SPINAL REHABILITATION CENTER
HEAL SMARTER. LIVE BETTER.

Patient Intake Form

Date:	**First Name:**	**Last Name:**	**DOB:**	**Age:**
Sex: O M O F O Other		**Ethnicity:**	**Height:**	**Weight:**
Marital Status: OS OM OW OD OSep		**Spouse Name:**	**# Of Children:**	
Home #:		**Cell #:**		
Address:				
City:	**State:**	**Zip:**	**Email:**	
Emergency Contact:		**Emergency Relation:**	**Emergency #:**	

1. Describe your symptoms _____

_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

a. Constantly (76-100% of the day)
b. Frequently (51-75% of the day)
c. Occasionally (26-50% of the day)
d. Intermittently (0-25% of the day)

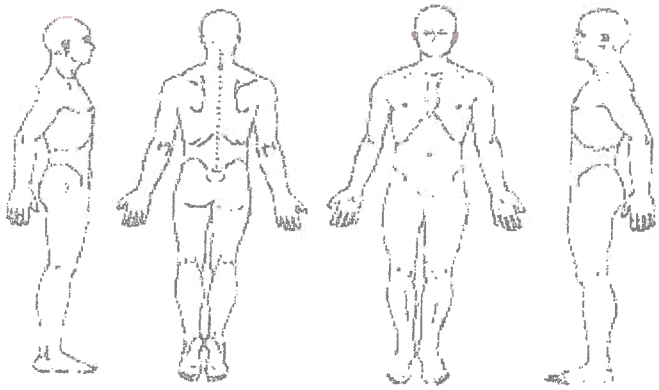
3. What describes the nature of your symptoms?

a. Sharp
b. Dull ache
c. Numb
d. Shooting
e. Burning
f. Tingling
g. _____

4. How are your symptoms changing?

a. Getting better
b. Not changing
c. Getting worse

Indicate where you have pain or other symptoms



5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much pain interfered with your normal work *(including both work outside the home and housework)*

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No one ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. What treatment did you receive and when? _____

b. What test have you had for your symptoms and when were they preformed?

① Xrays *date:*_____ ③ CT Scan *date:*_____
② MRI *date:*_____ ④ Other *date:*_____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① No one ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other _____

Continued ->

10. What is your occupation? _____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

What type of regular exercise do you preform? ① None ② Light ③ Moderate ④ Strenuous

For each of the conditions listed below, place a check in the Past column if you had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	
O	O	Headaches
O	O	Neck Pain
O	O	Upper Back Pain
O	O	Mid Back Pain
O	O	Low Back Pain
O	O	Shoulder Pain
O	O	Elbow/Upper Arm Pain
O	O	Wrist Pain
O	O	Hand Pain
O	O	Hip/Upper Leg Pain
O	O	Knee/Lower Leg Pain
O	O	Ankle/Foot Pain
O	O	Jaw Pain
O	O	Joint Swelling/Stiffness
O	O	Arthritis
O	O	Rheumatoid Arthritis
O	O	General Fatigue
O	O	Muscular Incoordination
O	O	Visual Disturbances

Past	Present	
O	O	Dizziness
O	O	High Blood Pressure
O	O	Heart Attack
O	O	Chest Pains
O	O	Stroke
O	O	Angina
O	O	Kidney Stones
O	O	Kidney Disorders
O	O	Bladder Infection
O	O	Painful Urination
O	O	Loss of Bladder Control
O	O	Prostate Problems
O	O	Abnormal Weight Gain/Loss
O	O	Loss of Appetite
O	O	Abdominal Pain
O	O	Ulcer
O	O	Hepatitis
O	O	Liver/Gallbladder Disorder

Past	Present	
O	O	Cancer
O	O	Tumor
O	O	Asthma
O	O	Chronic Sinusitis
O	O	Diabetes
O	O	Excessive Thirst
O	O	Frequent Urination
O	O	Smoking/Use Tobacco
O	O	Drug/Alcohol Use
O	O	Allergies
O	O	Depression
O	O	Systemic Lupus
O	O	Epeliepsy
O	O	Dermatitis/Eczema/Rash
O	O	HIV/AIDs
Females Only		
O	O	Birth Control Pills
O	O	Hormonal Replacement
O	O	Pregnancy

Indicate if an immediate family member has/had any of the following:

① Rheumatoid Arthritis ② Heart Problems ③ Diabetes ④ Cancer ⑤ Lupus ⑥_____

List all Prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

List all surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient Signature: _____ **Date:** _____

Doctor's Additional Comments: _____

_____

Doctor's 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 _____

SPINAL REHABILITATION
CENTER
HEAL SMARTER. LIVE BETTER.

800 Geneva Parkway North, Suite 102
Lake Geneva, WI 53147
262-248-4105

Spinal Rehabilitation Center of Lake Geneva Consent Form

The Nature of Chiropractic Examination and Treatment: The doctor will perform a physical examination. X-rays may be taken to evaluate your condition. The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop" similar to the noise produced when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction may also be used. Exercises may be recommended.

Benefits of chiropractic treatment: Many or most patients will feel improvement in motion, decreased muscle and joint pain and improved well-being after a series a chiropractic adjustments.

Possible Risks: As with any health care procedure, complications are possible following chiropractic treatment. Complications could conceivably include muscular strain, ligamentous sprain, dislocations of joints, fracture of bone, or injury to intervertebral discs, nerves, or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. X-rays produce ionizing radiation. There are reported cases of stroke associated with visits to medical doctors and chiropractors. The best quality scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, it indicates that patients may be consulting medical doctors and/or chiropractors for symptoms of headache and neck pain when they are in the early stages of a stroke. The possibility of such injuries occurring in association with chiropractic treatment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare" to "extremely rare".

Other treatment options which could be considered may include the following:

1. *Over-the-counter analgesics.* The risks of these medications include irritation to the stomach, liver, and kidneys, increased cardiovascular risk, and other side effects in a significant number of cases.
2. *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these prescription drugs include all side effects as above, plus patient dependence in a significant number of cases.
3. *Hospitalization* in conjunction with medical care adds additional risk of exposure to medical error, infection and other complications in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. This informed consent will remain in effect unless there are significant changes in my diagnosis. I have the right to withdraw my consent at any time, upon written notice. I have the right to refuse treatment at any time.

Printed Name _____ Signature _____ Date _____

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____

have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name: _____ **Date of Birth:** _____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Spinal Rehabilitation Center of Lake Geneva.

I understand that the Notice describes the uses and disclosures of my protected health information Spinal Rehabilitation Center of Lake Geneva and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement

SPINAL REHABILITATION
CENTER
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Spinal Rehabilitation Center of Lake Geneva
800 Geneva Parkway N, Ste102
Lake Geneva, WI 53147
(262) 248-4105
(262) 248-4127 fax

Patient Financial Responsibility Policy

Patients with Health Insurance:

This office will provide insurance processing and billing services for you, as a courtesy, however, any quote to us from your insurance company is not a guarantee of payment.

1. It is your responsibility to pay any deductible amount, co-insurance, co-pay or any other balances designated by your insurance carrier.
2. You can opt to pay for services using our Cash/Wellness fees rather than billing your health insurance. Payment is due at the time of service.

*Patients who **do not** have Health Insurance:*

Since we will not need to pay staff to bill and follow-up with insurance companies, we enjoy passing these savings on to you. Your services should be paid in full at each visit. A written copy of our fee schedule is available upon request.

We will strive to work out feasible payment options for anyone who is in need of care. Unless other prior written agreements have been made with our Billing Department, any outstanding balance after insurance has processed **or** a balance of more than 90 days old shall be considered "delinquent".

Our office will forward all "delinquent accounts" to United Credit Collection Agency, Elkhorn WI.

For the Patient:

- Remember that you are ultimately responsible for any charges incurred in this office.
- **Your signature** on this document indicates that you agree to pay for any outstanding charges incurred in this office.

Please review and sign:

I authorize payment of insurance benefits directly to Spinal Rehabilitation Center of Lake Geneva. I also authorize the Doctor(s) to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits or inform them of concurrent treatment.

By signing below I indicate that I have read, understand, and agree with the terms on this page.

_____

Signature of responsible party (Parent of Legal Guardian) Date

I ***Elect*** to: _____Bill my Health Insurance _____Cash/Wellness Patient

SPINAL REHABILITATION CENTER
HEAL SMARTER. LIVE BETTER.

Spinal Rehabilitation Center of Lake Geneva
800 Geneva Parkway N, Ste102
Lake Geneva, WI 53147
(262) 248-4105
(262) 248-4127 fax

Michael Krueger, D.C.
Margo Nolte, D.C.

TIME OF SERVICE CARE ESTIMATE

Services / Products	Time of Service Fee
Exam	$50
X-Ray	$100/View
Spinal Adjustment	$50
Extremity Adjustment	$20
Electrical Stimulation	$20
Spinal Decompression	$140
Low Level Laser	$85
Knee On Trac	$140
Matrix Therapy	$125
Exercise Rehabilitation (15 minutes)	$30
Soft Tissue (15 minutes)	$30
Taping (Per Body Area)	$10
Vibe Plate (15 minutes)	$10
Hormone Testing	$400 - $650
Food Sensitivity Testing	$150 - $500
Orthotics	$300
CBD Oil / Balm 1000mg	$70
Ice Pack	$20
E-Stim Replacement Pads	$5.00 / set

**Other services may be performed. If you have questions on these service charge(s) please inquire at front desk.

Patient Signature: _____ *Date:* _____

Witness: _____ *Date:* _____