CONFIDENTIAL HEALTH INFORMATION

Afford A Care Chiropractic, Inc.
1223 Brookfield Rd
P.O. Box 233
Hubbard, OH 44425
Phone 330.448.0111
Fax 330.448.0544

Please provide your driver's license and insurance card(s) for us to copy
We comply with all HIPPA & all federal privacy standards.
All information supplied is strictly confidential.

______________________________ ________-______-_______ O Male O Female ______/______/______
Full name including middle initial **SS#** **Gender** **Birth date**

______________________________ ______________________________ ______ ______________
Address **City** **State** **Zip**

O Single O Married O Divorced O Widowed ( ) ____________ ( ) ____________ ( ) ____________
Marital status **Home phone** **Cell phone** **Work phone**

______________________________ O Yes O No
Email address **Okay to contact me with this info**

____________ ____________ ____________ ____________ ____________
Emergency contact – name **Relation** **Cell** **Home** **Work**

O Home phone O Cell O Work O Email
Preferred method of contact

O Insurance O Self-pay O Other ____________ *If work or auto related – inform front desk*
Who is responsible for this bill

O Caucasian O African American O Asian O Native American O Latin American O Other ______________________
Race

O Hispanic O Latino O Non-Hispanic/Non-Latino O Other ______________________
Ethnicity

____________________ ____________________ ____________________
Who may we thank for referring you to our office? **Primary Care Physician's Name** **Primary Care Physician's City & State**

O Employed full time O Employed part time O Unemployed O Retired O Full time student O Part time student ____________
Your employment status

O Yes O No _____/_____/_____ O Yes O No ______________________
Ever involved in an auto accident? **When?** **Any Injuries? If yes, describe**

O Yes O No ______________________________
Any problems remaining from the above accident? If yes, describe

____________________ ____________________ O Yes O No ____________________
Patient employed by **Occupation** **Have you missed work due to this problem? If yes, list dates**

______________________________ ____________________ ________ ______________
Address of patient's employer **City** **State** **Zip**

____________________ ____________________ ____________________ _____/_____/_____
Name of spouse **Spouse employed by** **Occupation** **DOB of spouse**

O **I have NO insurance** ____________________ ____________________ _____/_____/_____
Insurance Carrier **Insured's name** **DOB of insured**

How important is your health to you (1 = very little; 10 = extremely important): 1 2 3 4 5 6 7 8 9 10

*Please read each statement and **initial** your agreement to the following:*

_______ I hereby authorize Afford A Care Chiropractic, Inc., to furnish information concerning my present illness and DIRECT the insurer to pay without equivocation, directly to them, any and all benefits due him as a result of this claim. I hereby authorize this office to release all information necessary, including diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I am also aware that I am personally responsible for charges &/or balances not covered by my insurance. I understand that it is my personal responsibility to know the coverage of my insurance and if there are any special requirements, such as but not limited to: referral by a primary physician or prior authorization. A copy or scan of this form is as legally acceptable as the original.

_______ I authorize Afford A Care Chiropractic, Inc.,/Clarence L. Wray, Jr., D.C., to send copies of my records to my family physician stated on this form (or later informed to them) as they see fit.

_______ To the best of my knowledge, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my concern.

______________________________ ______________________________ _____/_____/_____
If the patient is a child, print the child's full name ***Signature of patient / parent / legal guardian*** ***Date***

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

__________________________________ _____/_____/_____
Patient's Signature *Date*

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

__________________________________ _____/_____/_____
Patient's Signature *Date*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Jones Integrated Physical Medicine & Afford A Care Chiropractic, Inc.
(Please initial one of the following options and sign below.)

__________ I wish to receive a paper copy of Privacy Notice.

__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X____ ________________________
Signature of Patient/Guardian Date

____ ________________________
Witness (Office Staff) Date

RED FLAG QUESTIONNAIRE

Name ______________________________________ DATE _____/_____/_____ Age _____

Please check the appropriate response. If "yes", please explain. If you are not sure, check the "?" box.

NO	YES	?	
☐	☐	☐	Do you have a past history of cancer?
☐	☐	☐	Have you had any unexplained weight loss?
☐	☐	☐	Does your pain improve with rest?
☐	☐	☐	Are you over 50 years old?
☐	☐	☐	Failure to respond to a course of conservative care (4-6 weeks)?
☐	☐	☐	Have you had spinal pain greater than 4 weeks?

NO	YES	?	
☐	☐	☐	Prolonged use of corticosteroids (such as organ transplant Rx)?
☐	☐	☐	Intravenous drug use?
☐	☐	☐	Current or recent urinary tract, respiratory tract or other infection
☐	☐	☐	Immunosuppression medication &/or condition

NO	YES	?	
☐	☐	☐	History of significant trauma?
☐	☐	☐	Minor trauma in person > 50 years old?
☐	☐	☐	Do you have osteoporosis (weak bones)?
☐	☐	☐	Are you over 70 years old?
☐	☐	☐	Any history of prolonged use of corticosteroids?

NO	YES	?	
☐	☐	☐	Acute onset urinary retention or overflow incontinence (wet underwear)
☐	☐	☐	Loss of anal sphincter tone or fecal incontinence (bowel accidents)
☐	☐	☐	Saddle anesthesia (numbness in the groin region)
☐	☐	☐	Global or progressive muscle weakness in the legs (legs give out)

COMMENTS:

____

____

____

____

____

Activities of Daily Living & Emotional Questionnaire

This form helps me determine how your condition is affecting your life and guides me in developing your treatment plan to give you the best care possible.

Name ____ Date _____/_____/_____

What is your main health condition/problem? ____

____

Does anyone else in your family have this same or similar problem? ❑ Yes ❑ No If yes, list: ______________________

____

How long have you been suffering from this problem? ____________________________________

Before you began to suffer with this problem, was there an earlier accident, injury, or condition that may or may not have been directly related this problem (examples: fall, auto accident, repetitive motion on the job, etc.)?

❑ Yes ❑ No If yes, describe: ____

____

How often do you find yourself suffering from this problem? _____________________________

How long does the problem last? Give details of timing: ________________________________

Is the problem: ❑ Getting worse ❑ Staying the same ❑ Getting better ❑ Varies

What have you tried in the past (heat, ice, rest, OTC meds, prescriptions, PT, vitamins, herbs) and what was the result of each (helped, made worse, etc.)? ____

____

____

Have you become discouraged or frustrated because of this problem? ❑ Yes ❑ No

When the problem is at its worst, can you explain in your own words how it feels? _______________

____

How does that make you feel? ____

When this problem is at its worst, does in make you feel older than you are? ❑ Yes ❑ No

Give me an example if a day when your problem was at its worst; how did it ruin things for you? __________

____

How does this problem affect your:

Family: ____

Work: ____

Hobbies/Recreational life: ____

Other: ____

Has this problem interrupted your sleep pattern yet?

- Trouble falling asleep ❑ Yes ❑ No
- Not enough restful sleep ❑ Yes ❑ No
- Awakening in middle of the night ❑ Yes ❑ No
- Waking earlier than you normally would ❑ Yes ❑ No
- Comments about sleep: ____

What activities does this problem prevent you from doing, either partially or totally, that you would really like to be doing again? ___________

____

This problem has been going on for __________________ (time). How do you see yourself in the future if you don't make the commitment to improve the condition? ____

On a scale of 1 to 10, 10 being the highest, rate your commitment to getting rid of the problem: 1 2 3 4 5 6 7 8 9 10

Do you have any concerns that would interfere with your commitment? ❑ Time ❑ Transportation ❑ Other: ______________________

Current Conditions:

❑ Aids	❑ Cancer	❑ Multiple Sclerosis	❑ Spinal Disc Disease	❑ STD's	❑ Ulcer
❑ Allergies	❑ Bone Fracture	❑ Heart Problem	❑ Low Blood Pressure	❑ Sinus Trouble	❑ Polio
❑ Anemia	❑ Cirrhosis/Hepatitis	❑ HIV/ARC	❑ Mental/Emotional Difficulty	❑ Epilepsy	❑ Scoliosis
❑ Arthritis	❑ Diabetes	❑ High Blood Pressure	❑ Prostate Trouble	❑ Thyroid Trouble	❑ Diverticulitis
❑ Asthma	❑ Dislocated Joints	❑ Kidney Trouble	❑ Rheumatic Fever	❑ Tuberculosis	

❑ Other – list: ____

Family History of Illness: *Please check the box if you have a family member with one of the following.*
In the comment section at the bottom, list the condition and put ***M*** *for mother,* ***F*** *for father, or* ***S*** *for sibling.*

❑ Aids	❑ Cancer	❑ Multiple Sclerosis	❑ Spinal Disc Disease	❑ STD's	❑ Ulcer
❑ Allergies	❑ Bone Fracture	❑ Heart Problem	❑ Low Blood Pressure	❑ Sinus Trouble	❑ Polio
❑ Anemia	❑ Cirrhosis/Hepatitis	❑ HIV/ARC	❑ Mental/Emotional Difficulty	❑ Epilepsy	❑ Scoliosis
❑ Arthritis	❑ Diabetes	❑ High Blood Pressure	❑ Prostate Trouble	❑ Thyroid Trouble	❑ Diverticulitis
❑ Asthma	❑ Dislocated Joints	❑ Kidney Trouble	❑ Rheumatic Fever	❑ Tuberculosis	

❑ Other – list: ____

List any past tests and diagnosis for the condition(s) you have come this office for: ❑ None	
Past treatments (list doctors and hospitals) for this condition and your response: ❑ None	
List current medications & over-the-counter drugs and dosage *(or include a copy)*: ❑ None	
List all vitamins/herbs/minerals you are taking: ❑ None	
List all surgeries and dates: ❑ None	
List allergies: ❑ None	
Do you drink alcohol? ❑ No ❑ Yes **Drinks per week** ____	**Cigarettes?** ❑ Current every day smoker ❑ Former smoker ❑ Current some days smoker ❑ Never smoked ❑ Heavy tobacco smoker ❑ Light tobacco smoker
Caffeine? ❑ No ❑ Yes **Drinks per day?** ____	**Exercise?** ❑ No ❑ Yes ❑ Light ❑ Moderate ❑ Strenuous **Hours per week?** _____
Additional Comments:	

Signature ____ *Date* _____/_____/_____

All questions in this questionnaire are strictly confidential and will become a part of your medical record

Review of Systems

Name ___________________________________ Date _____/_____/_____

CONSTITUTIONAL ○ **NONE OF BELOW**
○ Appetite change ○ Fever ○ Weight loss ○ Night sweats ○ Weight gain
○ Fatigue ○ Weakness ○ Trouble Sleeping ○ Chills ○ Restlessness

EYES ○ **NONE OF BELOW**
○ Blurry ○ Double vision ○ Vision loss ○ Tearing ○ Redness
○ Pain ○ Sensitivity to light ○ Glaucoma ○ Flashing lights ○ Specks
○ Cataracts Other ____

EAR/NOSE/THROAT ○ **NONE OF BELOW**
○ Ringing in ears ○ Ear pain ○ Nasal congestion ○ Nasal drainage ○ Nose bleeds
○ Mouth/throat irritation ○ Tooth problem ○ Sinus pain ○ Sore tongue ○ Dry mouth
○ Sore throat ○ Hoarseness ○ Decreased hearing ○ Bleeding gums ○ Bad breath
○ Altered taste/smell ○ Voice change ○ Swollen glands in neck ○ Earaches ○ Ear drainage
○ Thrush ○ Neck lumps Other ______________________________________

CARDIOVASCULAR ○ **NONE OF BELOW**
○ Chest pain/pressure ○ Heart racing ○ Palpitations ○ Sweating ○ Leg swelling
○ High blood pressure ○ Low blood pressure ○ Tightness ○ Shortness of breath ○ Anemia
○ Swelling ○ Difficulty breathing lying down ○ Sudden awakening shortness of breath Other ___________________________

RESPIRATORY ○ **NONE OF BELOW**
○ Cough ○ Yellow/green sputum ○ Blood in sputum ○ Shortness of breath ○ Wheezing
○ Painful breathing ○ Asthma ○ Recurrent respiratory infection Other _______________________

GASTROINTESTINAL ○ **NONE OF BELOW**
○ Swallowing difficulties ○ Nausea ○ Vomiting ○ Diarrhea ○ Constipation
○ Pain ○ Blood in stool ○ Blood in vomitus ○ Heartburn ○ Change in appetite
○ Change in bowel Habits ○ Rectal bleeding ○ Stomach pain or Cramping Other ___________________________

GENITOURINARY ○ **NONE OF BELOW**
○ Incontinence ○ Abnormal bleeding ○ Abnormal discharge ○ Urinary frequency ○ Urinary hesitancy
○ Pain ○ Impotence ○ Sexual problem ○ Infection ○ Urinary retention
○ Urgency ○ Uterine fibroids ○ Ovarian cysts ○ Cancer ○ Prostate problems
○ Change in urinary strength Other ______________________________________

MUSCULOSKELETAL ○ **NONE OF BELOW**
○ Muscle or joint pain ○ Stiffness ○ Back pain ○ Redness of joints ○ Swelling of joints
○ Trauma ○ Arthritis ○ Weakness ○ Muscle wasting ○ Sprain/fracture
○ Rheumatoid arthritis ○ Chronic pain Other ______________________________________

INTEGUMENTARY ○ **NONE OF BELOW**
○ Rashes ○ Lumps ○ Itching ○ Dryness ○ Color changes
○ Hair and nail changes ○ Eczema ○ Excessive sweating ○ Easy bruising ○ Increased bleeding
Other ____

NEUROLOGICAL ○ **NONE OF BELOW**
○ Headache ○ Dizziness ○ Change in voice ○ Change in taste ○ Change in vision
○ Change in hearing ○ Loss/change sensation ○ Trouble walking ○ Balance problem ○ Coordination problem
○ Shaking ○ Speech problem ○ Seizures ○ Migraines Other ____________

MENTAL ○ **NONE OF BELOW**
○ Nervousness ○ Stress ○ Depression ○ Memory loss ○ Mood swings
○ Irritability ○ Confusion ○ Anxiety Other ___________________________

ENDOCRINE ○ **NONE OF BELOW**
○ Cold intolerance ○ Heat intolerance ○ Blood sugar problem ○ Weight gain ○ Missed periods
○ hot flashes/sweats ○ Change in body hair ○ Change in libido ○ Increased thirst ○ Increased urination
○ Change in appetite ○ Inability to lose weight ○ Weight loss for no reason Other ___________________________

HEMATOLOGIC ○ **NONE OF BELOW**
○ Bruising easily ○ Bleed easily ○ Swelling ○ Anemia ○ Enlarge lymph node
Other ____

ALLERGIC/IMMUNOLOGIC ○ **NONE OF BELOW**
○ Itch ○ Post-nasal drip ○ Watery/itchy eyes ○ Nasal drainage ○ Immunosuppressed
Other ____

BACK INDEX

Patient Name ____________________________________ **Date** _____/_____/_____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by ***circling*** *the number for the one statement that applies to you. If two or more statements apply, circle the one statement that most closely describes your problem.*

Pain Intensity

0 The pain comes and goes and is very mild
1 The pain is mild and does not vary much
2 The pain comes and goes and is moderate
3 The pain is moderate and does not vary much
4 The pain comes and goes and is very severe
5 The pain is very severe and does not vary much

Personal Care

0 I do not have to change my way of washing or dressing in order to avoid pain
1 I do not normally change my way of washing or dressing even though it causes some pain
2 Washing and dressing increases the pain but I manage not to change my way of doing it
3 Washing and dressing increases the pain and I find it necessary to change my way of doing it
4 Because of the pain I am unable to do some washing and dressing without help
5 Because of the pain I am unable to do any washing or dressing without help

Lifting

0 I can lift heavy weights without extra pain
1 I can lift heavy weights but it causes extra pain
2 Pain prevents me from lifting heavy weights off the floor
3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table)
4 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
5 I can only lift very light weights

Walking

0 I have not pain while walking
1 I have some pain while walking but it doesn't increase with distance
2 I cannot walk more than 1 mile without increasing pain
3 I cannot walk more than 1/2 mile without increasing pain
4 I cannot walk more than 1/4 mile without increasing pain
5 I cannot walk at all without increasing pain

Sitting

0 I can sit in any chair for as long as I like
1 I can only sit in my favorite chair for as long as I like
2 Pain prevents me from sitting more than 1 hour
3 Pain prevents me from sitting more than 1/2 hour
4 Pain prevents me from sitting more than 10 minutes
5 I avoid sitting because it increases pain immediately

Standing

0 I can stand as long as I want without pain
1 I have some pain while standing but it does not increase with time
2 I cannot stand for longer than 1 hour without increasing pain
3 I cannot stand for longer than 1/2 hour without increasing pain
4 I cannot stand for longer than 10 minutes without increasing pain
5 I avoid standing because it increases pain immediately

Sleeping

0 I get no pain in bed
1 I get pain in bed but it does not prevent me from sleeping well
2 Because of pain my normal sleep is reduced by less than 25%
3 Because of pain my normal sleep is reduced by less than 50%
4 Because of pain my normal sleep is reduced by less than 75%
5 Pain prevents me from sleeping at all

Social Life

0 My social life is normal and gives me no extra pain
1 My social life is normal but increases the degree of pain
2 Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.)
3 Pain has restricted my social life and I do not go out very often
4 Pain has restricted my social life to my home
5 I have hardly any social life because of the pain

Traveling

0 I get no pain while traveling
1 I get some pain while traveling but none of my usual forms of travel make it worse
2 I get extra pain while traveling but it does not cause me to seek alternate forms of travel
3 I get extra pain while traveling which causes me to seek alternate forms of travel
4 Pain restricts all forms of travel except that done while lying down
5 Pain restricts all forms of travel

Changing degree of pain

0 My pain is rapidly getting better
1 My pain fluctuates but overall is definitely getting better
2 My pain seems to be getting better but improvement is slow
3 My pain is neither getting better or worse
4 My pain is gradually worsening
5 My pain is rapidly worsening

If you have been involved in an accident or if you have had something happen (example: you lifted something or slipped) please tell the doctor)

NECK INDEX **Patient Name** ____________________________________ **Date** _____/_____/_____

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by **circling** the number for the one statement that applies to you. If two or more statements apply, circle the one statement that most closely describes your problem.*

Pain Intensity

0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain comes and goes and is moderate
3 The pain is fairly severe at the moment
4 The pain is very severe at the moment
5 The pain is the worst imaginable at the moment

Personal Care

0 I can look after myself normally without causing extra pain
1 I can look after myself normally but it causes extra pain
2 It is painful to look after myself and I am slow and careful
3 I need some help but I manage most of my personal care
4 I need help every day in most aspects of self care
5 I do not get dressed, I wash with difficulty and stay in bed

Lifting

0 I can lift heavy weights without extra pain
1 I can lift heavy weights but it causes extra pain
2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table)
3 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
4 I can only lift very light weights
5 I cannot lift or carry anything at all

Reading

0 I can read as much as I want with no neck pain
1 I can read as much as I want with slight neck pain
2 I can read as much as I want with moderate neck pain
3 I cannot read as much as I want because of moderate neck pain
4 I can hardly read at all because of severe neck pain
5 I cannot read at all because of neck pain

Headaches

0 I have no headaches at all
1 I have slight headaches which come infrequently
2 I have moderate headaches which come infrequently
3 I have moderate headaches which come frequently
4 I have severe headaches which come frequently
5 I have headaches almost all the time

Concentration

0 I can concentrate fully when I want with no difficulty
1 I can concentrate fully when I want with slight difficulty
2 I have a fair degree of difficulty concentrating when I want
3 I have a lot of difficulty concentrating when I want
4 I have a great deal of difficulty concentrating when I want
5 I cannot concentrate at all

Work

0 I can do as much work as I want
1 I can only do my usual work but no more
2 I can only do most of my usual work but no more
3 I cannot do my usual work
4 I can hardly do any work at all
5 I cannot do any work at all

Driving

0 I can drive my car without any neck pain
1 I can drive my car as long as I want with slight neck pain
2 I can drive my car as long as I want with moderate neck pain
3 I cannot drive my car as long as I want because of severe neck pain
4 I can hardly drive at all because of severe neck pain
5 I cannot drive my car at all because of neck pain

Sleeping

0 I have no difficulty sleeping
1 My sleep is slight disturbed (less than 1 hour sleepless)
2 My sleep is mildly disturbed (1-2 hours sleepless)
3 My sleep is moderately disturbed (2-3 hours sleepless)
4 My sleep is greatly disturbed (3-5 hours sleepless)
5 My sleep is completely disturbed (5-7 hours sleepless)

Recreation

0 I am able to engage in all my recreation activities without neck pain
1 I am able to engage in all my usual recreation activities with some neck pain
2 I am able to engage in most but not all of my usual recreation activities because of neck pain
3 I am only able to engage in a few of my usual recreating activities because of neck pain
4 I can hardly do any recreation activities because of neck pain
5 I cannot do any recreation activities at all

If you have been involved in an accident or if you have had something happen (example: you lifted something or slipped) please tell the doctor)