Mr. \ Mrs. \ Ms. \ Miss

First Name: _____ M.I.:____ Last Name: _____

What Do You Prefer To Be Called: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SS #: _____ Sex:_____ Single \ Married \ Divorced \ Widow

Spouse Name: _____ Email: _____

Home #: _____ Cell #: _____ Other #: _____

Emergency Contact: _____ Relationship: _____ T: _____

How did you hear about us? _____

Who can we thank for the referral? _____

Who is your Primary Care Doctor? _____

Do you have Medicare? ☐ Yes ☐ No

Primary Insurance: _____

Secondary Insurance: _____

POLICY

Legacy Clinic utilizes an outside billing service. **You will be responsible for the cost of the initial exam($119 for exam without X-rays - $175 for Exam with X-rays).** You may be asked to pay for additional services in advance but any reimbursement received will be credited to your account or refunded to you. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Legacy Clinic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions. I acknowledge that we have provided you this information and accept responsibility for payments due to Legacy Clinic.

_____ _____ _____

Signature Date Parent (If patient is a minor)

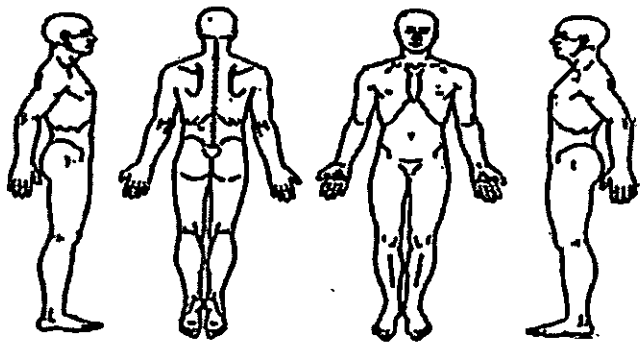
Describe your PRIMARY symptoms: _____

List other symptoms: _____

Have you had any x-rays\MRIs\CTs taken that are related to your symptoms? ☐ Yes ☐ No

Where: _____

Indicate on the drawings below where you have pain/symptoms:



How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the type of pain?

☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse ☐ Achy
☐ Burning ☐ Shooting ☐ Stiff ☐ Sharp w/ Motion ☐ Shooting w/ Motion
☐ Stabbing w/ Motion ☐ Electric like ☐ Other: _____

How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

Using a scale from 0 – 10 (10 being the worst), how would you rate your symptom?

0 1 2 3 4 5 6 7 8 9 10 (Please Circle)

Who else have you seen for these symptoms?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Orthopedist ☐ Physical Therapist
☐ Other: _____

How long have you had these symptoms? _____

How\When do you think your symptoms began? _____

Do you consider your symptoms to be severe? ☐ Yes ☐ Yes, at times ☐ No

What aggravates your symptoms? _____

What alleviates your symptoms? _____

What concerns you the most about your symptoms\ what do they prevent you from doing?

_____

What is your: **Height:** _____ **Weight:** _____ **Blood Pressure:** _____

How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

SOCIAL HISTORY

1. **Smoking: → How often?** ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. **Alcoholic Beverage: consumption occurs →** ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. **Recreational Drug use:** ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. **Extracurricular Activities:**_____

5. **Impact of Current Condition on Work Capacity:** ☐ No Effect ☐ Painful ☐ Limits ☐ Unable to work

What extracurricular activities do you participate in? _____

Indicate if you have any immediate family members with any of the following:

☐Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Cancer ☐ ALS ☐ Heart Problems

List all prescription medications you are currently taking: _____

_____

List all of the Supplements/Vitamins you are currently taking: _____

_____

List all surgical procedures you have had: _____

_____

Have you ever been hospitalized? ☐ No ☐ Yes
If yes, why_____

Have you ever significant past trauma? ☐ No ☐ Yes

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
☐	☐ Headaches	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Upper Back Pain	☐	☐ Chest Pains	☐	☐ Frequent Urination
☐	☐ Mid Back Pain	☐	☐ Stroke	☐	☐ Smoking/Tobacco Use
☐	☐ Low Back Pain	☐	☐ Angina	☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain	☐	☐ Kidney Stones	☐	☐ Allergies
☐	☐ Elbow/Upper Arm Pain	☐	☐ Kidney Disorders	☐	☐ Depression
☐	☐ Wrist Pain	☐	☐ Bladder Infection	☐	☐ Systemic Lupus
☐	☐ Hand Pain	☐	☐ Painful Urination	☐	☐ Epilepsy
☐	☐ Hip Pain	☐	☐ Loss of Bladder Control	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Upper Leg Pain	☐	☐ Prostate Problems	☐	☐ HIV/AIDS
☐	☐ Knee Pain	☐	☐ Abnormal Weight Gain/Loss		
☐	☐ Ankle/Foot Pain				
		☐	☐ Loss of Appetite	**For Females Only**	
☐	☐ Jaw Pain	☐	☐ Abdominal Pain	☐	☐ Birth Control Pills
☐	☐ Joint Pain/Stiffness	☐	☐ Ulcer	☐	☐ Hormonal Replacement
☐	☐ Arthritis	☐	☐ Hepatitis	☐	☐ Pregnancy
☐	☐ Rheumatoid Arthritis	☐	☐ Liver/Gall Bladder Disorder		
☐	☐ Cancer	☐	☐ General Fatigue		
☐	☐ Tumor	☐	☐ Muscular Incoordination		
☐	☐ Asthma	☐	☐ Visual Disturbances		
☐	☐ Chronic Sinusitis	☐	☐ Dizziness		
☐	☐ Other:_____				

I affirm that the information I have given is correct to the best of my knowledge. The information I have provided will remain confidential, and I understand that it is my responsibility to inform this office of any changes in my medical status

PRINT PATIENT NAME _____ SIGNATURE _____ DATE _____

INFORMED CONSENT

I understand and am informed that, as in all health care, in the practice of chiropractic there is a small inherent risk of injury which includes but is not limited to, muscle strains, sprains, fractures, dislocation, intervertebral disc injury, and cardiovascular accident. I understand that Dr. John C. Theeck will not be able to anticipate all potential complications, but will rely on clinical expertise and judgment to determine the correct course of treatment, which will be in my best interests considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and herby consent to voluntarily participate in orthopedic, neurologic and physical performance testing, as well as manipulative, and exercise/rehabilitation therapies as deemed appropriate by Dr.'s of Legacy Clinic. If at any time, I have further questions or decide not to continue to consent in treatment, I understand I have that right and it is my duty to notify my doctor.

PRINT PATIENT NAME _____ SIGNATURE _____ DATE _____

If patient is a minor:

PRINT PARENT/GUARDIAN NAME _____ SIGNATURE _____ DATE _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print) _____ Date _____

Parent, Guardian or Patient's legal representative _____

Signature _____

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

Name _____ Relationship _____

Name _____ Relationship _____

Patient Name: _____ **DOB:** _____

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it,** personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully.**

Ask us to explain, if you don't understand why Medicare won't pay.

Ask us how much these items or services will cost you:
(Estimated Cost: $119.00 – $175.00 for Initial Exam & X-rays).

Medicare ONLY covers Spinal Manipulation/Adjustment for Chiropractic Care.

Medicare will not pay for:

_____

X Because the following are excluded* from Medicare benefits:

Chiropractic examinations.
X-ray procedures preformed/order by a chiropractic physician.
Extremity manipulation.
Acupuncture.
Physiotherapy such as, but not limited to, ultrasound, electric muscle stimulation, interferential, intersegmental traction and diathermy.
Rehabilitation services.
Massage.
Trigger point therapy.
Biofreeze or other muscle analgesic balms.
Orthopedic foot supports (orthotics).
Orthopedic back supports.
Orthopedic pillows.
Nutritional supplements.
Maintenance Adjustments.

*** This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

_____ _____

DATE **Signature**

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**

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**