

NUSSBAUM CHIROPRACTIC – CPI

First Name: _____ Middle: _____ Last: _____ Date: _____
 Home address: _____ apt#: _____ City: _____ State: _____ Zip _____
 Home phone#: _____ Cell phone#: _____ Carrier _____
 E-Mail address: _____ sex: M F Date of Birth: _____ age: _____
 Height: _____ Weight: _____ # of children _____ Marital Status: M S W D Spouse's Name: _____
Emergency Contact _____ Phone # of Emergency Contact _____
 Employer: _____ Occupation: _____ Work Phone# _____
 Your Physician: _____ Referred by: _____

List the Problems you want us to address:

1. _____
2. _____
3. _____

When did the primary problem start? _____ Approximate Date: _____

Did it come on: Instantly Over several minutes Over several hours Other _____

Briefly describe what activity you were doing: _____

What positions or activities make it better? Lifting Sitting Standing Walking Other _____

What positions or activities make it worse? Lifting Sitting Standing Walking Other _____

Have you had problems in this area of your body before? _____ If yes, describe briefly: _____

What other doctors, therapists, or chiropractors have you seen in the past?

Do you exercise regularly? (Briefly describe how often, how long, what type...)

Have any of the following tests been done?

Test	Approx. Date	Where was the test done?	Results
X-Rays			
MRI			
CAT Scan			
Mylegram			
EMG			
Other			

Have you had any of these treatments previously?

	Helped A Lot	Helped A Little	No Effect	Made Worse	How often do you do this?
Chiropractic Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Electrical Stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list prescription or over-the-counter medications you routinely take:

Name of Medication	What is it for?	Dose and Frequency	When did you start?

Have you been hospitalized or had any surgery in the past 5 years? _____ If yes, briefly describe when and what for:

Do any of the following diseases run in your family? (Grandparents, parents, siblings, children)

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Stroke ☐ Depression

Circle all that you have had in the last 3 months:

Accidental bowel movements

Bloody or black stools

Constipation

Diarrhea

Problems with bowel movements

Accidental urination

Burning, foul smelling, cloudy, or bloody urine

Inability to urinate

Problems with urination

Urge to urinate more frequently than usual

Chest pain or tightness

Coughing or coughing up blood

Difficulty talking or swallowing

Fevers or chills

Nausea and/or vomiting

Shortness of breath

Stomach or belly pain

Depression

Frequent headaches

Loss of vision or double vision

Difficulty sleeping

If yes, how long does it take to fall asleep? _____

How many times a night do you awaken? _____

Problems with sexual function

Unexpected weight loss of more than 10 lbs.

Difficulty walking

Leg cramps when walking or at night

Loss of balance/falling

Numbness or tingling in arms, forearms, or hands

Numbness or tingling in thighs, legs, or feet

Poor coordination

Swelling in feet or ankles

Weakness in thighs, legs, or feet

If you are female:

Is there any chance you could be pregnant now?

Yes No

Are your symptoms worsened near your period?

Yes No

Any known allergies:-List all: _____

Demographic: preferred Language: _____ Race: _____

Ethnicity: circle one Hispanic/Latina or NOT Hispanic/Latino

Do you smoke? No Yes

NUSSBAUM CHIROPRACTIC L.L.C.

873 N Casaloma Dr

Appleton, WI 54913-8606

FUNCTIONAL RATING

NAME: _____ DATE: _____ Phone#: _____

In order to properly assess your condition we must understand how much your problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

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 Sleep Mildly Disturbed Sleep Moderately Disturbed Sleep Greatly Disturbed Sleep Totally Disturbed Sleep

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

0-----1-----2-----3-----4
No Pain; Mild Pain; Moderate Pain; Moderate Pain; Severe Pain
No Restrictions No Restrictions Need To Go Slowly Need Some Assistance Need 100% Assist

4. Travel (driving, etc.)

0-----1-----2-----3-----4
No Pain On Mild Pain On Moderate Pain On Moderate Pain On Severe Pain On
Long Trips Long Trips Long Trips short Trips Short Trips

5. Work

0-----1-----2-----3-----4
Can Do Usual Work Can do usual work Can Do 50% Can Do 25% Can Not Work
Plus Unlimited Extra Work No Extra Work Of Usual Work Of Usual 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 Can Not Do Any Activities

7. Frequency Of Pain

0-----1-----2-----3-----4
No Pain Occasional Pain Intermittent Pain Frequent Pain Constant Pain
25% Of The Day 50% Of The Day 75% Of The Day 100% Of The Day

8. Lifting

0-----1-----2-----3-----4
No Pain With Increased Pain With Increased Pain With Increased Pain With Increased Pain With
Heavy Weight Heavy Weight Moderate Weight Light Weight Any Weight

9. Walking

0-----1-----2-----3-----4
No Pain Increased Pain Increased Pain Increased Pain Increased Pain
Any Distance After 1 Mile After ½ Mile After ¼ Mile With All Walking

10. Standing

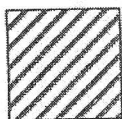
0-----1-----2-----3-----4
No Pain After Increased Pain Increased Pain Increased Pain Increased Pain
Several Hours After Several Hours After 1 Hour After ½ Hour With Any Standing

Score: _____

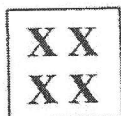
NUSSBAUM CHIROPRACTIC – PAIN DIAGRAM

NAME: _____ DATE: _____

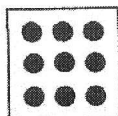
Please Draw where you feel your symptoms. Use the appropriate symbols.



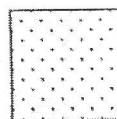
Aching Pain



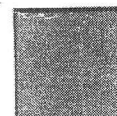
Stabbing Pain



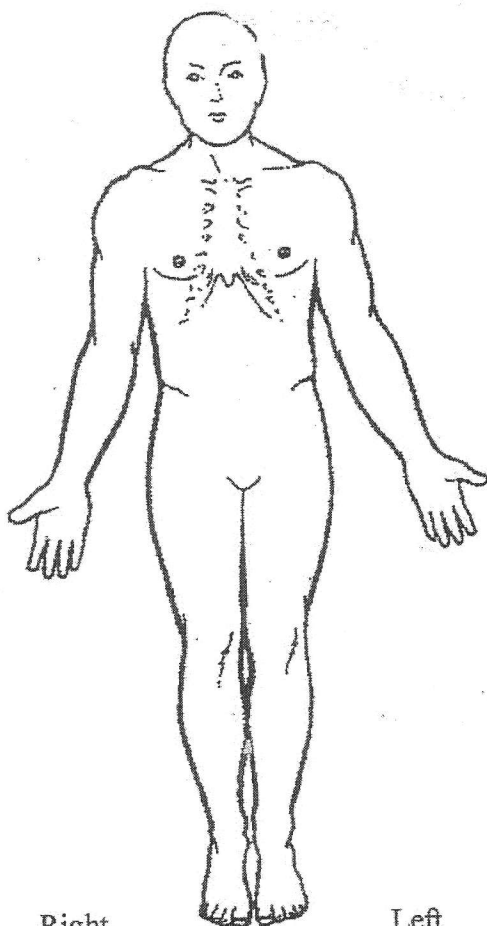
Burning Pain



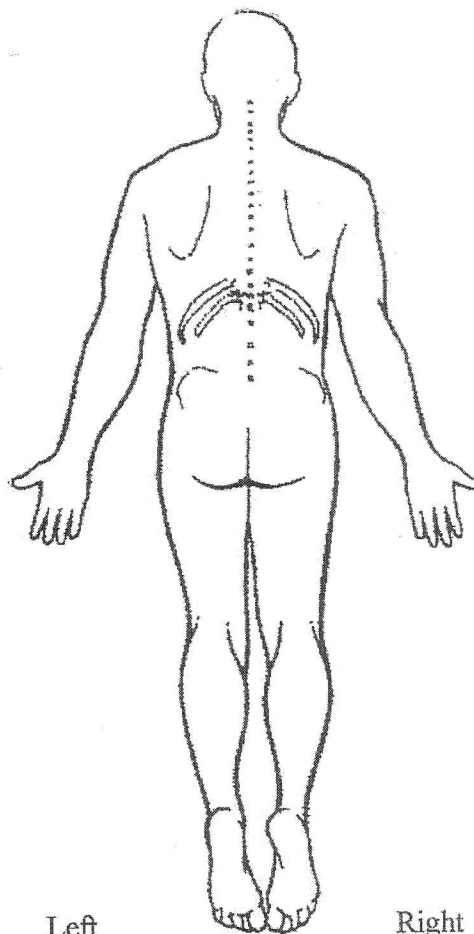
Pins & Needles



Complete Numbness



FRONT VIEW



BACK VIEW

Please circle the appropriate pain level that most accurately represents your pain with 0 being no pain and 10 being unbearable.

At Best: 0 1 2 3 4 5 6 7 8 9 10
 At Worst: 0 1 2 3 4 5 6 7 8 9 10

NUSSBAUM CHIROPRACTIC – CONSENT FORM

920-734-2400

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Doctor Patient
Initials

____ ____ I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms I can call the number listed above to speak with the doctor during normal business hours. If I am out of town or unable to contact the doctor, I can present myself to an emergency room or other health care facility.

____ ____ If any tests were performed outside of this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the results at my next scheduled appointment.

____ ____ I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic.

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

____ ____ I have read the above consent, with the doctor, as indicated by our initials. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

To be completed by the patient:

Print Patient's Name

Signature of Patient
(or parent/guardian)

Date Signed

Doctor's Signature

NUSSBAUM CHIROPRACTIC – FINANCIAL POLICY

The following is the financial policy adopted by our office. Please feel free to ask about any portion you do not understand.

Insurance Information: Your insurance policy is a contract between you and your insurance carrier. Our professional services are rendered to you not your insurance company. We will, as a courtesy to you, bill your insurance company for you. However, you will be responsible for all charges not paid/covered or refunded to your insurance company. If your insurance policy does not provide chiropractic coverage or you do not want to use your insurance policy, you will be required to pay by cash, check or debit/credit card at each visit. Supplies are not covered and will not be billed to your insurance company. Co-pays are to be paid same day as service. If you have a deductible, we will bill your insurance and wait for payment till we hear from them. We send out statements once a month and accept payment in full.

Cash Patients: We ask that cash patients pay in full at each visit.

Medicare Patients. We do accept assignment on Medicare claims. Medicare covers only a portion of the Chiropractic adjustment. They do not cover any exams, x-rays or any therapies in our office. If you have a secondary Medicare plan, usually Medicare will send those out for you.

Medicare Supplement Plans also cover the adjustment only, usually with a co-pay. Co-pays are to be paid at time of service.

Personal Injury/Auto Patients: We will work with your Auto insurance and attorneys, but please remember that you are responsible for your bill. We can't work with 3rd party insurance. We will bill your health insurance only after your Med Pay is exhausted.

Worker's Comp patients: We will bill your worker's comp carrier. Please make sure you report your injury at work. We will need you to get a billing address, claim number and phone number for your case as soon as you can. If your claim is denied, we will bill your health insurance, but remember you are responsible for your entire balance.

Nutritional Patients: Payments are to be paid in full same day as service. We do not bill your insurance.

Missed Appointments: We realize that everyone can forget an appointment once in awhile, which is why we will not charge you for your first missed appointment. However, to avoid this becoming a habit, you will be charged \$20.00 for your second missed appointment and for every one thereafter. We also require a 4 hour window if you need to cancel and reschedule. You will be charged \$20.00 if you cancel later than this.

Signature: _____ Date: _____

Print any underage Children's names: _____

Nussbaum Chiropractic LLC

873 N Casaloma Drive, Appleton WI 54913 phone#: 920-734-2400

HIPPA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your healthcare information. YOU have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

+protected health information may be disclosed or used for treatment, payment or healthcare operations

+the practice reserves the right to change the privacy policy as allowed by law.

+The practice has the right to revoke this consent in writing at any time and all full disclosures will then cease.

+the practice may condition receipt of treatment upon execution of this consent.

May we phone, email or sent a text to you to confirm appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes NO

If yes, please name the members allowed: _____

This Consent was signed by: Please print name: _____

Signature _____ date: _____

Witness: _____ date: _____