Fifer Family Chiropractic LLC

Dr. John M. Fifer
Doctor of Chiropractic

Name _____ **Date** _____

Home Address _____ **City** _____

State _____ **Zip** _____

Cell Phone _____ **Phone Provider** _____ **Home Phone** _____

Marital Status M S W D **SSN:** _____ **Height/Weight:** _____

Date of Birth _____ **Age** _____ **Email** _____

Employer _____

Referral Name _____ **Relation** _____

1. What are your present symptoms? _____

2. When did your symptoms begin? _____

3. How did your symptoms begin? (i.e. lifting, etc.) _____

4. Please describe the character of your current pain. You may check one or more answers.

( ) Aches ( )Burning ( )Deep ( ) Pulling ( ) Sharp ( ) Shooting ( )Stabbing ( ) Stiffness

( ) Throbbing ( ) Tightness ( ) Tingling ( ) Other: _____

5. On a scale from 0-10, with 10 being the worst pain you have experienced and 0 being no pain what would you rate your pain at it's worse? _____

6. How often are the complaints present?

( ) Constant 100% of the time ( ) Frequently 75% ( ) Intermittent 50% ( ) Occasional 25%

7. Is your pain: ( ) Increasing ( ) Decreasing ( ) Not Changing

8. Pain is aggravated by : ( ) Walking ( ) Sitting ( ) Riding in a car ( ) Standing

( ) Lifting ( ) Bending ( )Stretchir ( ) Twisting ( ) Other _____

9. Pain is improved by : ( ) Medication ( ) Rest ( ) Exercise ( ) Therapy

( ) Chiropractic Adjustment ( ) Other _____

10. Have you had any tests for this complaint? (i.e. x-rays, MRI, CT) _____

If so where? _____

11. Is it affecting your ability to work or be active? _____

12. Are you currently taking any medication for this complaint? ( ) Yes ( ) No

If yes, please list _____

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13. Are you taking any other medication? ( ) Yes ( )No

If yes, please list _____

14. Prior treatment for present symptoms? ( ) Yes ( ) No _____

15. Any recent falls / accidents / surgeries / broken bone? ( ) Yes ( ) No

If yes, please list _____

16. Any change in bowel or bladder (bathroom) function? ( ) Yes ( ) No

17. Any fever or chills? ( ) Yes ( ) No

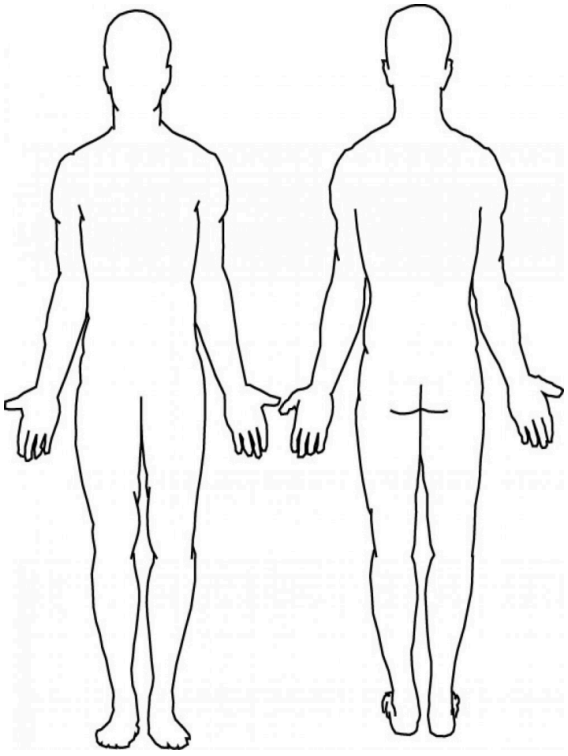
18. Have you seen any other physicians in the past 6 months? If yes, please list doctor's name and reason for visit. ( ) Yes ( ) No _____

19. Name of family doctor / primary care physician _____

20. Any surgeries? If so, when and what for? _____

PLEASE MARK YOUR AREA OF PAIN

P-Pain
N-NUMBNESS
T-TINGLING
B- BURNING
C-CRAMPING



Patient Signature: _____ **Date:** _____

7055 Pearl Road Suite 150/Middleburg Hts , OH 44130/440-885-0845/FAX 440-885-0944

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(All information is strictly confidential)

Medical History Check symptoms you currently have or have had in the past year.

Please list any medical conidtions you may be diagnosed with:

_____

General
( ) Chills
( ) Depression
( ) Dizziness
( ) Fever
( ) Forgetfulness
( ) Headache
( ) Loss of sleep
( ) Loss of weight
( ) Numbness
( ) Sweats

CARDIOVASCULAR
( ) Chest pain
( ) High/Low blood pressure
( ) Irregular/ Rapid heart beat
( ) Poor circulation
( ) Swelling of ankles
( ) Varicose veins

SKIN
( ) Bruise easily
( ) Hives
( ) Itching/Rash
( ) Change in moles
( ) Scars
( ) Sore that won't heal

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
( ) Arms ( ) Hips
( ) Back ( ) Legs
( ) Feet ( ) Neck
( ) Hands ( ) Shoulders

MEN ONLY
( ) Erection difficulti
( ) Lump i
( ) Penis discharge
( ) Sore on penis
( ) Other

WOMEN ONLY
( ) Abnormal Pap Smear
( ) Bleeding between periods
( ) Breast lump
( ) Extreme menstrual pain
( ) Hot flashes
( ) Nipple discharge
( ) Painful intercourse
( ) Vaginal discharge
( ) Other
Date of last period? _____
Are you pregnant? _____
No. of children ? _____

GENITO-URINARY
( ) Blood in urine
( ) Frequent Urination
( ) Lack of Bladder Control
( ) Painful urination

GASTROINTESTINAL
( ) Appetite poor
( ) Bloating
( ) Bowel changes
( ) Constipation
( ) Diarrhea
( ) Excessive thirst
( ) Gas
( ) Hemorrhoids
( ) Indigestion
( ) Nausea
( ) Rectal Bleeding
( ) Stomach pain
( ) Vomiting
( ) Vomiting blood

EYE, EAR, NOSE, THROAT
( ) Bleeding gums
( ) Blurred vision
( ) Crossed eyes
( ) Difficulty swallowing
( ) Double vision
( ) Earache/Ear discharge
( ) Hay fever
( ) Hoarseness
( ) Loss of hearing
( ) Nosebleeds
( ) Persistent cough
( ) Ringing in ears
( ) Sinus problems
( ) Vision-Flashes/Halos

Patient Signature: _____ **Date:** _____

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X-RAY CONSENT FORM

X-Ray Fees:

Includes one complete set of x-rays, radiology fee and exam	$100
Includes TWO complete set of x-rays, radiology fee and exam	$120

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. In addition, they may be required in order to administer treatment.

By signing below, I consent to having the diagnostic x-rays performed, which the doctor determines is clinically necessary and agree to the above fees.

Patient Signature _____ Date _____

FOR WOMEN ONLY

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiating, it is possible to injure the fetus.

I am aware that the ten days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am pregnant.	Yes	No
I could be pregnant.	Yes	No
My last menstrual period began on:	_____	

With full understand of the above, and believing that I am currently not at risk, I wish to have an x-ray examination performed today if requested by the doctor.

Patient Signature _____ Date _____

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Assignment of Payment

I (print name) _____ , have sought chiropractic treatment from Dr. John M. Fifer, D.C.

I understand that all fees for services rendered to me will be submitted either through my health insurance, Worker's compensation claim, or personal injury claim.

I fully understand that I am responsible for any out of pocket expenses such as deductibles, co-payments, co-insurances, and or non-payment of benefits due to coverage being exhausted or terminated. In the case of worker's compensation claims or personal injury claims, I understand I am fully responsible for any and all non-payment of submitted charges for services rendered.

Statements are mailed out the first week of each month. I understand that payment is due within 14 days of receiving the monthly statement. Balance overdue by 90 days will be subject to an interest charge of 5%.

Balances that are overdue will be referred to a collection agency. I understand that any fees or costs related to the collection process are my responsibility to pay.

In the case that the collection process should have to go to court, I understand that any and all costs and fees for court and attorneys are solely my responsibility.

Patient signature: _____ Date: _____

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by doctor or staff:

Name and address of clinic/office:
Fifer Family Chiropractic, LLC

Print name (s) doctor (s) tre
Dr. John M. Fifer D.C.

HIPAA Notice of Privacy Practices

Fifer Family Chiropractic
7055 Pearl Road Suite 150
Middleburg Hts, OH 44130

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

If you have any questions about the above notice, please contact our Office at
440-885-0845

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes,
we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's
privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health
related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or

local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature Date

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly 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 the worst 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 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 placed eg. 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 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 from walking more than 1 mile
- ☐ Pain prevents me from walking more than 1/2 mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting 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 for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ 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 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9 – Social life

- ☐ My social life is normal and gives 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 eg, sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10 – Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

.

References

1. Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.