESPONSIBLE FOR FULL BALANCE AND ATTORNEY FEES. Upon such referral interest will continue to be added in the amount of 1.5%.**

This is an agreement/contract between the undersigned patient, hereafter called "patient," and Aspinwall Chiropractic Clinic, L.L.C and/or Certified Rehab of Georgia, hereafter called "provider(s)," for full and complete payment of the provider's medical services and expense.

_____ 2. I hereby authorize _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to: *Aspinwall Chiropractic Clinic, L.L.C. or Certified Rehab of Georgia, 302 S. Greenwood Street, LaGrange, GA 30240* the expense benefit allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered have agreed to pay, in a current manner, any balance of said application charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

_____ 3. I authorize *Dr. James R. Aspinwall, D.C., Dr. L. Keith Aspinwall, D.C. or Kevin Baerwalde, P.T.* to release any medical information pertinent to my treatment to any authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage of my current policy. I certify that all insurance information given to this clinic is correct and complete. I also know that I am entitled to receive a copy of this authorization form upon request.

_____ 4. Fees for services, which include unpaid balances, deductibles and co-payments and in some cases coinsurance, are due at the time of service. Returned checks and unpaid balances may be subject to returned check fees, attorney fees, collection placement and collection fees.

_____ 5. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty days, the balance may be due in full from you. If any payment is made directly to you for services

billed by Aspinwall Chiropractic Clinic and/or Certified Rehab of Georgia, you recognize an obligation to promptly remit payment to Aspinwall Chiropractic Clinic and/or Certified Rehab of Georgia.

_____ 6. The above does not apply for those patients that are considered **Workers' Compensation**. However, be advised that as a compensation patient you may be held responsible for charges in the event that your claim is denied or not paid or determined not to be work related.

(ALL ACCIDENT PATIENTS MUST INITIAL #7 – automobile, Worker's Compensation, etc.....)

_____ 7. I, the undersigned patient am directing my attorney, _____ to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instruction herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the provider's additional protection. I further understand that payment is not contingent on any settlement, judgment or verdict by which may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the provider's interest, the provider will not await payment but, will require me to make payment on a current status.

(ALL PATIENTS MUST INITIAL #8)

_____ 8. The completion of disability and/or FMLA forms are not billable/reimbursable by insurance carriers, therefore fees are your responsibility for payment. Aspinwall Chiropractic Clinic and/or Certified Rehab of Georgia fees related to completion of these documents are expected to be paid upon presentation of forms for completion.

Consent For Treatment **(ALL PATIENTS MUST INITIAL #9)**

_____ 9. I hereby authorize *Dr. James R. Aspinwall, D.C., Dr. L. Keith Aspinwall, D.C. or Kevin Baerwalde, P.T.* and whomever he/she may designate as his/her assistant(s) to perform diagnostic test, including but not limited to radiographs and to administer treatment as is necessary. **I also certify that no guarantee or assurance has been made to the results that may be obtained.**

Consent For Treatment of Minor *(if applicable)*

10. I hereby authorize *Dr. James R. Aspinwall, D.C., Dr. L. Keith Aspinwall, D.C. or Kevin Baerwalde, P.T.* and whomever he may designate as his assistant(s), to perform diagnostic test, including but not limited to radiographs and to administer treatment as he deems necessary to my (please circle) SON DAUGHTER OTHER: _____,

Child's Name: _____ Child's D/O/B: _____.

Guardian's Signature: _____ **DATE:** _____

We understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. Our financial counselor is available to assist you or answer any questions you may have.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW:

Patient's Name: _____ D/O/B: _____

_____ **DATE:** _____

Signature of **Patient** or **Responsible Party**

_____

Relationship to patient if other than patient

Witnessed by: _____ **DATE:** _____

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Functional Rating Index

For use with Neck and/or Back Problems only

Patient Number: _____

Name (please print): _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

How long have you had the pain? _____ Years _____ Months _____ Weeks

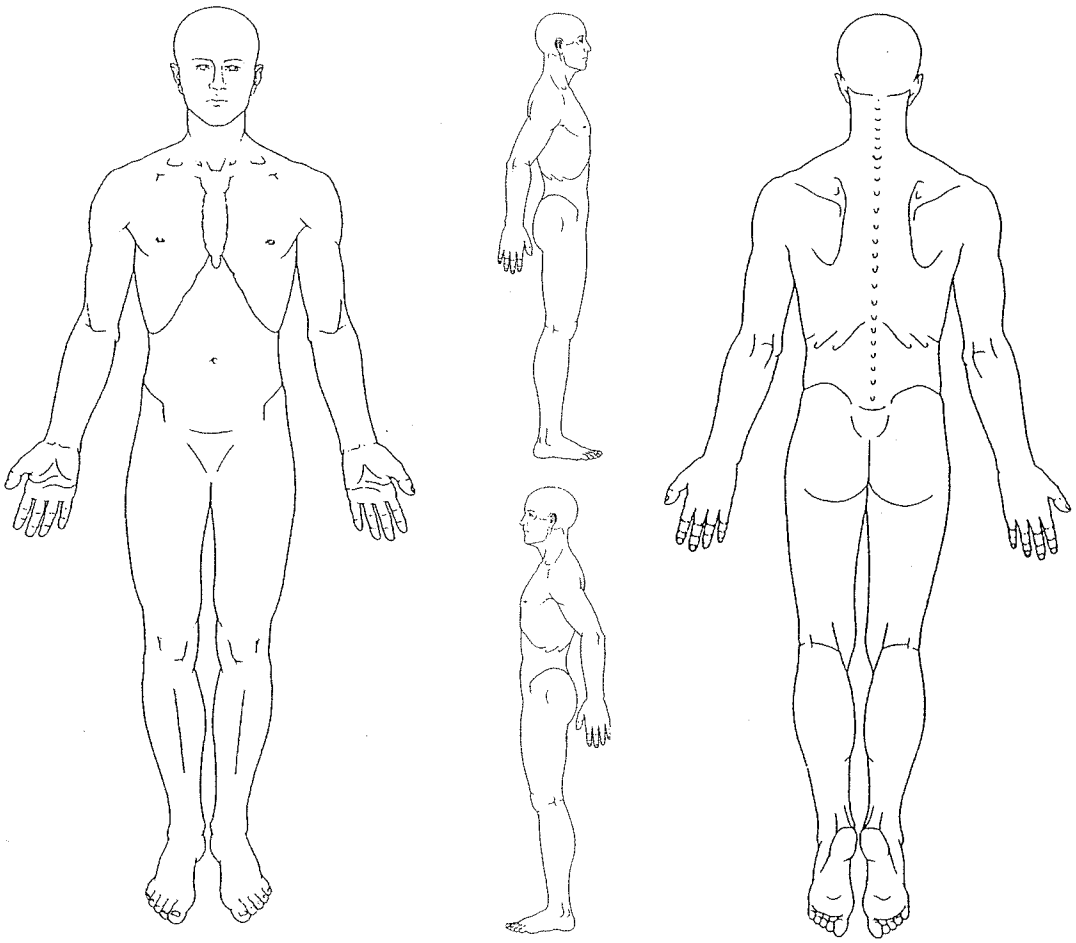
Is this the first episode of pain? _____ Yes _____ No

Other comments: _____

_____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

Please remember to complete both sides of this form



KEY:

A = ACHE
B = BURNING
N = NUMBNESS
P = PINS & NEEDLES
S = STABBING
O = OTHER

Feise RJ, Menke JM. Functional Rating Index: a new valid and reliable instrument to measure the magnitude of clinical changes in spinal conditions. *Spine*, 2001; 26:78-87.

Functional Rating Index

For use with Neck and/or Back Problems only

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now. (Please indicate **N** for Neck and **B** for Back).

1. Pain Intensity:

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worse Possible Pain

2. Sleeping:

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain No Restriction	Mild Pain No Restriction	Moderate Pain need to go slowly	Moderate Pain need some assistance	Severe Pain need 100% assistance

4. Travel (driving, etc.):

0	1	2	3	4
No Pain on long trips	Mild Pain on long trips	Moderate Pain on long trips	Moderate Pain on short trips	Severe Pain on short trips

5. Work:

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do a few activities	Can not do any activities

6. Recreation:

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do 25% of usual work	Can not work

7. Frequency of pain:

0	1	2	3	4
No pain	Occasional pain 25% of the day	Intermittent pain 50% of the day	Frequent pain 75% of the day	Constant pain 100% of the day

8. Lifting:

0	1	2	3	4
No pain with heavy lifting	Increased pain with heavy lifting	Increased pain with moderate weight	Increased pain with light weigh	Increased pain with any weight

9. Walking:

0	1	2	3	4
No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing:

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Patient Signature

Date