CAHABA WELLNESS
SPORTS & FAMILY CHIROPRACTIC

Roderick White, D.C.

DATE OF VISIT ___/___/20___ Patient____ Age_________________

Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms ______________________

FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? ________________________________

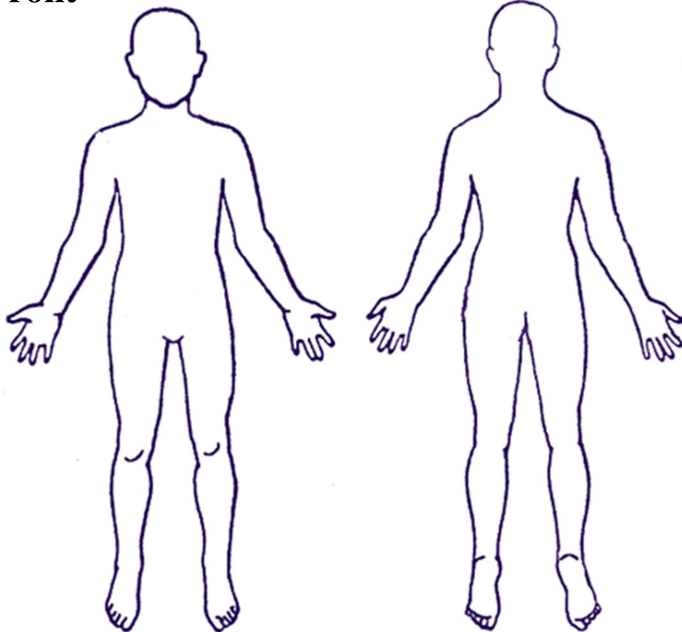
____

PAIN SCALE: Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
NONE		LITTLE			MEDIUM			SEVERE		EXCRUCIATING	

SUBJECTIVE PAIN ASSESSMENT

Front **Back**



RATE YOUR PAIN

- Place an “X” on the drawings to the left wherever you have stabbing or sharp pain.

- Place an “O” on the drawings to the left wherever you have numbness or tingling.

Patient or authorized representative signature: ____ **Date:**

Chiropractic Case History/Patient Information

First Name:____________________ MI: ______ Last Name: ______________________ DOB: _____________

Address:____________________________________City:___________________ State:______ Zip:___________

E-mail Address (we **only** use your e-mail address for appointment reminders and office communications):

____

Cell Phone: __________________________________ Home Phone: ___________________________________

Best number to reach you regarding appointments: ☐ Home ☐ Cell ☐ Work

Age:_______ Race:________ Marital Status: M S W D Social Security #: ______________________________

Occupation:_________________________ Employer:____

Employer's Address:___________________________________ Work Phone:______________________________

Spouse:___________________ Occupation:________________ Employer:________________________________

Names and Ages of Children:____

Name of Nearest Relative:________________________ Address:______________________Phone:___________

How did you find out about our office?____

Family Medical Doctor:____

May we have your permission to update your medical doctor regarding your care at this office?___________

Please check any and all insurance coverage that may be applicable in this case**:**

Major Medical Worker's Compensation Medicaid Medicare Auto Accident
Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company:____

Policy Holder:___________________________________ Relationship to Patient: ________________________

Policy Holder's DOB: ______________________________ SS#: ____

Name of Secondary Insurance Company (if any):____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. The following person(s) have my permission to receive my personal health information:

____

Patient's Signature:____ Date:________________

Guardian's Signature Authorizing Care:______________________________________ Date:________________

Patient Name:___________________________________

Date of Birth: __________________

Oswestry Index

Please mark in each section, the **one** box that most accurately describes your present situation.

Section 1 – Pain Intensity
☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)
☐ I can look after myself without causing extra pain
☐ I can look after myself normally but it is very painful.
☐ 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 my personal care.
☐ I need help every day in most aspects of self-care.
☐ I do not get dressed, 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 gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. 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 lift only very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking
☐ Pain does not prevent me walking any distance.
☐ Pain prevents me walking more than 1mile.
☐ Pain prevents me walking more than ¼ of a mile.
☐ Pain prevents me walking more than 100 yards.
☐ 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 sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting for more than 1 hour.
☐ Pain prevents me from sitting for more than ½ hour.
☐ Pain prevents me from sitting for more than 10 minutes.
☐ Pain prevents me from sitting at all.

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 me extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing for more than ½ an hour.
☐ Pain prevents me from standing for more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 – Sleeping
☐ My sleep is never disturbed by pain.
☐ My sleep is occasionally disturbed by pain.
☐ Because of pain, I have less than 6 hours sleep.
☐ Because of pain, I have less than 4 hours sleep.
☐ Because of pain, I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life
☐ My social life is normal and cause me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling
☐ I can travel anywhere without pain.
☐ I can travel anywhere but it gives extra pain.
☐ Pain is bad but I manage journeys of over two hours.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to receive treatment.

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 present
☐ My pain is neither getting better no worse
☐ My pain is gradually worsening.

Section 11 - Previous Treatment
Over the past three months have you received treatment, tablets or medicines of any kind for your pain? Please check the appropriate box.
☐ No
☐ Yes (if yes, please state the type of treatment you have received)

For Office Use: ________Pts. ________%

Patient Name: ____

Date: ____________________

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:____

Date symptoms appeared or accident happened:____

Is this due to: Auto___ Work____ Other____

Have you ever had the same or a similar condition? Yes No If yes, when and describe:_____________

____

Days lost from work:_________________ Date of last physical examination:_________________________

Do you have a history of stroke or hypertension?____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): ____

____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe:____

What medications or drugs are you taking?____

____

Do you have any allergies to any medications? Yes No

If yes, describe:____

Do you have any allergies of any kind? Yes No

If yes, describe:____

Do you have any Congenital Condition? Yes No If YES, Describe _______________________________

Women: Are you pregnant?___________________

SOCIAL HISTORY

Please circle all that apply.

Vigorous Exercise	Tobacco Use	Financial Pressures
Moderate Exercise	Caffeine	Other Mental Stresses
Alcohol Use	High Stress Activity	Other (Please Specify):
Drug Use	Family Pressures	__________________________

Patient Name: ____

Have you had, or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

Headaches______ Frequency	___________	Loss of Balance	___________
Neck Pain	___________	Fainting	___________
Stiff Neck	___________	Loss of Smell	___________
Sleeping Problems	___________	Loss of Taste	___________
Back Pain	___________	Unusual Bowel Patterns	___________
Nervousness	___________	Feet Cold	___________
Tension	___________	Hands Cold	___________
Irritability	___________	Arthritis	___________
Chest Pains/Tightness	___________	Muscle Spasms	___________
Dizziness	___________	Frequent Colds	___________
Shoulder/Neck/Arm Pain	___________	Fever	___________
Numbness in Fingers	___________	Sinus Problems	___________
Numbness in Toes	___________	Diabetes	___________
High Blood Pressure	___________	Indigestion Problems	___________
Difficulty Urinating	___________	Joint Pain/Swelling	___________
Weakness in Extremities	___________	Menstrual Difficulties	___________
Breathing Problems	___________	Weight Loss/Gain	___________
Fatigue	___________	Depression	___________
Lights Bother Eyes	___________	Loss of Memory	___________
Ears Ring	___________	Buzzing in Ears	___________
Broken Bones/Fractures	___________	Circulation Problems	___________
Rheumatoid Arthritis	___________	Seizures/Epilepsy	___________
Excessive Bleeding	___________	Low Blood Pressure	___________
Osteoarthritis	___________	Osteoporosis	___________
Pacemaker	___________	Heart Disease	___________
Stroke	___________	Cancer	___________
Ruptures	___________	Coughing Blood	___________
Eating Disorder	___________	Alchoholism	___________
Drug Addiction	___________	HIV Positive	___________
Gall Bladder Problems	___________	Ulcers	___________

FAMILY HISTORY

Please review the below-listed diseases and conditions and if applicable, circle any family member who has the condition.

• Arthritis	Father	Mother	Sibling
• Back Trouble	Father	Mother	Sibling
• Cancer	Father	Mother	Sibling
• Diabetes	Father	Mother	Sibling
• Heart Trouble	Father	Mother	Sibling
• High Blood Pressure	Father	Mother	Sibling
• Migraine	Father	Mother	Sibling
• Scoliosis	Father	Mother	Sibling

If any of the above family members are deceased, please list their age at death and cause:

____

I certify the information provided is accurate to the best of my knowledge:

Signature of Patient/Legal Guardian ____

Date ________________________

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.

______________________________ ___________________

Patient Signature Date

For further information regarding this notice, please contact our office at (205) 664-8881

INFORMED CONSENT

Name: ___________________________________

Clinic Name: Cahaba Wellness

Doctor's Name: Roderick White, D.C.

Address: 263 Village Parkway, Helena, AL 35080

Phone: (205) 664-8881

Fax: (205) 664-8980

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

With any treatment there is no guarantee, however, it is our hope that you feel better and function well with treatment in our office. It is our policy that you let us know of any concerns you have regarding your treatment or any other issues you may have. We look forward to serving you and hope you always have a positive experience in our office. Again, please let us know if you have any problems, concerns or questions.

Date: _____________________________

Signature: __________________________

Signature of Parent or Guardian (if patient is a minor) _________________________________

FINANCIAL AGREEMENT

In consideration for services rendered or to be rendered at Dr. Roderick C. White, LLC, dba Cahaba Wellness, I agree and fully understand the following:

1. I authorize the release of any information acquired in the course of my examination and/or treatment necessary for the process of this claim/assignment.
2. I direct payment of medical benefits otherwise payable to me to Cahaba Wellness.
3. I will pay any and all charges known not to be covered by insurance at the time of services rendered.
4. I will deliver to Cahaba Wellness, any checks received from an insurance company relative to services rendered within 3 days of receipt of said checks. I also agree that Dr. Roderick White be given Power of Attorney to endorse/sign my name on any checks from third party payers for payment of services rendered at this clinic.
5. I hereby understand and agree to pay for all services rendered regardless if they are deemed medically unnecessary or a non-covered service by my insurance carrier. I understand that the clinic staff makes no representation as to coverage of my insurance and I do not rely on any insurance information conveyed to me by the clinic staff.
6. If my plan required a referral prior to evaluation, treatment or for ongoing care, I understand it is my responsibility to obtain the referral and/or authorization in these circumstances. Any claims denied due to non-authorization or non-certification will be my responsibility.
7. I understand and agree that Cahaba Wellness may charge a fee for copying records and/or radiographs and for missed appts. Without 24 hours notice.
8. I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsibility for payment. However, I understand that this clinic will prepare any necessary reports and forms to assist me in making any claims with my insurance companies and that any amount authorized to be paid directly to Cahaba Wellness, will be credited to my account on receipt. I understand that if a collection procedure is necessary to satisfy my bill, I am responsible to pay said costs, consisting of court, collection and attorney fees.

Patient Signature:______________________________ Date:______________

Witnessed by: ______________________________ Date:______________