McCracken Co. Chiropractic • Dr. Mark E. Atnip, D.C. • 2731 Jackson St. • Paducah, KY 42003 • 270-444-7111

PATIENT INFORMATION

First Name_____ Last Name_____ M.I.____ Nickname_____

SS# _____Date of Birth _____ Age_____ Gender: M F

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell: _____

E-Mail Address: _____

May we text you for updates or reminders? □ Y □ N

Your Employer (or School) _____ Your Occupation: _____

Employer Address _____ City _____ State _____ Zip _____

Have you ever been to a Chiropractor? □ Y □ N If yes, Where?_____

□ Married □Single □ Widow(er) □ Divorced □ Separated □ Life Partner

If married: Spouse's Name _____ Spouse's Birth Date _____

Spouse's Employer _____ Spouse's Occupation _____

INSURANCE INFORMATION (Please allow our staff to photocopy your current health ins. card(s) & a photo I.D.)

Do you have Insurance? □ Yes □ No Primary Ins:_____ Secondary Ins:_____

Do you have a Flex plan, HSA, or HRA? □ Yes □ No

Are you the policy holder? □ Yes □ No **If no**: Name of Policy Holder _____

Date of Birth of Policy Holder _____ Policy Holder's Relationship to patient _____

I herby instruct and direct any and all insurance companies, lawyers, or employers liable for my health care benefits to pay by check made out and mailed to: **McCracken County Chiropractic • 2731 Jackson St. • Paducah KY 42003**

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I hereby authorize and direct you, my insurance carrier, to pay directly to McCracken Co. Chiropractic such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect McCracken Co. Chiropractic. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by McCracken Co. Chiropractic. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option. **A photocopy of this Assignment shall be considered as effective and valid as the original.**

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case to facilitate collection under this Assignment, Lien and Authorization.

I understand I am ultimately responsible for payment to this office. If for any reason my insurance company should pay me for services received in this office instead of paying directly to McCracken Co. Chiropractic, I understand that payment is for services performed here, and I must bring the payment in immediately upon receipt.

I have read and understand the foregoing.

Patient's Signature _____ **Date** _____

How did you hear about us? _____

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CASE HISTORY

Full Name: _____ Date of Birth: _____

Please fill out the following for the primary condition for which you are here to be treated:

1. Is your condition related to an accident? □ Yes □ No If yes: Date of Accident _____ □ Auto □Work Related □Other
2. Family history related to present condition: _____
3. Personal habits: □ Tobacco □ Alcohol □ Vitamins □ Exercise □ Recreational drugs
   □ Medications & reasons _____

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary; we would like to confirm that you are not pregnant at this time:

Female history: **Are you pregnant at this time?** □ Yes □ No □ Unsure but could be **I am Male** □
Date of last menstrual cycle_____□ Regular □ Irregular Using birth control pills □ Yes □ No

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Are you experiencing or do you have any of the following: (check all that apply) or □ **None of the below**

□ A sore that won't heal	□ Difficulty swallowing	□ Persistent cough/hoarseness
□ Any bleeding/discharge	□ Lump/thickening anywhere	□ Wart/mole changes
□ Bladder/bowel problems	□ Night pain	□ Weight loss without trying

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Review of Systems
In addition to the symptom(s)/dysfunction(s) listed above, are you experiencing any of the following?

Neuromusculoskeletal System (Check all that apply) or □ **None of the below**

□ Sensory changes	□ Facial drooping	□ Loss of balance	□ Seizure	□ Headache
□ Atrophy	□ Vision trouble	□ Memory loss	□ Dizziness	□ Anxiety
□ Joint deformity	□ Mood swings	□ Speech problems	□ Twitches	□ Limited range of motion
□ Psychiatric disorders	□ Joint locking	□ Muscle weakness	□ Stiffness	□ Depression
□ Difficulty walking	□ Joint swelling	□ Numbness	□ Tremors	□ Concussion
□ Lack of coordination	□ Popping noises	□ Extremity deformity		

Cardiovascular System (Check all that apply) or □ **None of the below**

□ Chest pain	□ Dizziness	□ Fainting	□ Carotid blockage	□ Hypertension
□ Ankle swelling	□ Known vascular disease	□ Jaw pain	□ Phlebitis	□ Pin Stroke
□ Mitral valve prolapse	□ Changes in skin color	□ Previous stroke	□ Varicose veins	□ Blood clots
□ Shortness of breath				

Past History List any surgeries you have had (including appendix, tonsils, wisdom teeth, etc)

1. _____ When? _____
2. _____ When? _____
3. _____ When? _____
4. _____ When? _____

List any hospitalization other than surgeries, when & for what: _____
List any diagnosed conditions: (examples: diabetes, cancer, etc): _____
List any current Doctors & conditions not previously listed: _____
List any major or minor falls or accidents & when occurred: _____
List any cracked or broken bones & when occurred: _____

Patient's Signature _____ Date _____

STAFF ONLY
Did patient require assistance with paperwork? □ Yes □ No (_____) If yes, Does Patient have a Power Attorney □ Yes □ No (____)
ROS AND PFSH information reviewed with patient and agree with findings. _____

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Name: _____ Date of Birth: _____ Date: _____

List your Pains/Complaints from Most Severe (1) to Least Severe (4)

	1.	2.	3.	4.
Today, I have the following physical complaints:	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
Is this Complaint Sharp, Dull, Achy, Throbbing, Numb, Shooting or Other (explain)?	❒ Dull ❒ Sharp ❒ Burning ❒ Numbness/tingling ❒ Aching ❒ Electric / Shooting	❒ Dull ❒ Sharp ❒ Burning ❒ Numbness/tingling ❒ Aching ❒ Electric / Shooting	❒ Dull ❒ Sharp ❒ Burning ❒ Numbness/tingling ❒ Aching ❒ Electric / Shooting	❒ Dull ❒ Sharp ❒ Burning ❒ Numbness/tingling ❒ Aching ❒ Electric / Shooting
How often do you feel this Complaint? Constant, Daily, "Off & On" or Weekly?	❒ Constant ❒ Daily ❒ Off & On ❒ Weekly ❒ Monthly ❒ Other _____	❒ Constant ❒ Daily ❒ Off & On ❒ Weekly ❒ Monthly ❒ Other _____	❒ Constant ❒ Daily ❒ Off & On ❒ Weekly ❒ Monthly ❒ Other _____	❒ Constant ❒ Daily ❒ Off & On ❒ Weekly ❒ Monthly ❒ Other _____
How long have you had this complaint?	_____ _____	_____ _____	_____ _____	_____ _____
What Caused your complaint?	_____ _____	_____ _____	_____ _____	_____ _____
Is it getting better, worse, or staying the same?	❒ Better ❒ Worse ❒ Same	❒ Better ❒ Worse ❒ Same	❒ Better ❒ Worse ❒ Same	❒ Better ❒ Worse ❒ Same
What makes it better?	_____ _____	_____ _____	_____ _____	_____ _____
What makes it worse?	_____ _____	_____ _____	_____ _____	_____ _____
When do symptoms appear? How long?	_____ _____	_____ _____	_____ _____	_____ _____
Scale of 1 to 10 At its worst, rate your discomfort.	10 = Excruciating 0 = No discomfort Circle one: 10 9 8 7 6 5 4 3 2 1	10 = Excruciating 0 = No discomfort Circle one: 10 9 8 7 6 5 4 3 2 1	10 = Excruciating 0 = No discomfort Circle one: 10 9 8 7 6 5 4 3 2 1	10 = Excruciating 0 = No discomfort Circle one: 10 9 8 7 6 5 4 3 2 1
On Average, rate your pain.	10 9 8 7 6 5 4 3 2 1	10 9 8 7 6 5 4 3 2 1	10 9 8 7 6 5 4 3 2 1	10 9 8 7 6 5 4 3 2 1
At its best, rate your pain.	10 9 8 7 6 5 4 3 2 1	10 9 8 7 6 5 4 3 2 1	10 9 8 7 6 5 4 3 2 1	10 9 8 7 6 5 4 3 2 1
How have you taken care of this in the past? How has it worked for you?	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
Helping this issue would increase my Quality of life by:	❒ 10-20% ❒ 30-40% ❒ 50-60% ❒ 70-80% ❒ 90% ❒ 100%	❒ 10-20% ❒ 30-40% ❒ 50-60% ❒ 70-80% ❒ 90% ❒ 100%	❒ 10-20% ❒ 30-40% ❒ 50-60% ❒ 70-80% ❒ 90% ❒ 100%	❒ 10-20% ❒ 30-40% ❒ 50-60% ❒ 70-80% ❒ 90% ❒ 100%

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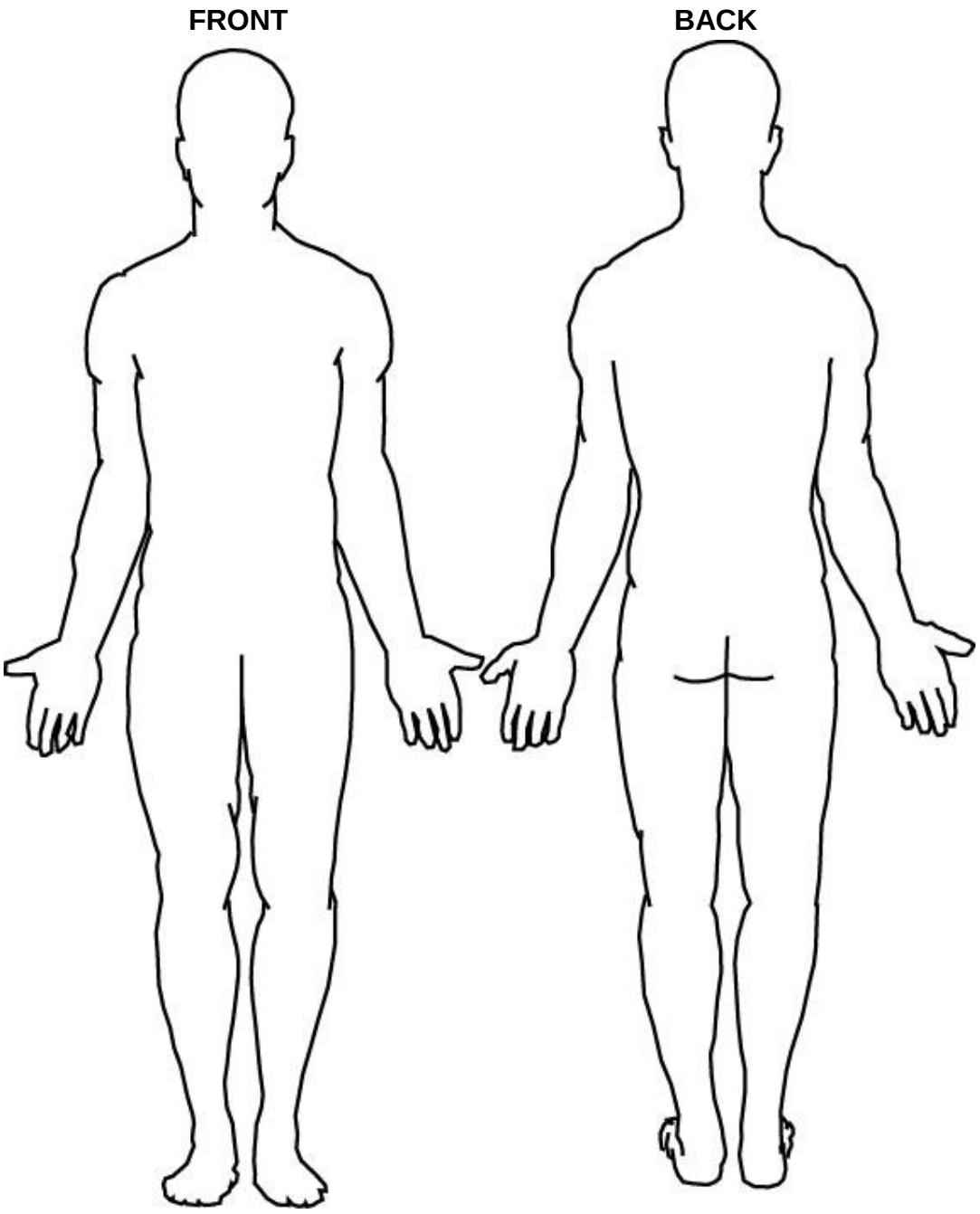
PAIN DRAWING

Full Name: _____ Date of Birth: _____



INSTRUCTIONS: Mark these drawings according to where you hurt (for example, if the right side of your neck hurts, mark the drawing on the right side of the neck). Please indicate which sensations you feel by referring to the key below.

////////	Dull	XXXX	Sharp	OOOO	Burning
=====	Numbness/Tingling	+++++	Aching	# # # #	Electric/Shooting

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Full Name:_____ D.O.B.:_____

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Functional Rating Index

To properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage every day activities. For each item below, please circle the number that ***right now*** most closely describes your condition.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect	Mildly disturbed	Moderate disturbed	Greatly disturbed	Totally disturbed

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No problems No restrictions	Mild problems	Moderate problems / Go slowly	Moderate problems	Severe problems / Need assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work (job, housework, yardwork)

0	1	2	3	4
Can do usual work plus extra work	Can do usual work no extra work	Can do 50% usual work	Can do 25% usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of Pain

0	1	2	3	4
No pain	Occasional pain 25% of the day	Intermittent pain 50% of the day	Frequent pain 75% of the day	Constant 100% of the day

8. Lifting

0	1	2	3	4
No pain w/ heavy weight	Increased pain w/ heavy weight	Increased pain w/ moderate weight	Increased pain w/ light weight	Increased pain w/ any weight

9. Walking

0	1	2	3	4
No pain any distance	Increased pain after 12 min	Increased pain after 6 min	Increased pain after 3 min	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Office Use Only

Total Score_____

Patient's Signature _____ Date_____

CONSENT TO TREAT

Patient Name: _____

A patient coming to the doctor gives the doctor permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities, or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he is aware that such care may be contra-indicated. 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**.**

I understand it is my responsibility to fill out my case history completely and to the best of my knowledge, and to inform the doctor of any information that is not listed on my case history. I also understand that it is my responsibility to inform the doctor of any changes that may occur once I have filled out that information. I authorize Dr. Mark E. Atnip to treat me.

I have read and understand the foregoing.

Patient's Signature _____ **Date** _____

(Authorization expires three years from date above)

Patient Authorization for the Use and Disclosure of Protected Health Information

1. I have been presented a copy of the McCracken Co. Chiropractic Notice of Privacy Policy.
2. I have read and fully understand the McCracken Co. Chiropractic Notice of Privacy Policy.
3. I am aware I can contact the Privacy Officer at any time regarding any questions I may have concerning the McCracken Co. Chiropractic Notice of Privacy Policy.
4. I understand I can request a limitation to the disclosure of my protected health information at any time in writing.
5. I understand that there are security cameras in use throughout this facility at all times. I understand that the video gained from the cameras will be used for security and training purposes only. I give my consent to be treated under these conditions.
6. I expressly acknowledge that this authorization is voluntary.
7. I understand I may get a copy of this form by request after I sign it.
8. I understand that the information used or disclosed pursuant to this authorization, may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
9. I hereby authorize McCracken Co. Chiropractic to use and/or disclose my protected health information in accordance with the procedures outlined in the McCracken Co. Chiropractic Notice of Privacy Policy.

Signature_____ **Date**_____

Of patient or legal guardian if patient is under 18 or otherwise unable to sign for himself/herself. (Authorization expires three years from date above)