

Back In Motion Chiropractic – Confidential Patient Questionnaire

Name: _____ Date of birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Text Reminder: Yes/ No Cell phone provider: _____

Sex: M / F Marital Status: Married / Single Social Security #: _____

Email Address: _____

Occupation: _____ Employer: _____

Do you have health insurance? _____ (**If yes, please provide card for copying*)

Do you have accident insurance *such as AFLAC, Combined, etc?* Yes ___ No ___

Is the reason for your visit today:

Auto Injury: Yes/No

Work Comp Injury: Yes/No

Emergency Contact: _____ Relationship to you: _____

Emergency Contact Phone: _____

Regular M.D. _____

Last Seen: _____ For? _____

Previous/Other Chiropractor: _____

Last Seen: _____ For? _____

How/From whom did you hear about our office? _____

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**Please read & sign the following:** *I, the undersigned, do hereby attest that this questionnaire has been completed true to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand and agree that insurance policies are a contract between the insurance company and the policy holder, not the doctor, and as such I am responsible to know any policy limitations that might exist. I hereby authorize Back In Motion Chiropractic to release my records as necessary to obtain any pertinent third party reimbursement and/or to other pertinent healthcare providers. I authorize my insurance carrier, if I have one, to pay benefits directly to Back In Motion Chiropractic for services I receive at this clinic. This is a direct assignment of insurance benefits.*

**Signed:** \_\_\_\_\_ **Dated:** \_\_\_\_\_

# Patient Health Questionnaire

American Chiropractic Network

ACN Use Only rev 4/23/99

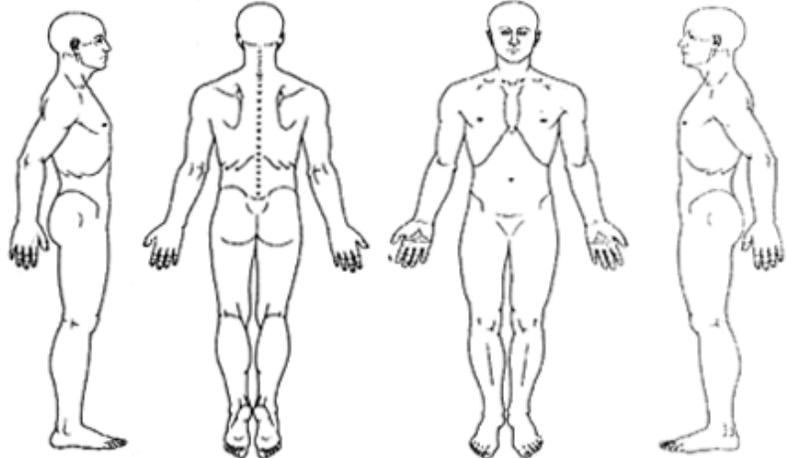
Patient Name \_\_\_\_\_

Date \_\_\_\_\_

1. When did your symptoms start: \_\_\_\_\_ Describe your symptoms and how they began: \_\_\_\_\_

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

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



3. What describes the nature of your symptoms?

- ① Sharp                      ④ Shooting
- ② Dull ache                ⑤ Burning
- ③ Numb                      ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. How bad are your symptoms at their:

None Unbearable

a. worst: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

b. best: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

|               |                               |                                    |                                  |                                          |                              |   |   |   |   |
|---------------|-------------------------------|------------------------------------|----------------------------------|------------------------------------------|------------------------------|---|---|---|---|
| ①             | ②                             | ③                                  | ④                                | ⑤                                        | ⑥                            | ⑦ | ⑧ | ⑨ | ⑩ |
| No complaints | Mild, forgotten with activity | Moderate, interferes with activity | Limiting, prevents full activity | Intense, preoccupied with seeking relief | Severe, no activity possible |   |   |   |   |

7. What activities make your symptoms worse: \_\_\_\_\_

8. What activities make your symptoms better: \_\_\_\_\_

9. Who have you seen for your symptoms?

- ① No One
- ③ Medical Doctor
- ⑤ Other
- ② Other Chiropractor
- ④ Physical Therapist

a. When and what treatment? \_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_
- ③ CT Scan date: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ④ Other date: \_\_\_\_\_

10. Have you had similar symptoms in the past?

- ① Yes                      ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ③ Medical Doctor
- ⑤ Other
- ② Other Chiropractor
- ④ Physical Therapist

11. What is your occupation?

- ① Professional/Executive
- ④ Laborer
- ⑦ Retired
- ② White Collar/Secretarial
- ⑤ Homemaker
- ⑧ Other
- ③ Tradesperson
- ⑥ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ③ Self-employed
- ⑤ Off work
- ② Part-time
- ④ Unemployed
- ⑥ Other

12. What do you hope to get from your visit/treatment (select all that apply):

- ① Reduce symptoms
- ③ Explanation of condition/treatment
- ⑤ How to prevent this from occurring again
- ② Resume/increase activity
- ④ Learn how to take care of this on my own
- ⑥

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have been offered a copy of this office's  
Notice of  
Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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# **Informed Consent for Chiropractic Treatments and Care**

*Back in Motion  
1453 Sixth Street  
Brookings, SD 57006  
605-692-2225*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me (or on the patient named below, for whom I am legally responsible) by Rodney Brandenburger, DC and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Rodney Brandenburger, DC.

I will have an opportunity to discuss with Rodney Brandenburger, DC and/or with office clinic personnel the nature and purpose of chiropractic adjustments and other procedures before they are administered.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further agree that all doctor's notes and patient records may be sent to my personal health insurance and/or any other responsible insurance carrier, including workers' compensation or auto insurance, or to attorney's or other parties which request records in order to determine payment on my behalf to Rodney Brandenburger, DC.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

## **If patient is a minor or physically or legally incapacitated:**

Patient's Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Legal Guardian Signature \_\_\_\_\_