NORTH HILLS CHIROPRACTIC

PATIENT INFORMATION

Please complete the following forms to the best of your knowledge. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help you.

Patient's Full Name:_____ Today's Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ Carrier:_____

Birth Date: _____ Gender: _____Male _____ Female

Are You: _____ Minor _____ Single _____ Married _____Separated _____ Divorced _____ Widowed

Email Address: _____ (Health tips, Updates, Schedule Changes)

May we contact you for appointment reminders via e-mail or text message? ☐ YES ☐ NO

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Whom may we thank for referring you to us?:_____

PATIENT HEALTH QUESTIONNAIRE

Describe your symptom(s): _____

_____

a. When did your symptom(s) start? _____

b. How did your symptom(s) begin? _____

How often do you experience your symptoms?

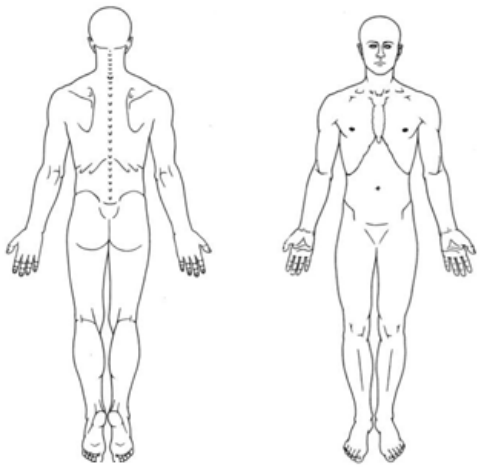
☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Which word best describes your symptoms?

☐ Sharp ☐ Radiating
☐ Numb ☐ Sore
☐ Shooting ☐ Stabbing
☐ Burning ☐ Stiff
☐ Dull ☐ Stinging
☐ Pinching ☐ Throbbing
☐ Pounding ☐ Tight
☐ Tingling ☐ Aching

Indicate where you have pain or other symptoms?



Aggravated by:

_____

_____

Relieved by:

_____

_____

Average pain intensity:

Last 24 hours: **no pain** ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **unbearable pain**

Past 4 weeks: **no pain** ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **unbearable pain**

DOCTOR USE ONLY

NORTH HILLS CHIROPRACTIC

During the *past 4 weeks* how much of the time has your condition interfered with your usual daily activities? (Including both work outside the home and housework, etc.)
☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little bit ☐ None

Who have you seen for your current symptoms?
☐ No One ☐ Chiropractor ☐ Medical Doctor
☐ Physical Therapist ☐ Other_____

What treatment did you receive and when:_____

What tests have you had for your symptoms and when:
_____

Have you had similar symptoms/episodes in the past? ☐ Yes ☐ No
If yes, who did you see for care? _____

What is your normal activity/exercise level? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

For each condition below, check if you have had it in the past and/or present:

Past / Present	Past / Present	Past / Present
☐ ☐ Headache	☐ ☐ Dizziness	☐ ☐ Diabetes
☐ ☐ Neck Pain	☐ ☐ Heart Attack	☐ ☐ Excessive Thirst
☐ ☐ Upper Back Pain	☐ ☐ Chest Pain	☐ ☐ Tobacco Use
☐ ☐ Mid Back Pain	☐ ☐ Stroke	☐ ☐ Allergies
☐ ☐ Low Back Pain	☐ ☐ Kidney Stones	☐ ☐ Drug Dependence
☐ ☐ Shoulder Pain	☐ ☐ Kidney Disorder	☐ ☐ Alcohol Dependence
☐ ☐ Elbow / Arm Pain	☐ ☐ Bladder Infection	
☐ ☐ Wrist Pain	☐ ☐ Painful Urination	☐ ☐ Allergies
☐ ☐ Hand Pain	☐ ☐ Abdominal Pain	☐ ☐ Depression
☐ ☐ Hip/Upper Leg Pain	☐ ☐ Ulcer	☐ ☐Epilepsy
☐ ☐ Knee / Lower Leg	☐ ☐ Hepatitis	☐ ☐ HIV/AIDS
☐ ☐ Ankle / Foot Pain	☐ ☐ General Fatigue	**Other Health Problems**
☐ ☐ Jaw Pain	☐ ☐ Cancer	☐ ☐_____
☐ ☐ Joint Pain	☐ ☐ Tumor	☐ ☐_____
☐ ☐ Frequent Urination	☐ ☐ Asthma	
☐ ☐ Rheumatoid Arthritis	☐ ☐ Chronic Sinusitis	**Females Only**
☐ ☐ Liver/Bladder Disorder	☐ ☐ Osteoporosis	☐ ☐ Birth Control
☐ ☐ Muscle Un-coordination	☐ ☐ Dermatitis/Eczema	☐ ☐ Hormone Replacement
☐ ☐ Visual Disturbance	☐ ☐ Arthritis	☐ ☐Pregnancy
☐ ☐ High Blood Pressure	☐ ☐ Systemic Lupus	

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐Lupus
☐ High Cholesterol ☐ Stroke ☐ Other _____

List all prescriptions, over-the-counter medications, and nutritional/herbal supplements you are taking: _____
_____

_____

List all surgical procedures you have had and times you have been hospitalized:
_____

_____

Patient / Guardian Signature: _____ Date_____

DOCTOR USE ONLY

NORTH HILLS CHIROPRACTIC, INC.

208 Lemmon Drive
Reno, Nevada 89506
Phone: (775) 972-4488
Fax: (775) 972-1853

Financial Agreement

North Hills Chiropractic and the Doctors participate in many insurance plans, but not all of them. It is your responsibility to know whether the doctor you are seeing is a participant on your plan. Charges for services rendered by North Hills Chiropractic will be submitted directly to your insurance company for payment, as a courtesy to you. All copays and deductibles are due at the time of service. We will try our best to notify you of your financial obligations at the time of your visit, but it is ultimately your responsibility to know and pay your financial obligations. **Copays and/or deductibles collected upfront are an estimated amount. You will be responsible for any amount not paid by your insurance.**

Should you not have insurance coverage, you will be considered a self-pay patient. We offer discounted rates and you will be responsible for paying the total charges at the time of your visit.

*** Patients should note that not all Chiropractic procedures, exams and/or modalities are covered by insurance. Patients may be directly responsible for such fees. We will do our best to inform you of your benefits at the time of your visit.

*** It is your responsibility to notify our office if prior authorization/referrals are required.

*** **Please be aware that our office has a 24-hour cancellation policy.** You will be charged a fee of $20 for every appointment that is broken without giving 24 hour notice. 24 hour notice can be given when we are closed, such as on the weekends, by simply leaving a message on our voicemail 24 hours prior to your appointment time.

Authorization

I authorize North Hills Chiropractic, Dr. David D. Berg, DC., to release any information acquired during my exam and treatment for the purpose of claim payment. I further authorize payment directly to the doctor for benefits due to me for this service. I recognize and accept personal responsibility for any balance remaining after payment of such benefits.

Patient Name Social Security #

Signature Date

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Privacy Policy

Our office is fully committed to compliance with HIPAA guidelines by:

1. Providing appropriate security for our patients records
2. Protecting the privacy of our patients' medical information
3. Providing our patients with proper access to their medical records, one a signed release is obtained.
4. Appropriately maintaining our patients information and billing process in compliance with National HIPAA standards
5. NOT providing patients' data to marketers or pharmaceutical companies for the purpose of research

I acknowledge that I have read and understand the privacy policy of North Hills Chiropractic, Inc.

_____ _____

Patient/Legal Guardian Signature Date

_____ Please be advised that pursuant to Federal Law, your medical records will be kept for 5
Initials years, after which, they may be destroyed.

Yes____ No___ Can messages be left on your answering machine, voicemail, or with family members?

Please list the alternate phone number that you which to receive calls about appointments, billing issues, or any other information, if you do not wish to be contacted at home.
*Preferred Alternate Phone Number:*_____

*** If left blank, we will assume it is okay to call your home phone number and also leave messages for you ***

Informed consent for chiropractic treatment

To the patient: you have the right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures. The chiropractic treatment may be performed by the doctor and/or staff.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

*Broken bones	*Increased symptoms and pain
*Dislocations	*No improvement of symptoms or pain
*Sprains/strains	*Stroke
*Burns or frostbite	* Worsening/aggravation of spinal conditions

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, and paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to have treatment. I intend this consent to cover the entire course of treatment for my current condition.

To be completed by patient	To be completed by staff or Doctor
_____	_____
Print name	witness to patient signature
_____	_____
Date signed	Date signed

Clinic Use Only:

_____
_____
_____
_____
_____

Vital Signs: Height _____ Ft _____In Weight:_____ lbs BP: _____/_____ Pulse: _____

Alert & Oriented: _____ Gait & Station: _____

Skin – (Scars/Blemishes): Head Trunk RUE LUE RLE LLE

_____

Lymphatic Exam: Neck, Axilla, Other

_____

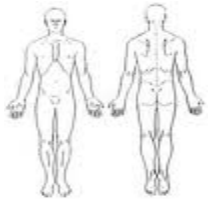
Neurological: DTR Biceps (R) _____ (L) ____ Patellar (R) _____ (L) _____ Finger to nose _____ Finger Fan _____

Sensory Pinwheel: Upper Extremity ___ Lower Extremity ____Motor / Strength: Upper Extremity ___ Lower Extremity ___

Pain / Tenderness with Palpation or Numbness / Weakness

Comments:

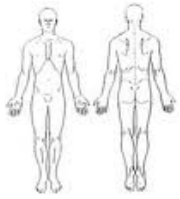
_____
_____
_____
_____
_____



Tissue / Tone Changes

Comments:

_____
_____
_____
_____
_____



Range of Motion Abnormality:

Cervical ROM

Flexion: Mild Mod Severe Restricted Pain R L
Extension: Mild Mod Severe Restricted Pain R L
Lateral Flexion: Mild Mod Severe Restricted Pain R L
Rotation: Mild Mod Severe Restricted Pain R L

Cervical Testing	**L**	**Neutral**	**R**
Foraminal Compression:	+ / -	+ / -	+ / -
Shoulder Depression:	+ / -	--------	+ / -

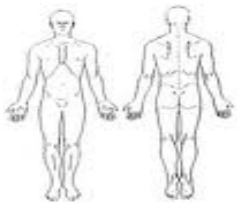
Lumbar ROM

Flexion: Mild Mod Severe Restricted Pain R L
Extension: Mild Mod Severe Restricted Pain R L
Lateral Flexion: Mild Mod Severe Restricted Pain R L

Asymmetry/Misalignment/Joint Fixations

Spinal:
C0 1 2 3 4 5 6 7 **T**1 2 3 4 5 6 7 8 9 10 11 12 **L**1 2 3 4 5 **SI** R L **SAC**
Extremities:
Shoulder:AC/GH/SC - R/L **Hip**- R/L **Knee**- R/L **Ankle**- R/L
Other: _____

Lumber Testing	**L**	**R**
Straight Leg Raise	+ / -	+ / -
Yeoman's Test	+ / -	+ / -
Braggard's Test	+ / -	+ / -
Patrick's Test	+ / -	+ / -
Kemp's Test	+ / -	+ / -



Diagnosis:

M99.01	M99.02	M99.03	M99.05
M54.2	M54.02	M54.5	M99.06
S13.4XXA	S23.3XXA	S33.5XXA	M99.07
G44.319		M54.30	M26.63
M54.13		M54.17	

Short Term Goals:

___ Decrease pain intensity by 25-50%
___ Improve deficient ranges of motion 25-50%
___ Decrease muscle hypertonocity
___Decrease inflammation
___Other: _____

Long Term Goals:

___Decrease pain an additional 50-75%
___Restoration of normal upright posture to as normal as possible
___Reduction of spinal misalignments
___Improve Range of Motion
___Other: _____

Treatment Plan: ____x/week for ____weeks

The Following Chiropractic Therapies may be utilized, but not necessarily at every visit: Muscle Stim., Heat, Ice, Propreoception, Exercises, Cold Laser and Manual Therapy
**The use of these procedures will be determined at each visit based upon the patient's progress. Daily notes will describe the anatomical area, frequency, duration, etc, for any intervention employed

Provider's Signature_____ **Date:** _____

☐ David D. Berg, D.C.