ZIMMER CHIROPRACTIC

447 S. Water Street
Marine City, MI 48039
(810) 765-5622

610 Minnie Street
Port Huron, MI 48060
(810) 987-7500

Name_____DOB___/___/___Age_____Today's Date___/___/___
Address _____ City_____ State_____ Zip_____
SSN:_____-____-_____ Driver's License #_____ Sex: *Male Female* (circle one)
Home #( )_____Page/Cell #( )_____Work #( )_____
Email_____Occupation_____
Employer's Name _____
Address: _____ *City*_____ *State*_____ *Zip*:_____
Single Married Divorced Widowed Name of Spouse _____
# of children_____ Names of children_____
Who can we thank for referring you to our office? _____

Was this injury a result of: ☐ Work Injury? ☐ Car Accident? ☐ Other Injury? (check one)

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT: As a chiropractic office that centers on family wellness, we focus on helping you reach your optimum health potential. Our first goal is to locate and eliminate any and all interference to reaching your maximum potential while addressing the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. We all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes when it's already too late! Your answers to the following questions will give us a general view of the stresses you have faced in your life. This will allow us to better assess your current status and more accurately determine your true health potential.

THE BEGINNING YEARS – Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

BIRTH HISTORY – *Please check all that apply.*

☐ Mother smoked/drank/drugs during pregnancy ☐ Epidural/Med's in Labor ☐ Breech
☐ C-Section ☐ Forceps Delivery ☐ Vacuum Extractor Used ☐ Labor Induced
☐ Complications ☐ Other _____

CHILDHOOD YEARS (0-17 years) – *Please check all that apply.*

☐ Childhood illness ☐ Serious Falls ☐ Active in sports ☐ Very Inactive
☐ Car Accident(s) ☐ Surgery/Stitches ☐ Alcohol Abuse ☐ Smoker
☐ Antibiotics ☐ Drug Abuse ☐ OTC Medications ☐ Vaccinated
☐ Broken Bones ☐ Under Chiropractic Care ☐ Severe Emotional Trauma(s)_____

ADULT YEARS (Age 18 to Present) – *Please check all that apply.*

☐ Present Smoker ☐ Former Smoker ☐ OTC Medications ☐ Poor sleep
☐ Alcohol Use ☐ Play Sports ☐ Surgery/Stitches: yrs old? _____ ☐ Work Injury
☐ High Job Stress ☐ High Personal Stress ☐ Poor Diet ☐ Drive a lot
☐ Flat feet ☐ Prescription Medications ☐ Not Enough Sleep ☐ Broken Bones
☐ No Exercises ☐ Severe Health Problems ☐ Wear Orthotics/Lifts ☐ Sit a lot
☐ Car Accidents: _____ (yrs old?) ☐ *Other Injuries*:

_____

☐ Have been under chiropractic care in the past – How long ago was your last adjustment?_____

Please list all prescriptions you are currently taking: _____

_____

ZIMMER CHIROPRACTIC
ISSUES THAT BROUGHT YOU TO OUR OFFICE

**If you have no symptoms or complaints and you are here for wellness care please check the box below.
☐ **WISH TO HAVE WELLNESS SERVICES** (Skip to FAMILY HEALTH PROFILE at the bottom of this form.)

CHIEF COMPLAINT(S) _____

_____

How has this affected your life?_____

_____

If you have pain, is it… ☐ Mild ☐ Moderate ☐ Severe ☐ Intolerable
☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐ Traveling ☐ Radiating

Since it began, is it… ☐ About the same ☐ Variable ☐ Getting better ☐ Getting worse
What makes it worse?_____
What has made it better in the past but stopped working?_____
What makes it better?_____

Does it interfere with… ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Exercise
☐ Hobbies ☐ Leisure activity ☐ Other _____

Did you have an injury? ☐ Yes ☐ No *If yes, please explain* _____

How long have you had this problem? _____
Have you had similar problems in the past?_____
Is there a time of day that is worse typically? ☐ Yes ☐ No If Yes, when? _____

Other doctors/treatments you've tried for this problem (Please list):
☐ Chiropractor_____
☐ Medical Doctor *(their names)*_____
☐ Other _____

****PLEASE CHECK ALL RECURRING OR SEVERE SYMPTOMS YOU HAVE EVER HAD, EVEN IF THEY SEEM UNRELATED TO YOUR CURRENT PROBLEM:**

☐ Headaches/Migraines	☐ Pins & Needles in legs/feet	☐ Recurring Infection
☐ Infertility/Impotence/Miscarriage	☐Pins & Needles in arms	☐ Loss of Smell
☐ Back stiffness/pain	☐ Loss of balance	☐ Dizziness/vertigo
☐ Buzzing/ringing in ears	☐ Sinus Problems/Issues	☐ Nervousness/Anxiety
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste
☐ Stomach Upset	☐ Fatigue	☐ Depression
☐ Tension/Stress	☐ Irritability/Mood Swings	☐ Sleeping Problems
☐ Neck stiffness/pain	☐ Cold hands	☐ Cold feet
☐ Diarrhea/Constipation/Gas	☐ Foot Problems	☐ Shortness of breath
☐ Hot Flashes	☐ Cold Sweats	☐ Light bothers eyes
☐ Problems urinating	☐ Heartburn/Acid reflux	☐ High Blood Pressure
☐ Pre-Menstrual Syndrome	☐ Menopause	☐ Ulcers
☐ Jaw/TMJ Problems	☐ Other: _____	

FAMILY HEALTH PROFILE – In our office, we are not only interested in your health & well being, but also that of your family and loved ones. Please mention any health conditions or concerns you may have about your:
CHILDREN_____ SIBLINGS _____
SPOUSE _____ OTHER _____
PARENTS _____

Current exercises: _____ # days per week: _____ **Current supplements** (*list*): _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. If the office accepts an assignment of benefits under any insurance plan, the Patient will remain primarily responsible for all bills and shall be obligated to pay any and all sums not actually paid by the insurance carrier. I agree to allow this office to examine me for further evaluation.

_____ ____/____/_____
Signature Date

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark 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.

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.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair 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.

Walking

⓪ I have no 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.

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 and 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.

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.

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.

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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark 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.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly 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).

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.

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.

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.

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 moderate 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.

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 my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation 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.

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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC
It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS
The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read, and understand the foregoing.

DATE _____ SIGNATURE _____

PATIENT NAME _____

ZIMMER CHIROPRACTIC OFFICE

PRIVACY PRACTICES NOTICE

I acknowledge that **Zimmer Chiropractic Office's** "Notice of Privacy Practices" has been provided to me. I understand I have the right to review **Zimmer Chiropractic Office's** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Zimmer Chiropractic Office.**

The Notice of Privacy Practices for **Zimmer Chiropractic Office** is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and **Zimmer Chiropractic Office's** duties with respect to my protected health information.

Zimmer Chiropractic Office reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I give my permission for Zimmer Chiropractic Office to contact me, to leave a message, or send a card regarding any appointments.

_____

Patient Name

_____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Zimmer Chiropractic
447 S Water St Marine City
610 Minnie St Port Huron

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

Medical Information Release Form

I _____ hereby give permission for Zimmer Chiropractic, to discuss my care information including, past and future visit(s), insurance information, cost of care, and any other information with the following people.

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

_____ Date _____
Print Patient Name

_____ Date _____
Patient Signature

Zimmer Chiropractic
447 S. Water St. Marine City, MI 48039 810-765-5622
610 Minnie St. Port Huron, MI 48039 810-987-7500

ZIMMER CHIROPRACTIC

447 S. Water St.
Marine City, MI 48039
810-765-5622

610 Minnie St.
Port Huron, MI 48060
810-987-7500

If insurance is under Spouse or Parent we will need Insured's Date of Birth

_____/_____/_____

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this office the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this office.

A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____

Patient Signature Date

RELEASE OF INFORMATION

I authorize this office to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release this office of any consequence thereof.

_____ _____

Patient Signature Date

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this office including my insurance deductible, copayment and any services rejected by my insurance company.

_____ _____

Patient Signature Date

Zimmer Chiropractic
PATIENT CENTERED MEDICAL HOME
PATIENT PROVIDER PARTNERSHIP AGREEMENT

At ***Zimmer Chiropractic*** our goal is to provide you with the highest standard of healthcare. This can be accomplished by establishing us as your Patient Centered Medical Home. Below are some guidelines to make the best of this partnership:

This means that our practice will make every effort to:

- Build a strong link with you that supports open and honest discussion regarding your health and treatment plan.
- Care for all stages of your life including acute care, chronic care and preventative care.
- Establish health maintenance and wellness plans for you along with treatment and self-management plans for any chronic conditions.
- Consider all your needs when we work with you to develop your treatment plans and health goals.
- Provide you with information to help you learn how to self-manage your condition and assist you with establishing goals.
- Work with you to create a plan for any other urgent health care need that may arise.
- Direct and coordinate all elements of your care through any necessary referrals to specialists, hospitalizations, home health agencies and community resources.
- Be available to you by phone and in the office to answer your questions and concerns.

This means you should make every effort to:

- Make and keep all appointments recommended by our office. If you must cancel an appointment, make every attempt to reschedule it as soon as possible.
- Follow through with recommended testing and contact the office if you cannot get these tests completed.
- Participate and commit to the treatment plan and health goals developed by you and your physician or other health professional.
- Be sure you understand the treatment plan. If you do not understand, ask questions until you feel comfortable with the agreed upon treatment plan.
- Tell us immediately if you are not able to follow the treatment plan for any reason so we can assist you in adjusting the plan so you get the best results.
- Communicate your health and wellness goals to your physician

Signature_____ Date:_____