# Welcome to

# HEALTHQUEST

## *Your Family Wellness Office*

**(770) 509-3400**

Thank you for choosing our office for chiropractic care. We are committed to providing your family with the highest quality of corrective and wellness chiropractic care available so that you and your family can enjoy an active, healthy life. We will be working together to help you and your family reach your health and wellness goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during your Chiropractic Report.

We look forward to a long, healthy relationship with you and your family.

# WORKER'S COMP. PATIENT HISTORY

Name______________________________________________ Phone(        )______________________________

Address____________________________________________City_________________State_______Zip__________

Birthdate____________________Age_______Sex____________ S/S#__________________________________

Email_____________________________________________ Occupation______________________________

Employer___________________________________________ Phone(        )______________________________

Address____________________________________________City_________________State______Zip__________

**ATTORNEY**

Name______________________________________________Phone(        )______________________________

Address____________________________________________ City________________State_____Zip___________

**NATURE OF INJURY**

1) Date of Injury:_____________________ Time of Day:_______________

2) Type of work: (   )Office/Clerical (   )Light Labor (   )Moderate Labor (   )Hard Labor

3) In your own words, please describe accident::

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

4) Did you have any physical complaints BEFORE THE ACCIDENT? (   ) Yes (   ) No If yes please describe in detail:

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

5) Please describe how you felt:
   a. DURING the accident:_____________________________________________________________
   b. IMMEDIATELY AFTER the accident:__________________________________________________
   c. LATER THAT DAY:________________________________________________________________
   d. THE NEXT DAY:__________________________________________________________________

6) What are your PRESENT complaints and symptoms? ___________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

7) Do you have any congenital (from birth) factors which relate to this problem? (   )Yes (   )No If yes, please describe:_________

_______________________________________________________________________________________

8) Do you have any previous illnesses which relate to this case? (   )Yes (   )No If yes, please describe:_______________

_______________________________________________________________________________________

9) Have you ever been involved in an accident before? (   )Yes (   )No If yes please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: ________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

10) Where were you taken after the accident?______________________________________________________________

11) Have you been treated by another doctor since the accident? ( )Yes ( )No If yes, please list he doctor's name and address:_______________________________________________________________________________

12) Since the injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

13) CHECK SYMPTONS YOU HAVE NOTICED SINCE THE ACCIDENT:

| | | | |
|---|---|---|---|
| ☐ Headache | ☐ Dizziness | ☐ Lights Bother Eyes | ☐ Diarrhea |
| ☐ Neck Pain | ☐ Head Seems Too Heavy | ☐ Loss of Memory | ☐ Feet Cold |
| ☐ Neck Stiff | ☐ Pins & Needles in Arms | ☐ Ears Ring | ☐ Hands Cold |
| ☐ Sleeping Problems | ☐ Pins & Needles in Legs | ☐ Face Flushed | ☐ Stomach Upset |
| ☐ Back Pain | ☐ Numbness in Fingers | ☐ Buzzing in Ears | ☐ Constipation |
| ☐ Nervousness | ☐ Numbness In Toes | ☐ Loss of Balance | ☐ Cold Sweats |
| ☐ Tension | ☐ Shortness of Breath | ☐ Fainting | ☐ Fever |
| ☐ Irritability | ☐ Fatigue | ☐ Loss of Smell | |
| ☐ Chest Pain | ☐ Depression | ☐ Loss of Taste | |

Symptoms Other than Above:____________________________________________________________

_______________________________________________________________________________

14) Have you lost time from work as a result of this accident? ( )Yes ( )No If yes, please complete this question:

a) Last Day Worked:___________________________________________________________

b) Type of Employment:________________________________________________________

c) Present Salary:_____________________________________________________________

d) Are you being compensated for time lost from work? ( )Yes ( )No If yes, please state type of compensation you are receiving:_________________________________________________________________

15) Do you notice any activity restrictions as a result of this injury? ( )Yes ( )No

If yes, please describe in detail: ________________________________________________

_______________________________________________________________________________

16) Other Pertinent Information:____________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________ _______________________

Patient Signature Date

# HealthQuest Chiropractic Center

## PRACTICE MEMBER'S AUTHORIZATION

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several practice members (patients) being seen in the same room/area at the same time. Practice members are within sight of one another and some ongoing details of care are discussed within earshot of other practice members, staff, and anyone else who may be present in the office. This environment is used for ongoing care and is not the environment used for taking patient histories, performing consultations or examinations or special appointments or presenting reports of findings. These procedures are completed in a private, confidential room. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, and in the event that you or someone else would not agree with us we are providing this disclosure.

Furthermore you give authorization to HealthQuest for each of the following:

-permission to post your name on the office's 'welcome board' and 'thanks for referral board' and 'success board' where it may be plainly seen;

-use of 'patient files' and placing of files onto desk and computer area and wall slots where it may be seen or be in "incidental" contact with other people or their files;

-use of 'sign-in sheet' where you are to sign-in each visit and your name could be seen by others;

-keeping your credit card number on file and authorization to charge your card according to the terms agreed upon and applicable under the financial systems and policies in operation at HealthQuest;

-awareness of all employees of HealthQuest including staff, interns assistants, bookkeepers, accountants, coaches, consultants, cleaning crews, or other temporary hired help, being present at various times and having legal or illegal access to office property, including records. (all required and appropriate protective measures are being taken by HealthQuest);

-communicate to you via phone, mail or email regarding your care, in-office promotions or solicitations and business or personal matters.

It is our desire for any of our staff to use your office records, your name, address, email address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues, health related meetings, workshops, and products.

Use of this is intended to make your experience with our office more efficient and productive. If you chose not to authorize this information your decision will have no adverse effect on your care from HealthQuest Chiropractic or on your relationship with our staff.

**Your signature indicates your authorization of all of the activity outlined herein.**

This authorization may be revoked at any time. Revocation may be accomplished at any time by advising us (Dr. Christopher A. Rechter, privacy and security officer) in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed, and be aware that revocation is not possible in situations where actions have already been taken relying on this authorization.

A copy of this authorization has been provided to you and a signed copy will be kept on file and serve as your receipt and acknowledgement of your authorization.

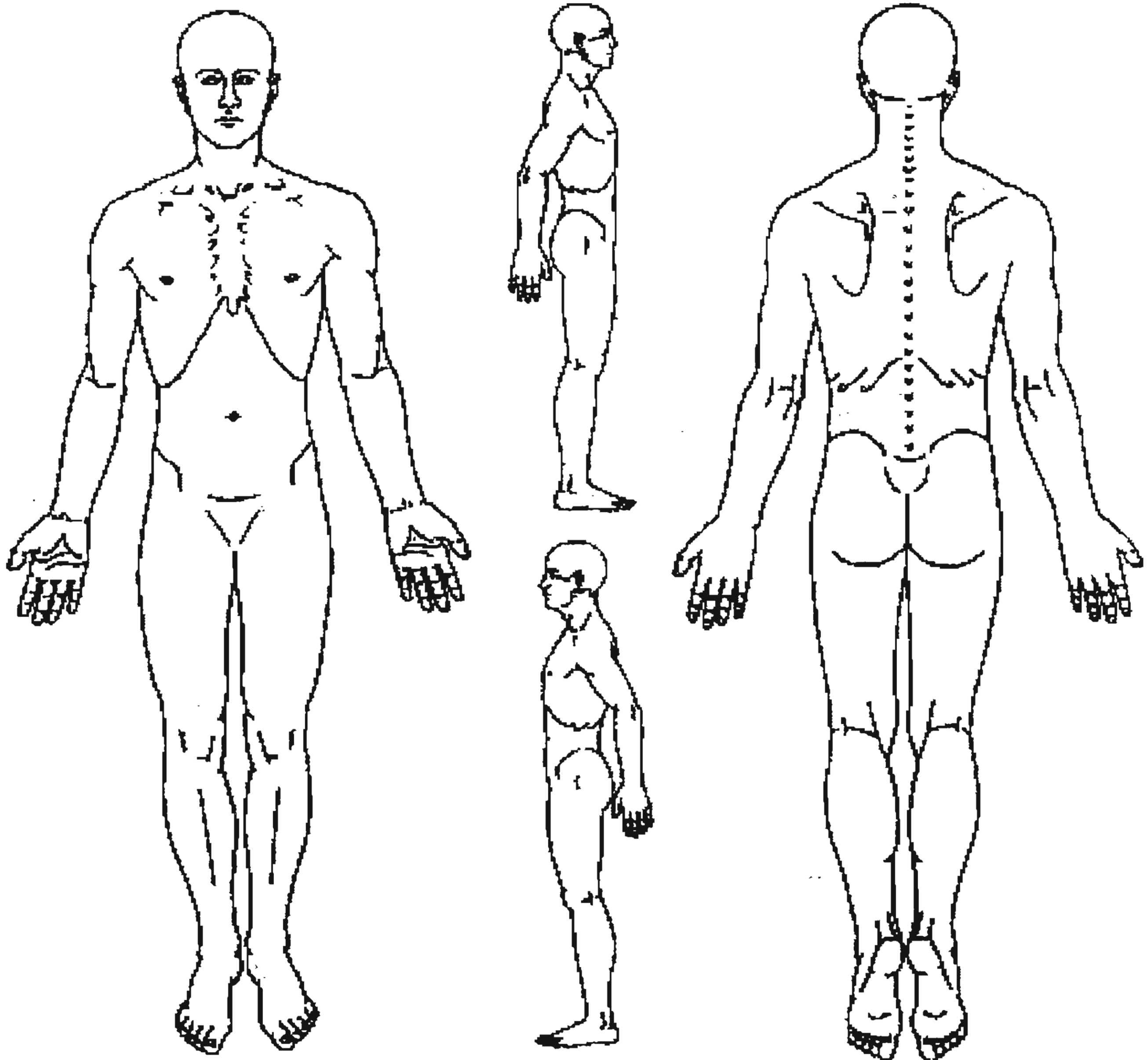
| | | |
|---|---|---|
| ____________________ Practice Member (signed) | __________ Date | ____________________ HealthQuest Representative (signed) |
| ____________________ Practice Member (printed) | | ____________________ HealthQuest Representative (printed) |

# THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME ______________________________________ DATE ______________

How long have you had back pain _______ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.



**A** = ACHE **B** = BURNING **N** = NUMBNESS
**P** = PINS & NEEDLES **S** = STABBING **O** = OTHER

HEALTHQUEST CHIROPRACTIC CENTER

# Office Fee Schedule and Financial Policy

**Today's charges will include consult, exam, x-rays, and your first adjustment, as well as your Report of Findings on the following visit. This fee does not include care on your return visit. Any further care must be agreed upon in writing by both parties.**

| Service | Service Fees | Self-Pay |
|---|---|---|
| Consultation | N/C | N/C |
| Extended Consultation | $80 | $50 |
| Initial Exam/Computer Scans | $150 | $80 |
| Progress Exam/Computer Scans | $80 | $50 |
| X-Rays (per view) | $50 | $30 |
| Adjustment | $65 | $45 |
| Electric Stimulation | $50 | $20 |
| Massage Therapy | $180 | $70 |

## Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best service possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your care at the time service or in advance. You may arrange an Active Life Plan as well. Active Life Plans (ALP) include individual and family, yearly or monthly options. These Active Life Plans are designed to be the most cost-effective plans. We will discuss the details of these plans with you to help you determine your best options. Please choose one of the two below to be used.

- ☐ **Health Insurance:** If you have insurance that you would like to use for your care we will be happy to verify it and inform you of your coverage in this office. If utilizing insurance we will be happy to file your claims for you. Remember, your agreement with your insurance company is between you and them. You will ultimately be responsible for all co-payments and deductibles, or denials for all services rendered to you.

- ☐ **Self-Pay: (Not available if utilizing insurance.)** This is an option if you have no insurance or your policy or deductible precludes you from using insurance, or if you wish to not use any insurance. As a self-pay patient, you will receive fees as indicated by the fee schedule above. As a self-pay member, you can pay for your care at the time of each visit, or for greater convenience, monthly and yearly payment options are available as well as packages of adjustments.

  There is no qualifying diagnosis provided along with any requested receipts so you are unable to submit these claims to your insurance company for reimbursement. You can, however, be given a receipt for tax purposes or a medical savings account (MSA) or health savings account (HSA) indicating the total amount you have paid for chiropractic care during the year.

  If you acquire insurance for a special situation such as an auto accident or a workers compensation injury and choose to utilize that coverage, you will be charged our regular office fees until such claim is settled. We will assist in quick reimbursement on these claims. Once the claim is complete, you can return to self-pay fees again.

I have marked the one that applies to me. I have read and I understand the above policies.

______________________________________________ ____________________

Patient Date

**About Your Health**

**The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.**

## PATIENT HISTORY

Name ______________________________________________ Email ___________________________________________

Date of Birth __________________Age___________________ Social Security Number ______ - ______ - ____________

Address ____________________________________________________________________________________________

City ____________________________________________ State __________________ Zip _____________________________

Phone (H) ____________________________ (W) ______________________________ (Cell) ___________________________

Spouse's Name _____________________________________ Children _______________________________________________

Your Occupation __________________________________ Employer ________________________________________________

Insurance Company _____________________________________________ Policy Number ______________________________

Have you ever received chiropractic care? Y N Who & When?_____________________________________________

Who referred you to this office? ________________________________________________________________________

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## WHAT BRINGS YOU TO OUR OFFICE?

**FIRST COMPLAINT:** ______________________________________________________________________________

Date when symptom first appeared ________________________________________________________________________

Did it begin _____ Gradual _____ Sudden _____ Progressive over time

How did it occur (if applicable) ________________________________________________________________________

What makes the symptoms worse? ________________________________________________________________________

What relieves the symptoms? ____________________________________________________________________________

Type of pain ____ Sharp ____Dull ____Ache ____Burn ____Throb ____Constant ____Intermittent

Does the pain radiate into your ____Arm ____Leg ____Does not radiate

Do you experience numbness or tingling? ____Y ____N

How often do you experience these symptoms? (___100% ___75% ___50% ___25% ___10%)

Severity of pain/complaint (circle 1-10) No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain

List previous treatments for this condition. Physician/other: ________________________________________________

---

**OTHER COMPLAINT:** ______________________________________________________________________________

Date when symptom first appeared ________________________________________________________________________

Did it begin _____ Gradual _____ Sudden _____ Progressive over time

How did it occur (if applicable) ________________________________________________________________________

What make the symptoms worse? _________________________________________________________________________

What relieves the symptoms? ____________________________________________________________________________

Type of pain ____ Sharp ____Dull ____Ache ____Burn ____Throb ____Constant ____Intermittent

Does the pain radiate into your ____Arm ____Leg ____Does not radiate

Do you experience numbness or tingling? ____Y ____N

How often do you experience these symptoms? (___100% ___75% ___50% ___25% ___10%)

Severity of pain/complaint (circle 1-10) No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain

List previous treatments for this condition. Physician/other: ________________________________________________

---

**OTHER COMPLAINT:** ______________________________________________________________________________

Date when symptom first appeared ________________________________________________________________________

Did it begin _____ Gradual _____ Sudden _____ Progressive over time

How did it occur (if applicable) ________________________________________________________________________

What make the symptoms worse? _________________________________________________________________________

What relieves the symptoms? ____________________________________________________________________________

Type of pain ____ Sharp ____Dull ____Ache ____Burn ____Throb ____Constant ____Intermittent

Does the pain radiate into your ____Arm ____Leg ____Does not radiate

Do you experience numbness or tingling? ____Y ____N

How often do you experience these symptoms? (___100% ___75% ___50% ___25% ___10%)

Severity of pain/complaint (circle 1-10) No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain

List previous treatments for this condition. Physician/other:

_______________________________________________________

PATIENT SIGNATURE______________________________________________DATE ____________________

**Additional Symptoms:**

| | | |
|---|---|---|
| ❑Headaches | ❑Pins & Needles in Legs | ❑Fainting |
| ❑Neck Pain | ❑Pins & Needles in Arms | ❑Loss of Smell |
| ❑Neck Stiff | ❑Numbness in Fingers | ❑Loss of Taste |
| ❑Back pain | ❑Numbness in Toes | ❑Hands Cold |
| ❑Nervousness | ❑Shortness of Breath | ❑Feet Cold |
| ❑Tension | ❑Chest Pains | ❑Diarrhea |
| ❑Irritability | ❑Dizziness | ❑Stomach Upset |
| ❑Fatigue | ❑Lights Bother Eyes | ❑Constipation |
| ❑Depression | ❑Loss of Memory | ❑Cold Sweats |
| ❑Face Flushed | ❑Ears Ring/Buzzing | ❑Loss of Balance |
| ❑Sleeping Problems | ❑Fever | ❑Allergies |

**Please list all past surgeries:**

Type ______________________________________ When _________________________________ Doctor ___________________

Type ______________________________________ When _________________________________ Doctor ___________________

Type ______________________________________ When _________________________________ Doctor ___________________

Type______________________________________ When _________________________________ Doctor ___________________

**Please list all previous accidents/falls/injuries/hospitalizations:**

What ______________________________________ When _________________________________ Injuries _________________

What ______________________________________ When _________________________________ Injuries _________________

What ______________________________________ When _________________________________ Injuries _________________

What ______________________________________ When _________________________________ Injuries _________________

What ______________________________________ When _________________________________ Injuries__________________

**Please list any medications you are currently taking (include for how long and any side effects).**

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Regarding your **Birth Process**, please list any complications or special circumstances
(breech, forceps, vacuum extraction, difficulties, drugs, home birth, etc.).

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

**Current Health Behaviors:**

Do you smoke/use tobacco? Y / N

Alcohol/drug use? Y / N Please explain ___________________________________________________________________

Do you exercise? Y / N What/How often?___________________________________________________________________

Do you have a healthy/nutritious diet? Y / N Please explain _____________________________________________________

_______________________________________________________________________________________________

What supplements do you take? ________________________________________________________________________

_______________________________________________________________________________________________

**Please do not write below this line**

**DOCTORS NOTES:**

# NECK PAIN AND DISABILITY INDEX

Patient Name:_______________________________ Date:_____/_____/_____

**Please read instructions carefully.**

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and then mark the box that most closely describes your problem.

## 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 worse than imaginable at the moment.

## SECTION 2 - PERSONAL CARE (washing, dressing, etc.)

- ☐ 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 objects without any extra pain.
- ☐ I can lift heavy objects, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ☐ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ☐ I can lift very light objects.
- ☐ I cannot lift or carry anything at all.

## SECTION 4 - READING

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with light pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I can't read as much as I want to because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

## SECTION 5 - HEADACHES

- ☐ I have no headache at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

## SECTION 6 - CONCENTRATION

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

## SECTION 7 - WORK

- ☐ I can do as much work as I want.
- ☐ I can do only my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly work at all.
- ☐ I can't do any work at all.

## SECTION 8 - DRIVING

- ☐ I can drive without any neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive at all.

## SECTION 9 - SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

## SECTION 10 - RECREATION

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

## NECK PAIN SCALE

Rate the severity of your **Neck Pain** by indicating on the following scale.

**Absence** I------------------------------------------------------------I **Extreme**

# INFORMED CONSENT TO CHIROPRACTIC TREATMENT

**The Nature of Chiropractic Treatment**: The doctor will use his hands or a mechanical device in order to move your joints. You may or may not feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may or may not feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, or trigger point myotherapy may also be used.

**Possible Risks**: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of risks occurring**: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The probability of adverse reaction due to ancillary procedures is also considered "rare".

**Other Treatment Options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of Remaining Untreated**: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**Unusual Risks**: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

______________________________/_______________________________/_______________________

**Printed Name** **Signature** **Date**

**WITNESS**:

______________________________/_______________________________/_______________________

**Printed Name** **Signature** **Date**

## LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: ______________________________ Date: _____/_____/_____

**Please read instructions carefully.**
This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely describes your problem.

### SECTION 1 - PAIN INTENSITY

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is very severe.
- ❑ The pain is severe and does not vary much.

### SECTION 2 - PERSONAL CARE

- ❑ I do not have to change my way of washing or dressing to avoid pain.
- ❑ I do not normally change my way of washing or dressing even though it causes some pain.
- ❑ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ❑ Because of the pain, I am unable to do some washing and dressing without help.
- ❑ Because of the pain, I am unable to do any washing or dressing without help.

### SECTION 3 - LIFTING

- ❑ I can lift heavy objects without any extra pain.
- ❑ I can lift heavy objects, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy objects off the floor.
- ❑ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ❑ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ❑ I can only lift very light objects at the most.

### SECTION 4 - WALKING

- ❑ I have no pain on walking.
- ❑ I have some pain but it does not increase with distance.
- ❑ I cannot walk more than one mile without increasing pain.
- ❑ I cannot walk more than 1/2 mile without increasing pain.
- ❑ I cannot walk more than 1/4 mile without increasing pain.
- ❑ I cannot walk at all without increasing pain.

### 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 half an hour.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ I avoid sitting because it increases pain.

### SECTION 6 - STANDING

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than 1/2 hour without increasing pain.
- ❑ I cannot stand longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain.

### SECTION 7 - SLEEPING

- ❑ I get no pain in bed.
- ❑ I get pain in bed but it does not prevent me from sleeping well.
- ❑ Pain reduces my normal sleep by 1/4 each night.
- ❑ Pain reduces my normal sleep by 1/2 each night.
- ❑ Pain reduces my normal sleep by 3/4 each night.
- ❑ 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 pain.
- ❑ My social life is unaffected by pain apart form limiting more energetic interests.
- ❑ 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 hardly any social life because of the pain.

### SECTION 9 - DRIVING / RIDING IN CAR, ETC.

- ❑ 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 alternate forms of travel.
- ❑ I get extra pain while traveling which compels me to seek alternate 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 present.
- ❑ My pain is neither getting better or worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

### LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

**Absence I---------------------------------------------------------------I Extreme**

# HEALTHQUEST CHIROPRACTIC CENTER

## PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

In the course of your care as a patient at HeatlhQuest Chiropractic Center, all/any of its staff may use or disclose personal and health related information about you in the following ways:

-Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

-Your personal health information, including your clinical records, may be disclosed to all of the doctors and interns at HealthQuest.

-Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

-Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, missed appointments, information about alternatives to your present care, any letters from the office, or other health related information that may be of interest to you.

You are by law, hereby granted certain rights as follows:

-the right to amend your protected health information by notifying us, and we are to comply with this within 60 days

-the right to access, inspect, and copy your protected health information (inquire about exceptions)

-the right to request restrictions on certain uses and disclosures for treatment, payment, or health care operations, to which we are not required to agree.

-the right to confidential communication by alternative means or location (bearing in mind our "open adjusting" atmosphere for which you consent authorization)

If you are not at home to receive an appointment reminder or other message, the message may be left on your answering machine or with someone else. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

-If we are providing health care services to you based on the orders of another health care provider.

-If we provide health care services to you in an emergency.

-If we are required by law to provide care to you and we are unable to obtain consent after attempting to do so.

-If there is substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

-If we are ordered by the courts.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail or email information to you regarding your health care or about the status of your account or about the office in general or regarding an office newsletter. If you would like to receive this information at an address other than your home or if you would like the information in a different form please advise us in writing as to your preferences.

This notice shall serve as valid from the time you first begin care and continue on for anytime thereafter. You may revoke authorization at any time by submitting request in writing to Dr. Christopher A. Rechter at 1205 Johnson Ferry Road, Suite 122, Marietta, GA 30068. Revocation is not possible in situations where actions have been taken relying on this authorization.

For more information or to file a complaint, contact our security and privacy officer, Dr. Christopher A. Rechter, to whom you have the right to discuss your privacy and security questions or concerns, at 770-509-3400.

You also have the right to lodge a complaint with the Department of Health and Human Services through the Office of the Patient Advocate.

A copy of this notice is/has been promptly provided to you and this signed notice will be kept as part of your file and will serve for us as an "acknowledgment of (your) receipt of a privacy notice".

| ______________________ | __________ | ______________________ |
| --- | --- | --- |
| Practice Member | Date | HealthQuest Representative |

## QUADRUPLE VISUAL ANALOGUE SCALE

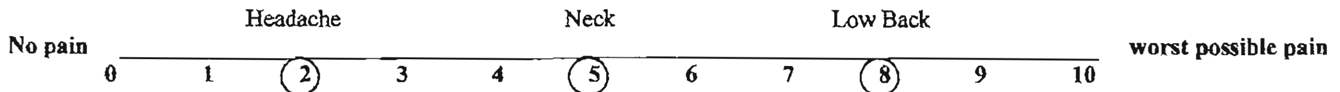
Patient Name ______________________________ Date ________________

**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:**

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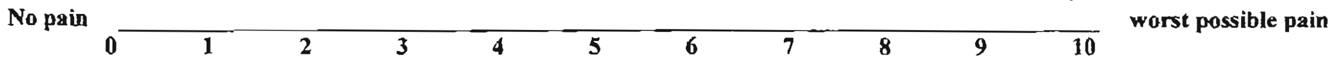
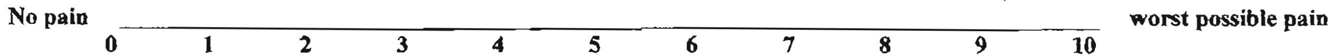
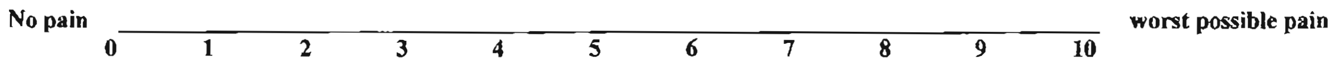
**1 – What is your pain RIGHT NOW?**



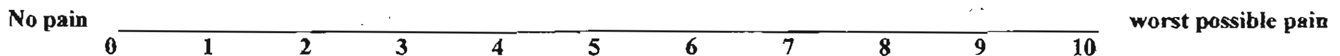

**2 – What is your TYPICAL or AVERAGE pain?**




**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

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# TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

**Adjustment**: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation**: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ________________________________ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____________________________________ ______________________
(Signature) (Date)