

Whom may we thank for referring you to this office? \_\_\_\_\_

## APPLICATION FOR CARE AT HEALING FRONTIERS

Today's Date: \_\_\_\_\_

HRN: \_\_\_\_\_

### PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ May we contact you via email? \_\_\_\_\_ Home phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ May we contact you at work? \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Number of children and ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Your primary care physician: \_\_\_\_\_ May we contact him/her to keep them abreast of your care? \_\_\_\_\_

### HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_ Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

**Primary** or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Second** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Third** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Fourth** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM

How long does it last?  It is constant **OR**  I experience it on and off during the day **OR**  It comes and goes throughout the week

How did the injury happen? \_\_\_\_\_

Condition(s) ever been treated by anyone in the past?  No  Yes **If yes**, when: \_\_\_\_\_ by whom? \_\_\_\_\_

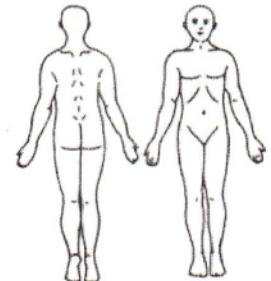
How long were you under care: \_\_\_\_\_ What were the results? \_\_\_\_\_

**PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

**R** = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms? \_\_\_\_\_

What makes your symptoms feel worse? \_\_\_\_\_



**LIST RESTRICTED ACTIVITY:**

**CURRENT ACTIVITY LEVEL**

**USUAL**

**ACTIVITY LEVEL**

_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

Is your problem the result of ANY type of accident?  Yes,  No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past?  No  Yes **If yes**, how many times? \_\_\_\_\_ When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried:  No  Yes **If yes**, please state **what** type of treatment: \_\_\_\_\_, and who provided it: \_\_\_\_\_ **How long ago?** \_\_\_\_\_ What were the results.  Favorable  Unfavorable → please explain. \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have or **N** for **Never** have had:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer  
\_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other serious conditions: \_\_\_\_\_

**PLEASE identify ALL PAST and any CURRENT conditions:**

	What	HOW LONG AGO	TYPE OF CARE RECEIVED/RESULT
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

**SOCIAL HISTORY**

- 1. **Smoking:**  cigars  pipe  cigarettes How often?  Daily  Weekends  Occasionally  Never
- 2. **Alcoholic Beverage:** consumption occurs  Daily  Weekends  Occasionally  Never
- 3. **Recreational Drug use:**  Daily  Weekends  Occasionally  Never
- 4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect? (See ADL form)

**FAMILY HISTORY:**

- 1. Does anyone in your family suffer with the same condition(s)?  No  Yes  
**If yes whom:**  grandmother  grandfather  mother  father  sister(s)  brother(s)  son(s)  daughter(s)  
Have they ever been treated for their condition?  No  Yes  I don't know
- 2. **Any other hereditary conditions** the doctor should be aware of?  No  Yes: \_\_\_\_\_

I hereby authorize payment to be made directly to Healing Frontiers for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Healing Frontiers for any and all services I receive at this office.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ Date: \_\_\_\_\_

## ACTIVITIES OF DAILY LIVING (ADL's)

**IMPORTANT:** This information is **very** important! The current Standard Of Care requires the tracking of your ADL's as one of the most important means to justify your care to insurance companies and other regulatory agencies.

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient signature: \_\_\_\_\_ Today's Date: \_\_/\_\_/\_\_

## OTHER SYMPTOMS:

Please mark **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never**

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> Headache                           | <input type="checkbox"/> Pregnant (Now)         | <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Prostate Problems        | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Neck Pain                          | <input type="checkbox"/> Frequent Colds/Flu     | <input type="checkbox"/> Loss of Balance  | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Jaw Pain, TMJ                      | <input type="checkbox"/> Convulsions/Epilepsy   | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Digestive Problems       | <input type="checkbox"/> Heart Problem        |
| <input type="checkbox"/> Shoulder Pain                      | <input type="checkbox"/> Tremors                | <input type="checkbox"/> Double Vision    | <input type="checkbox"/> Colon Trouble            | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Upper Back Pain                    | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Blurred Vision   | <input type="checkbox"/> Diarrhea/Constipation    | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Mid Back Pain                      | <input type="checkbox"/> Pain w/Cough/Sneeze    | <input type="checkbox"/> Ringing in Ears  | <input type="checkbox"/> Menopausal Problems      | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Low Back Pain                      | <input type="checkbox"/> Foot or Knee Problems  | <input type="checkbox"/> Hearing Loss     | <input type="checkbox"/> Menstrual Problem        | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain                           | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression       | <input type="checkbox"/> PMS                      | <input type="checkbox"/> Lung Problems        |
| <input type="checkbox"/> Back Curvature                     | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable        | <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Kidney Trouble       |
| <input type="checkbox"/> Scoliosis                          | <input type="checkbox"/> Skin Problems          | <input type="checkbox"/> Mood Changes     | <input type="checkbox"/> Learning Disability      | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | <input type="checkbox"/> ADD/ADHD               | <input type="checkbox"/> Eating Disorder  | <input type="checkbox"/> Liver Trouble            |   |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes     | <input type="checkbox"/> Allergies              | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Hepatitis (A,B,C)        |   |

A. Notifier: **HEALING FRONTIERS**

B. Patient Name:

C. Identification Number:

## Advance Beneficiary Notice of Non-coverage (ABN)

**NOTE:** If Medicare doesn't pay for D. \_\_\_\_\_ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. \_\_\_\_\_ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
EXAMINATION		\$66-\$149
EXTREMITY MANIPULATION	<b>THESE SERVICES ARE NOT COVERED BY MEDICARE</b>	\$30
ELECTRIC STIMULATION		\$20
TRACTION, MECHANICAL DECOMPRESSION		\$20 \$30

### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. \_\_\_\_\_ listed above.  
**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

### G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the D. \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- OPTION 3.** I don't want the D. \_\_\_\_\_ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

### H. Additional Information:

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

**CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov).**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

# Healing Frontiers

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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

\_\_\_\_\_  
Date

QUADRUPLE VISUAL ANALOGUE SCALE

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

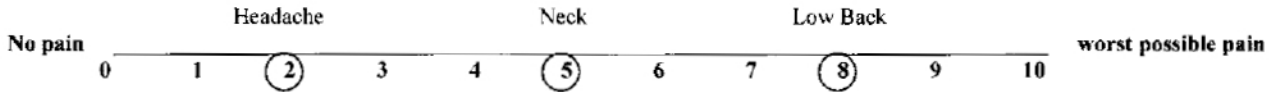
Date \_\_\_\_\_

Please read carefully:

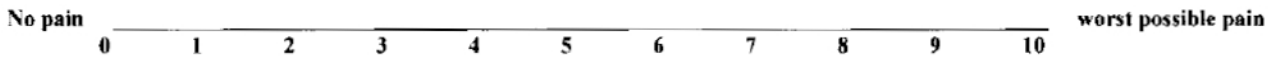
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

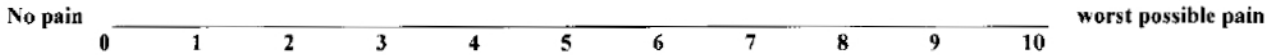
Example:



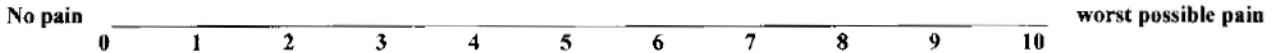
1 - What is your pain RIGHT NOW?



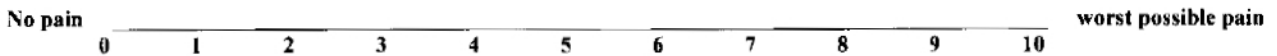
2 - What is your TYPICAL or AVERAGE pain?



3 - What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 - What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_

Examiner \_\_\_\_\_

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.