FOR OFFICE USE ONLY:
Patient Number: _____
Doctor: _____
Insurance: _____
Emp. Initials: _____

CHIRO REACTIVATION:
PATIENT INFORMATION:

****Please give your Driver's License and insurance card to the front desk to copy for your records.****
Patient Name: Last _____ First _____ Date _____ / _____ / _____
Address: _____ City _____ State _____ Zip _____
Cell Phone: (_____) _____ - _____ Home Phone (_____) ____ - _____ Birth date ____ / ____ / ____ Age ____
Sex: ____M ____F Driver's License: _____ Patient Soc. Sec. # _____ - _____ - _____
Marital Status: S M D W Spouse's Name: _____ Referred by: _____
Person responsible for payment: _____ Patient Employed by: _____
Occupation: _____ Work Phone: (____) ____ - _____
Email: _____
Preferred method of contact for appointment reminders (circle one): Phone (home or cell) / text / email
Have you ever been to a Chiropractor before?: YES NO
Have you filed a legal claim at this time (circle if yes): Auto accident / Personal injury / Workman's Compensation

CHIEF COMPLAINT: **Answer the questions as completely as possible. If a question does not apply, leave it blank.**

Reason for today's appointment: ☐ Neck pain ☐ Upper back pain ☐ Low back pain ☐ Other: _____

Which side of your body is the complaint on? ☐ Right ☐ Left ☐ Both

How long have you had this problem?
Date: _____ or _____day(s) _____ week(s) _____ month(s) _____ year(s)

How do you think your problem began?
_____

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (50-75%) ☐ Occasionally (26-49%) ☐ Intermittently (0-25%)

Rate the severity of your symptoms:
☐ Mild ☐ Moderate ☐ Severe

How does this effect your movement?
☐ Stiffness ☐ Spasms ☐ Cramps

What makes the symptoms worse?
_____

What makes the symptoms better?
_____

Please add any other information about the primary complaint that may be helpful:
_____

*****Please list any ADDITIONAL complaints that you have: (Other areas of pain, etc.)*****
_____

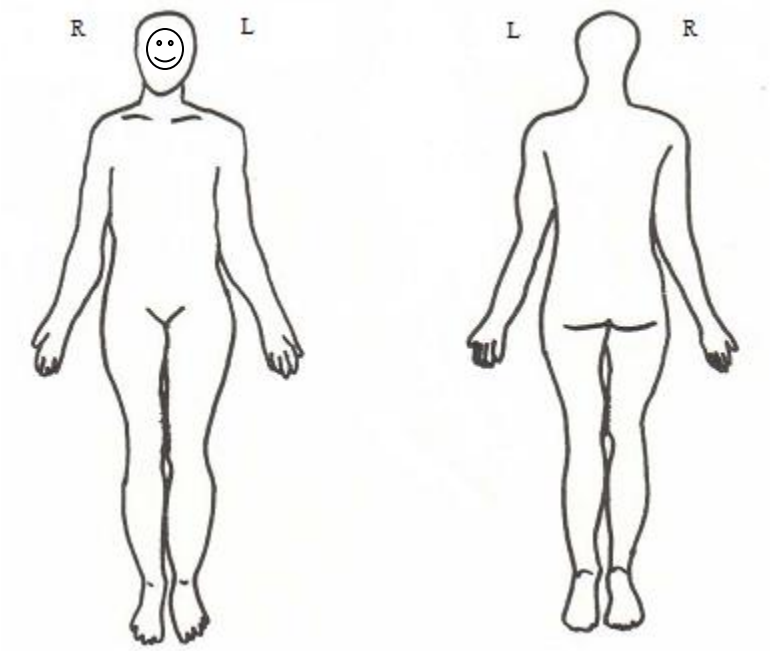
PATIENT'S INITIALS_____DATE_____

PAIN DRAWING:

INSTRUCTIONS: ***Mark the area on your body where you feel the described sensations:***

- ***Use the appropriate symbol***
- ***Mark the areas of spread***
- ***Include all affected areas***

KEY:	
Numbness / Tingling	**=======**
Pins & Needles	**oooooooo**
Burning pain	**xxxxxxxx**
Dull / achy pain	**……**
Sharp / Stabbing pain	**////////////////**



VISUAL PAIN SCALE

INSTRUCTIONS: ***Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate a score for each complaint. Please indicate your pain level right now, at its worst and at its best.***

Example:

Headache *Neck* *Low back*

No Pain ——— **Worst pain**

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

What is your pain RIGHT NOW?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its BEST?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its WORST?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

PATIENT'S INITIALS_____DATE_____

REVIEW OF SYSTEMS: Please CIRCLE any condition that you CURRENTLY HAVE. Or check NONE ☐.

ALLERGIC/IMMUNOLOGIC: ☐ NONE
Food Allergies Hay fever Frequent sinus problems Hives

CONSTITUTIONAL: ☐ NONE
Fainting Poor appetite Sudden weight gain Weakness Difficulty concentrating Dizzy spells Nervousness
Low libido Fatigue Sudden weight loss Chills Difficulty sleeping Fever Night sweats

ENDOCRINE: ☐ NONE
Hypothyroid Type I Diabetes (juvenile) Frequent infections Being tired a lot Changes in hair growth Excessive hunger
Extreme thinness General weakness Heat intolerance Eat to relieve fatigue Unexplained weight loss Hyperthyroid
Type II Diabetes Loss of appetite Unusually jumpy/nervous Cold intolerance Excessive Thirst
Drowsy after eating Shaky if hungry Hoarseness Unexplained weight gain

GASTROINTESTINAL: ☐ NONE
Anorexia/Bulimia Food Sensitivities Constipation Nausea Abdominal gas Acid reflux Black /tarry stools
Frequent indigestion Ulcer Heartburn Diarrhea Vomiting Abdominal pain Belching after meals
Difficulty swallowing

HEMATOLOGIC/LYMPHATIC: ☐ NONE
Jaundice Bleeding/bruising Swollen glands Leukemia Lymphoma Liver problems Anemia Blood clots Hemophilia Myeloma

MUSCULOSKELETAL: ☐ NONE
Osteoporosis Arthritis Back pain Joint pain Muscle weakness Frequent foot/leg cramps Heel spurs Joint stiffness
Scoliosis Neck pain TMJ pain Muscle pain Back injuries General muscle tension Hot joints Joint swelling

PSYCHIATRIC: ☐ NONE
Alcoholism Emotional stress Extreme worry Feeling miserable/blue Hallucinations Recurrent bad dreams
Being timid/shy Crying often Eating when nervous Feeling angered/ irritable Insecurity Phobias Sleep walking

CARDIOVASCULAR: ☐ NONE
High blood pressure High Cholesterol Poor Circulation Unusually slow heart rate Bleeding problems Blue extremities
Light-headed when standing Heart problems Low blood pressure Chest pain Ankle swelling Angina
Blood clots Cold hands/feet Heart murmur Leg pain walking short distances

EARS, NOSE &THROAT: ☐ NONE
Ear noises/ringing Chronic ear infection Loss of taste Blisters/Cold sores Deviated Septum Dysphagia
Ear pain Frequent colds Hearing loss Loss of smell Bleeding gums Dental Problems
Dry mouth Ear discharge Excessive saliva Gum disease

EYES: ☐ NONE
Blurred vision Injury Crossed Eyed Far Sightedness Glaucoma Near sightedness Swelling
Vision Headaches Burning sensation Cataracts Dry/Gritty Feeling heartbeat in eyes Itchy Redness
Tearing/crusting

GENITOURINARY: ☐ NONE
Kidney stones Prostate issues Infertility PMS symptoms Bladder control problems Foul smelling urine
Discolored urine Frequent urination Kidney/Bladder infections Bedwetting Erectile dysfunction Discharge
Burning Difficulty starting stream Dribbling Getting up at night to urinate

INTEGUMENTARY/SKIN: ☐ NONE
Skin cancer Eczema Hair loss Boils Coarse/bumpy skin Dandruff Excessive perspiration Itching Psoriasis
Acne Rashes Bruising Corns Dryness Hair changes Nail bed changes

NEUROLOGICAL: ☐ NONE
Anxiety Headaches Pins/needles Seizures Confusion Difficulty of Speech Epilepsy Forgetfulness
Depression Dizziness/Vertigo Numbness/Tingling Memory loss Convulsions Double vision Fainting spells Hand Trembling

RESPIRATORY: ☐ NONE
Coughing Asthma Emphysema COPD Chronic cough Coughing up blood Non-productive/dry cough
Shortness of breath Apnea Pneumonia Hay fever Asbestos exposure Congestion Difficulty breathing

PATIENT'S INITIALS_____DATE_____

FAMILY HISTORY: Please select the conditions that pertain to your family. (If known)

Relative:	Age: (if living)	Conditions/Illnesses:	Age at death:
Mother:	_____	_____	_____
Father:	_____	_____	_____

SOCIAL HISTORY: Please answer as completely as possible.

Marital Status: _____

Number of children: ____ Number of Pregnancies: ____ Number of miscarriages: ____ Number of abortions: ____

Highest level of education: _____

Do you feel that you eat a well-balanced diet? _____

How often do you exercise? _____ What types of exercises? _____

How often do you drink alcohol? _____

If you smoke cigarettes, how often? _____ If you chew tobacco, how often? _____

Have you ever used illegal drug? (circle) YES NO

If you use illegal drugs now, which ones? _____

Have you ever been treated for substance abuse? (circle) YES NO

Are your vaccinations up to date? (circle if known) YES NO

SURGICAL HISTORY:

Please list any surgeries that you have had in the past and the date if known. Also INCLUDE RIGHT OR LEFT side of body where applicable.

- □ **I have never had any previous surgery**

PROCEDURE:	DATE:	PROCEDURE:	DATE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES: Please list any allergies as well as your reaction to the allergen if known.

Enviromental: _____
Food: _____
Medication/Drug: _____

CURRENT MEDICATIONS:

Current Medications and Vitamin Supplements: (Please use reverse side if more space is required.)

NAME:	STRENGTH:	FREQUENCY:	NAME:	STRENGTH:	FREQUENCY:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

PATIENT'S INITIALS_____DATE_____

Neck Pain and Disability Index

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your **neck pain** has affected your ability to manage in everyday life. In each section, please fill in **ONE** box only which **most closely** describes your problem.

Section 1 Pain Intensity

- **A**. I have no pain at the moment.
- **B**. The pain is very mild at the moment.
- **C**. The pain is moderate at the moment.
- **D**. The pain is fairly severe at the moment.
- **E**. The pain is very severe at the moment.
- **F**. The pain is the worst imaginable at the moment.

Section 2 Personal Care

- **A**. I can look after myself normally without causing extra pain.
- **B**. I can look after myself normally but it causes extra pain.
- **C**. It is painful to look after myself and I am slow and careful.
- **D**. I need some help but manage most of my personal care.
- **E**. I need help every day in most aspects of self care.
- **F**. I do not get dressed, I wash with difficulty and stay in bed.

Section 3 Lifting

- **A**. I can lift heavy weight without extra pain.
- **B**. I can lift heavy weight but it gives extra pain.
- **C**. Pain prevents me from lifting heavy weights off the floor, but I can manage it they are conveniently positioned.
- **D**. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- **E**. I can lift very light weights.
- **F**. I cannot lift or carry anything at all.

Section 4 Reading

- **A**. I can read as much as I want with no pain in my neck
- **B**. I can read as much as I want with slight pain in my neck.
- **C**. I can read as much as I want with moderate pain in my neck.
- **D**. I can't read as much because of moderate pain in my neck.
- **E**. I can hardly read at all because of severe pain in my neck.
- **F**. I cannot read at all.

Section 5 Headaches

- **A**. I have no headaches at all.
- **B**. I have slight headaches which come infrequently.
- **C**. I have moderate headaches which come infrequently.
- **D**. I have moderate headaches which come frequently.
- **E**. I have severe headaches which come frequently.
- **F**. I have headaches almost all of the time.

Section 6 Concentration

- **A**. I can concentrate fully when I want with no difficulty.
- **B**. I can concentrate fully when I want with slight difficulty.
- **C**. I have a fair degree of difficulty in concentrating when I want.
- **D**. I have a lot of difficulty in concentrating when I want.
- **E**. I have a great degree of difficulty in concentrating when I want.
- **F**. I cannot concentrate at all.

Section 7 Work

- **A**. I can do as much work as I want.
- **B**. I can only do my usual work, but no more.
- **C**. I can do most of my usual work, but no more.
- **D**. I can hardly do any work at all.
- **E**. I cannot do my usual work.
- **F**. I can't do any work at all.

Section 8 Driving

- **A**. I can drive my car without any neck pain.
- **B**. I can drive my car as long as I want with slight pain in my neck.
- **C**. I can drive my car as long as I want with moderate pain.
- **D**. I can't drive my car as long as I want because of moderate pain.
- **E**. I can hardly drive at all because of severe pain in my neck.
- **F**. I can't drive my car at all.

Section 9 Sleeping

- **A**. I have no trouble sleeping.
- **B**. My sleep is slightly disturbed (less then 1hr. sleepless).
- **C**. My sleep is mildly disturbed (1-2 hrs. sleepless).
- **D**. My sleep is moderately disturbed (2-3 hrs. sleepless).
- **E**. My sleep is greatly disturbed (3-5 hrs. sleepless).
- **F**. My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 Recreation

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

PATIENT'S INITIALS_____DATE_____

Low Back Pain and Disability Index

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your **low back pain** has affected your ability to manage in everyday life. In each section, please fill in **ONE** box only which **most closely** describes your problem.

Section 1 Pain Intensity

- **A**. The pain comes and goes and is very mild.
- **B**. The pain is mild and does not vary much.
- **C**. The pain comes and goes and is moderate.
- **D**. The pain is moderate and does not vary much.
- **E**. The pain comes and goes and is very severe.
- **F**. The pain is very severe and doesn't vary much.

Section 2 Personal Care

- **A**. I can look after myself normally without causing extra pain.
- **B**. I can look after myself normally but it causes extra pain.
- **C**. It is painful to look after myself and I am slow and careful.
- **D**. I need some help but manage most of my personal care.
- **E**. I need help every day in most aspects of self care.
- **F**. I can't dress myself. I wash with difficulty and stay in bed.

Section 3 Lifting

- **A**. I can lift heavy weight without extra pain.
- **B**. I can lift heavy weight but it gives extra pain.
- **C**. Pain prevents me from lifting heavy weights off the floor.
- **D**. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- **E**. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- **F**. I can only lift very light weights at the most.

Section 4 Walking

- **A**. I have no pain while walking.
- **B**. I cannot walk more than one mile without increasing pain.
- **C**. I cannot walk more than ½ mile without increasing pain.
- **D**. I cannot walk more than ¼ mile without increasing pain.
- **E**. I can walk with crutches.
- **F**. I cannot walk at all without increasing pain.

Section 5 Sitting

- **A**. I can sit in any chair as long as I like.
- **B**. I can only sit in my favorite chair as long as I like.
- **C**. Pain prevents me from sitting more than one hour.
- **D**. Pain prevents me from sitting more than a half hour.
- **E**. Pain prevents me from sitting more than 10 minutes.
- **F**. I avoid sitting because it increases pain straight away.

Section 6 Standing

- **A**. I can stand as long as I want without pain.
- **B**. I have some pain on standing but it does not increase with time.
- **C**. I cannot stand for longer than one hour without increasing pain.
- **D**. I cannot stand for longer than a ½ hour without increasing pain.
- **E**. I can't stand for longer than 10 minutes without increasing pain.
- **F**. I avoid standing because it increases the pain straight away.

Section 7 Sleeping

- **A**. I get no pain in bed.
- **B**. I get pain in bed but it doesn't prevent me from sleeping well.
- **C**. Because of pain my normal night's sleep is reduced by < 1/4.
- **D**. Because of pain my normal night's sleep is reduced by < 1/2.
- **E**. Because of pain my normal night's sleep is reduced by < 3/4.
- **F**. Pain prevents me from sleeping at all.

Section 8 Traveling

- **A**. I get no pain while traveling.
- **B**. I get some pain while traveling but none of my usual forms of travel make it any worse.
- **C**. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- **D**. I get extra pain while traveling which compels me to seek alternative forms of travel.
- **E**. Pain restricts all forms of travel.
- **F**. Pain prevents all forms of travel except that done lying down.

Section 9 Social life

- **A**. My social life is normal and gives me no pain.
- **B**. My social life is normal but increases the degree of pain.
- **C**. Pain limits my more energetic interests, e.g. dancing, etc.
- **D**. Pain has restricted my social life and I do not go out very often.
- **E**. Pain has restricted my social life to my home.
- **F**. I have hardly any social life because of the pain.

Section 10 Changing Degree of Pain

- **A**. My pain is rapidly getting better.
- **B**. My pain fluctuates but overall is definitely getting better.
- **C**. My pain seems to be getting better but improvement is slow.
- **D**. My pain is neither getting better nor worse.
- **E**. My pain is gradually worsening.
- **F**. My pain is rapidly worsening.

PATIENT'S INITIALS_____DATE_____

HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Patient signature_____**Date**_____

Authorization and Assignment

AUTHORIZATION TO BILL INSURANCE: I understand my insurance will be billed for services rendered at Total Health Systems, PC.

AUTHORIZATION TO RELEASE INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any moneys due him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

MEDICARE ASSIGNMENT *(if applicable)*: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

ACKNOWLEGMENT AND UNDERSTANDING: I hereby acknowledge;

That if there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or if a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Total Health Systems PC, will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

SPECIAL CONSIDERATION: I understand that should I have a financial hardship and am unable to completely satisfy my deductible/copay/or coinsurance I will notify Total Health Systems, PC and a separate written contract will be created and signed.

Patient signature_____**Date**_____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, PHYSICAL THERAPY, AND/OR CHIROPRACTIC CARE. I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Total Health Systems, P.C. I understand, and am informed that, while extremely rare, there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient signature_____**Date**_____

Parent/Legal guardian name (please print)_____

Guardian Signature_____**Date**_____

PATIENT'S INITIALS_____DATE_____

TOTAL HEALTH SYSTEMS
Multi-Specialty Clinic
Chiropractic • Medical • Physical Therapy • Massage Therapy • Nutrition

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Total Health Systems, P.C. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

26672 Van Dyke ● Centerline ● Michigan 48015 ● (586) 756-7670
43740 Garfield ● Clinton Township ● Michigan 48038 ● (586) 228-0270
28098 23 Mile Rd ● Chesterfield Township ● Michigan 48051 ● (586) 949-0123
30045 Harper Ave ● St Clair Shores ● Michigan 48082 ● (586) 772-8560
57911 Van Dyke Rd ● Washington Township ● Michigan 48094 ● (586) 781-0800
Fax (586) 228-9019
www.totalhealthsystems.com

PATIENT'S INITIALS_____DATE_____

TOTAL HEALTH SYSTEMS
Multi-Specialty Clinic
Chiropractic • Medical • Physical Therapy • Massage • Nutrition • Fitness

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

☐ X-Rays ☐ History ☐ Diagnosis ☐ Treatment ☐ Reports
☐ Other: _____

Purpose of Release

☐ For the purpose of treatment at the above health care facility.
☐ Other: _____

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

_____
Name of Person Organization

_____
Name of Person Organization

Expiration Date of Authorization

This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contacting the Privacy Officer.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure. ***If you understand and agree with all of the above policies, please sign your name below.***

_____ _____
Patient or Legally Authorized Individual Signature | Date & Time

_____ _____
Print Patient's Full Name | Date of Birth (XX/XX/XXXX)

_____ _____
Witness Signature | Date

26672 Van Dyke ● Centerline ● Michigan 48015 ● (586) 756-7670
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