Integrated Spinal Solutions Patient Information

Patient Name:	**Today's Date:**
Address:	Home Telephone:
City/State/Zip:	Work Telephone:
Birth Date: Age:	Cellular Telephone:
Height: Weight:	Employer's Name:
Social Security Number:	Employer's Address:
Email:	
Marital Status: Single Married Divorced Widowed	Primary MD Name & Address

How were you referred to our office?	__ Location	__ Our Web Site	__ Other:_____
	__ Provider Manual	__ Yellow Pages	__ Spinal Talk at: _____
	__ Internet Search	__ Radio / TV	__ Existing Patient:_____

Emergency Contact Information

Nearest Adult Relative:	Relation to Patient:
Address:	Phone #:

Insurance Information

Does your insurance cover Chiropractic treatment?	☐ Yes ☐ No If yes, we need a copy of your card
If yes, indicate Insurance Company Name.	Carrier Name:
	Address:
If you are being seen for a work related or car accident injury we need the Claim Number and the Claims Adjusters Name.	Telephone Number:
	I.D. Number:
	Group Number:
Are you the insured person or a dependent?	☐ Insured ☐ Dependent (wife/husband/child)
If you are the insured persons dependent (spouse or child), we need the insured persons name, date of birth, social security number, name of the insured employers business and the address of the business.	Name of Insured Person:
	Social Security Number:
	Insured Date of Birth:
	Name of Insured Company
	Insured Company Address:

As a courtesy, our office will provide insurance billing services for you if you so desire. Please remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-pay and or any other balances not paid by your insurance carrier (except for contracted discounts). Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE REQUIRE PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT FOR INSURANCE PATIENTS.

Patient Signature (Parent or responsible party):_____ **Date:** _____

Patient Name:

Patient History Integrated Spinal Solutions
Phone (775) 828-9665 • Fax (775) 622-4150

When did your complaint begin?	
Cause:	☐ Car Accident ☐ At home ☐ Work related ☐ Other ☐ Fall ☐ Athletic injury ☐ After surgery
Have you ever had a similar injury or complaint in the past?	☐ No ☐ Yes : _____
Prior Treatment:	☐ ER Visits ☐ Physical Therapy ☐ Surgeries ☐ Other:
Prior Imaging:	☐ X-rays ☐ CT Scan ☐ MRI ☐ EMG
Quality of Pain:	☐ Local ☐ Electrical shock ☐ Ache ☐ Stabbing ☐ Radiates ☐ Sharp ☐ Tingle ☐ Throbbing ☐ Radiates to legs ☐ Dull ☐ Cramping ☐ Radiates to arms ☐ Burning ☐ Stinging
What aggravates your condition?	☐ Standing ☐ Lay Down ☐ Walk down hill ☐ Lifting ☐ Sitting ☐ Walk up hill ☐ Bending ☐ Other:
What helps?	☐ Standing ☐ Lay Right ☐ Bend Forward ☐ Other: ☐ Sitting ☐ Lay Left ☐ Change positions
Medical Conditions:	☐ Heart Disease ☐ Trauma ☐ Arthritis ☐ Diabetes ☐ Nerve Disease ☐ Toxin Exposure ☐ High Blood Pressure ☐ Psychiatric Disorders ☐ Other: _____ ☐ Ulcers ☐ Depression ☐ Current medications: ☐ Lung Disease ☐ Seizures
Family History:	☐ Heart Disease ☐ Nerve Disease ☐ Diabetes ☐ Psychiatric Disorders ☐ Arthritis ☐ High Blood Pressure ☐ Depression ☐ Toxin Exposure ☐ Ulcers ☐ Lung Disease ☐ Other: ☐ Trauma ☐ Seizures

Patient Name:

Have you recently experienced…

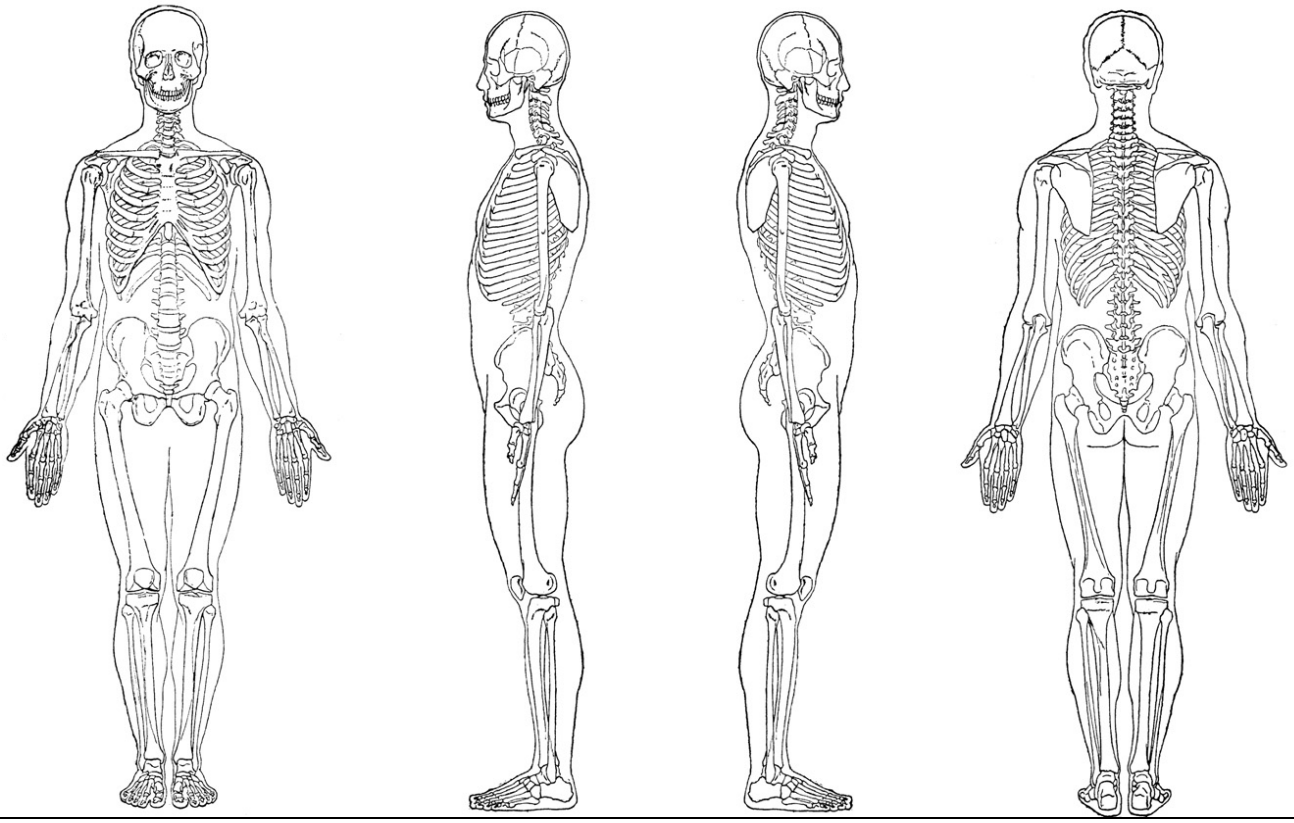
☐ Other Joint Pain	☐ Fatigue	☐ Chest Pain
☐ Tightness	☐ Sleeplessness	☐ Sweating
☐ Numbness	☐ Decreased Energy	☐ Vision Changes
☐ Balance Loss	☐ Nausea	☐ Hearing Changes
☐ Lack of Coordination	☐ Vomiting	☐ Dizziness
☐ Depressed Mood	☐ Fevers	☐ Headaches
☐ Loss of Appetite	☐ Chills	☐ Night Pain
☐ Recent Weight Gain	☐ Recent Weight Loss	☐ New Lump on Body
☐ Irritability	☐ Anxiety	☐ Painful Bowel Movement
☐ Blood or dark urine	☐ Shortness of Breath	☐ Painful urination

Bowel or Bladder Dysfunction present?

☐ No
☐ Yes: _____

Legend **S**=Sharp Pain **D**=Dull Pain **N**=Numbness **PN**=Pins & Needles **W**=Weakness **T**=Tightness

Mark with an "X" where you have pain. Use lines to show how far the discomfort extends.



Indicate the severity of your current symptoms by placing an "**X**" on the line scale below

No pain at all — Worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

INTEGRATED SPINAL SOLUTIONS, PC
TERMS OF ACCEPTANCE

Agreement to Financial Policy

I have agreed to pay charges at the time of service. I understand that I may pay by check, Visa or MasterCard. Emergency and after hour visits will be subject to additional charges. I agree to be charged a **missed appointment fee of $10** if I miss an appointment without giving at least 4 hours advanced notice. I understand that as the parent or guardian, I am responsible for full payment of child's care. I further understand that for unaccompanied minors, payment in full is still required at time of service. If I have insurance coverage I hereby assign directly to Integrated Spinal Solutions, pc all medical benefits, if any, payable to me if any services rendered. I also understand that there is a 1.5% monthly interest charge on any unpaid balance over one (1) month old. It is at the discretion of the doctor to collect or waive said fee and will depend upon the payment history of the account. By signing below, I agree that should my account be referred to a collection agency or an attorney for collections, I will be directly responsible for paying all reasonable attorney's fees, other legal fees and/or any and all collection expenses.

Patient Accepts Responsibility for Insurance Reimbursements and Approvals

I accept responsibility to know my policy limits and requirements. I further accept responsibility to seek pre-authorization, bill and collect reimbursement from my insurance carrier if applicable. I understand that my insurance policy is a contract between the insurance carrier and myself. I further understand that Integrated Spinal Solutions, pc is in no way a guarantee of coverage or reimbursement from my insurance carrier. I further understand that my health insurance will be billed as a courtesy but that I am ultimately responsible for payment. I understand that some of perhaps all of the services that I receive may not be considered reasonable and necessary under the Medicare program and/or other insurance plans. I understand that insurance claims that are over 90 days old and unpaid, will become my responsibility. By my presence and continuation of appointments, I consent and elect care provided by Dr. Xavier Martinez and/or his staff.

Patient Will Truthfully and Fully Disclose Health Status and History

I hereby state that all information that I hereby give Integrated Spinal Solutions, pc and/or it's staff will be complete and truthful. I will not misrepresent my presence, nature, severity or cause of my injuries. I further state that I will fully disclose my health history and authorize the release of all past medical records to Integrated Spinal Solutions, pc. I present myself for health reasons only and it is not my intent to mislead, defraud or coerce this office or any third party or misrepresent myself in any manner.

Patient Consents to Care and Accepts Responsibility

I consent to recommendations and care by the Doctor(s) of Integrated Spinal Solutions, pc for myself (or my children if minors) including, but not limited to examinations, x-rays, chiropractic adjustments, rehabilitative and physical therapy. I understand that my care will be individualized to me and therefore may not be comparable to standards or guidelines used or required by insurance companies, professional associates, and/or consensus groups. I understand that my treatment will comply with the inherent risks. These risks, though rare, could occur ranging from minor aggravation of current condition to serious conditions such as cerebral vascular accident or death. I am signing this consent after having been fully informed to my satisfaction by the Doctor(s) of Integrated Spinal Solutions, pc and/or his staff of the risks and benefits of the care and the risks and benefits of not having the recommended treatment. I have been informed and fully understand that there are no guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Doctor(s) of Integrated Spinal Solutions, pc and/or his staff.

Medicare Limits and Responsibilities Advance Notice

The only charge for Chiropractic that is covered by Medicare is manual manipulation of the spine. I accept responsibility to know the current Medicare guidelines and limits for covered services. I accept responsibility to pay for all covered non-covered or denied services. I have been notified by my physician that he believes that in my case Medicare is likely to deny payment for some services. If Medicare denies payment, I agree to be personally and fully responsible for payment. I understand that I must pay for services at the time of treatment. I also understand that Integrated Spinal Solutions, pc will bill all charges directly to Medicare as required by law. I authorize the release of my records as necessary for Medicare Billing.

I have read, understand and agree to the provisions and terms of acceptance. This agreement shall become effective upon signing and be irrevocable for the full extent of my treatment by the doctor.

Patient Name (please print): _____

Patient Signature: _____ Date:_____

THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

PATIENT NAME: _____ **DATE**: _____

Please read: This questionnaire is designed to enable us to understand how much your **LOW BACK** pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

SECTION 2 - Personal Care

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes 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 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.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., 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 only lift very light weights at the most.

SECTION 4 - Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 -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 more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

SECTION 6 -Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7 -Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of my pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life, and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of the pain.

SECTION 9 - Travel

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get ext ra pain while traveling, which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing degree of pain

†

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Patient Signature: _____

OSWESTRY NECK DISABILITY INDEX

PATIENT NAME: _____ **DATE**: _____

Please read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

- ☐ 0 I have no pain at the moment.
- ☐ 1 The pain is very mild at the moment.
- ☐ 2 The pain is moderate at the moment.
- ☐ 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.

SECTION 2 - Personal Care (washing, dressing, etc)

- ☐ 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; I am slow and careful.
- ☐ 3 I need some help but 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.

SECTION 3 - Lifting

- ☐ 0 I can lift heavy weights without extra pain.
- ☐ 1 I can lift heavy weights, but it gives me extra pain.
- ☐ 2 pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned for example on a table.
- ☐ 3 pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ 4 I can with only very light weights.
- ☐ 5 I cannot lift or carry anything at all.

SECTION 4 - Reading

- ☐ 0 I can read as much as I want to with no pain in my neck.
- ☐ 1 I can read as much as I want to with slight pain in my neck.
- ☐ 2 I can read as much as I want with moderate neck pain.
- ☐ 3 I can't read as much as I want because of moderate neck pain.
- ☐ 4 I can hardly read at all because of severe pain in my neck.
- ☐ 5 I cannot read at all.

SECTION 5 -Headaches

- ☐ 0 I have no headaches at all.
- ☐ 1 I have slight headaches that come infrequently.
- ☐ 2 I have slight headaches that come frequently.
- ☐ 3 I have moderate headaches that come infrequently.
- ☐ 4 I have moderate headaches that come frequently.
- ☐ 5 I have headaches almost all the time.

SECTION 6 -Concentration

- ☐ 0 I can concentrate fully when I want to with no difficulty.
- ☐ 1 I can concentrate fully when I want to with slight difficulty.
- ☐ 2 I have a fair degree of difficulty in concentrating when I want to.
- ☐ 3 I have a lot of difficulty in concentrating when I want to.
- ☐ 4 I have a great deal of difficulty in concentrating when I want to.
- ☐ 5 I cannot concentrate at all.

SECTION 7 -Work

- ☐ 0 I can do as much work as I want to.
- ☐ 1 I can only do my usual work, but no more.
- ☐ 2 I can 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 can't do any work at all.

SECTION 8 - Driving

- ☐ 0 I can drive my car without any neck pain.
- ☐ 1 I can drive my car as long as I want with slight pain in my neck.
- ☐ 2 I can drive my car as long as I want with moderate pain in my neck.
- ☐ 3 I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ 4 I can hardly drive at all because of severe pain in my neck.
- ☐ 5 I can't drive my car at all.

SECTION 9 - Sleeping

- ☐ 0 I have no trouble sleeping.
- ☐ 1 My sleep is slightly disturbed (less than one hour sleeplessness).
- ☐ 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).

SECTION 10 -Recreation

- ☐ 0 I am able to engage in all my recreation activities with no neck pain at all.
- ☐ 1 I am able to engage in all my recreational activities, with some pain in my neck.
- ☐ 2 I am able to engage in most, but not all of my usual of recreational activities because of pain in my neck.
- ☐ 3 I am able to engage in a few of my recreational activities because of pain in my neck.
- ☐ 4 I can hardly do any recreational activities because of pain in my neck.
- ☐ 5 I can't do any recreational activities at all.

Patient Signature: _____