

# PATIENT'S HEALTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ Patient ID# \_\_\_\_\_

If you have ever had a listed symptom in the *past*, please check that symptom in the *Past Column*. If you are presently troubled by a particular symptom, check that symptom in the *Present column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

<table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Past</th> <th style="text-align: left;">Present</th> <th style="text-align: left;">Condition</th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Neck Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Shoulder Pain (R_____ L_____)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pain in Upper Arm or Elbow (R_____ L_____)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hand Pain (R_____ L_____)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Wrist Pain (R_____ L_____)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Upper Back Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Low Back Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input 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<tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chronic Cough</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chronic Sinusitis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>General Fatigue</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Irregular Menstrual Flow</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Profuse Menstrual Flow</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Endometriosis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>PMS</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Loss of Bladder Control</td></tr> <tr><td><input 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If a family member has had any of the following, please mark the appropriate box:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Chronic Back Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic Headaches
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lupus
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> High Blood Pressure	

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a permanent disability rating?
		Location _____
<input type="checkbox"/>	<input type="checkbox"/>	Date rating received ____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Rating Percentage _____%

Present Weight \_\_\_\_\_ pounds      Height \_\_\_\_\_ feet \_\_\_\_\_ inches

**Please check any of the following that apply to you**

<table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Past</th> <th style="text-align: left;">Present</th> <th style="text-align: left;">Condition</th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pregnancy, # births _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Birth Control Pills, type _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Medications (list if not listed elsewhere)</td></tr> <tr><td>_____</td><td></td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hospitalizations/Surgical Procedures (list if not described elsewhere)</td></tr> <tr><td>_____</td><td></td><td>_____</td></tr> </table>	Past	Present	Condition	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, # births _____	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills, type _____	<input type="checkbox"/>	<input type="checkbox"/>	Medications (list if not listed elsewhere)	_____		_____	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations/Surgical Procedures (list if not described elsewhere)	_____		_____	<table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Past</th> <th style="text-align: left;">Present</th> <th style="text-align: left;">Condition</th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tobacco</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Alcohol</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Drug or Alcohol Dependence</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Coffee/Tea/Caffeinated Soft drinks:</td></tr> <tr><td></td><td></td><td>cups/cans per day _____</td></tr> </table>	Past	Present	Condition	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence	<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffeinated Soft drinks:			cups/cans per day _____
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I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PATIENT'S PRESENT COMPLAINTS

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone \_\_\_\_\_ Social Security# \_\_\_\_\_ Driver Lic.# \_\_\_\_\_  
 Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M / F Status M S W D No. Children \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Years Employed \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_  
 Person Responsible for this Account \_\_\_\_\_ Health Plan \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider understand your health condition.

Please describe your problem and how it began. Date problem began: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How bad is your pain? (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain

How often are your symptoms present?  
 Constantly     Frequently     Occasionally     Intermittently

Describe your current pain/symptoms:  
 Sharp/Stabbing     Throbbing     Aches  
 Dull     Soreness     Weakness  
 Numbness     Shooting     Gripping  
 Burning     Tingling     Other \_\_\_\_\_

Since it began, is your problem:  
 Improving     Getting Worse     No Change

What makes the problem better?  
 Nothing     Lying Down     Walking  
 Standing     Sitting     Movement  
 Exercise     Inactivity/rest     Other \_\_\_\_\_

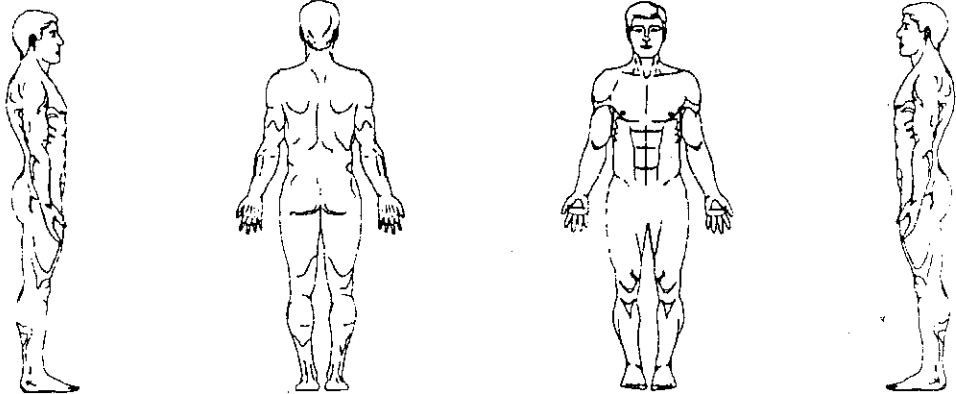
What makes the problem worse?  
 Nothing     Lying Down     Walking  
 Standing     Sitting     Movement  
 Exercise     Inactivity/rest     Other \_\_\_\_\_

Can you perform your daily home activities?  
 Yes     Yes, only with help     Not at all  
 Do you exercise?  
 Yes, almost daily     Yes, occasionally     Not at all  
 Describe your job requirements:  
 Mainly sitting     Light Labor     Heavy Labor  
 Can you perform your daily work activities?  
 Yes, all activities     Only some     Not at all  
 Describe your stress level:  
 None to mild     Moderate     High

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you had X-rays, MRI or other tests for this condition? What tests and When? \_\_\_\_\_

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# WORKERS' COMPENSATION HISTORY

Patient \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ S/S # \_\_\_\_\_  
Name of Compensation Carrier: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address of Carrier: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

1. Type of Business \_\_\_\_\_ Your Occupation \_\_\_\_\_
2. Date Injured \_\_\_\_\_ Hour \_\_\_\_\_ AM/PM Last Date Worked \_\_\_\_\_ Are you off work?  Yes  No
3. Previous Workers' Compensation Injury?  Yes  No
4. Accident reported to employer?  Yes  No Name of person reported accident to \_\_\_\_\_
5. Injured at: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
6. Length of time worked there prior to accident: \_\_\_\_\_
7. Type of work being done at time of injury: \_\_\_\_\_  
\_\_\_\_\_
8. In your own words, please describe accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Have you been treated by another doctor for this accident?  Yes  No  
If yes, please list doctor's name and address: \_\_\_\_\_  
\_\_\_\_\_  
What type of treatment did you receive? \_\_\_\_\_  
How long were you treated by this doctor? \_\_\_\_\_
10. Are you:  improved  unchanged  getting worse
11. What types of medicines are you taking? \_\_\_\_\_
12. Have you had physical therapy?  Yes  No If yes, how often? \_\_\_\_\_  
Does the physical therapy help?  Yes  No  Don't know
13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?  
 Yes  No  Don't know  
If yes, describe: \_\_\_\_\_  
\_\_\_\_\_
- Were these similar complaints the result of a previous accident(s)?  Yes  No
14. Have you had any other serious accidents which required medical care?  Yes  No  
Describe: \_\_\_\_\_
15. Have you had any serious illnesses that required hospitalization?  Yes  No  
Describe: \_\_\_\_\_
16. Have you had any surgeries?  Yes  No If yes, list type of surgeries and dates: \_\_\_\_\_  
\_\_\_\_\_
17. Have you had any nervous or mental illness?  Yes  No If yes, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SEE OVER

18. Have you received a medical discharge from the Armed Forces?  Yes  No

19. Have you returned to work since this accident?  Yes  No If yes, Date \_\_\_\_\_

Light duty  Regular duty  Full time  Part time

**CURRENT COMPLAINTS**

Currently, I have pain in my  low back  mid back  upper back  neck

My pain began  gradually  suddenly

I have pain  sometimes  all of the time

My pain goes into my  right leg  left leg  both  right arm  left arm

I have tingling and/or numbness in my  right leg  left leg  both  right arm  left arm

My pain is worse when I  cough or sneeze  sit  bend  walk  lift  push  pull

My pain wakes me up during the night  Yes  No

Changes in the weather affect my pain  Yes  No

I have neck stiffness  Yes  No

I have headaches  Yes  No

My pain is worse when I turn my head  Yes  No

**JOB DESCRIPTION:**

In a typical 8-hour workday, I Sit \_\_\_\_\_ hours Stand \_\_\_\_\_ hours Walk \_\_\_\_\_ hours

On the job, I perform the following activities:  Twist  Bend/Stoop  Squat  Kneel  Crawl

Crouch  Climb  Push  Pull  Balancing  Reach above shoulder level

On the job, I lift up to \_\_\_\_\_ pounds  Frequently  Occasionally  Continuously

Do you have to bend over while doing any lifting?  Yes  No

Are your feet used for repetitive movements, such as in operating foot controls?  Yes  No

Do you use your hand for repetitive actions?  Yes  No

Are you exposed to dust, fumes and/or gases?  Yes  No

Describe: \_\_\_\_\_

Briefly explain your job description: \_\_\_\_\_

**OTHER PAIN:**

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

SIGNATURE OF PATIENT

**PATIENT HISTORY**

Name: \_\_\_\_\_ Referred By: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ # of Children: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Social Security #: \_\_\_\_\_ California Driver's License # \_\_\_\_\_  
Email address: \_\_\_\_\_ (YOUR EMAIL ADDRESS WILL NOT BE SHARED WITH ANYONE.)

**PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential):**

**MAJOR COMPLAINT**

How long have you had this condition? \_\_\_\_\_  
Have you lost work days because of this condition? Yes ( ) No ( ) How many? \_\_\_\_\_  
Is the injury related to: Work accident ( ) Auto accident ( )  
When have you last seen a chiropractor? \_\_\_\_\_ Dr.: \_\_\_\_\_  
Why did you see this chiropractor? \_\_\_\_\_ Were you helped? \_\_\_\_\_  
What spinal maintenance programs were you given to follow to maximize the future stability of your spine?  
\_\_\_\_\_

Did you follow the program? \_\_\_\_\_ If not, why? \_\_\_\_\_

Why are you changing chiropractors? \_\_\_\_\_

WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy?) \_\_\_\_\_

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM? \_\_\_\_\_

\_\_\_\_\_ Temporary Relief (Help the symptom but do not fix the cause of the problem)

\_\_\_\_\_ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US?  
\_\_\_\_\_

What are your favorite activities or hobbies to do now? \_\_\_\_\_

Are your current problems affecting these activities or hobbies? \_\_\_\_\_

What activities are you looking forward to doing in retirement? \_\_\_\_\_

On a scale of 1 – 10 (10 being the most, and 1 being the least):

\_\_\_ How committed are you to being at your maximum health potential?

\_\_\_ How important is it for your family to be at their maximum health potential?

\_\_\_ How committed are you to preventing arthritis and maximizing your spinal stability?

What surgeries have you had? \_\_\_\_\_

List drugs or supplements you now take (prescription & non prescription): \_\_\_\_\_

Name other doctors you have seen for this condition: What was done, and for how long? \_\_\_\_\_

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

## INFORMED CONSENT

It is our responsibility to fully inform you of your treatment. Part of this includes a discussion of any potential side effects or complications. All treatments potentially can cause these reactions, and chiropractic manipulation is no different. It, however, has one of the safest records of the wide range of treatments that can be used for spinal disorders. Please feel free to ask the Doctor if you need any clarification.

Possible adverse effects of spinal manipulation can include soreness in the area of treatment, reactive muscle spasm, injury to the disc causing pressure on nerve tissue, fractures in weakened bones such as ribs, and injury to arteries in the neck resulting in stroke. Soreness or reactive muscle spasm or tightening are common but usually brief reactions to treatment. The other potential complications are rare. It is best to examine the frequency of these potential complications versus the relative frequency of the complications of the other typical treatments which may be used for a spinal disorder.

**DISC INJURY from manipulation causing spinal cord pressure**  
**1 per 100 million cases**  
**1 per 400 million (cmt)**

**ARTERY INJURY from manipulation causing stroke**  
**1 per 1 million**

**NEUROLOGICAL complication from**  
**Neck Surgery            1 per 64 (cases)**  
**Back Surgery            1 per 333 (cases)**

**DEATH RATE from neck surgery**  
**1 per 145**

Perhaps the most common alternative to spinal manipulation is the use of anti-inflammatory drugs or NSAIDs. These drugs cause fairly common and can also potentially cause serious complications.

<b>COMPLICATIONS ASSOCIATED WITH ANTI-INFLAMMATORY DRUG USE</b>	
Serious stomach or intestinal bleeding	1-4 per 100 users
Hospitalizations from complications	20,000 per year
Deaths from complications	2,600 per year

I have read the above and understand the risk of complication that may occur from spinal manipulation. With this understanding, I consent to treatment with spinal manipulation by Eric Belusa, DC or any DC at Performance Chiropractic.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you are entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the State's Office of Benefit Assistance and Enforcement at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

### EMPLOYEE:

1.	Name _____	Today's Date _____
2.	Home Address _____	
3.	City _____	State _____ Zip _____
4.	Date of Injury _____	Time of Injury _____ a.m. _____ p.m.
5.	Address/Place where injury happened _____	
6.	Describe injury and part of body affected _____ _____	
7.	Signature of employee _____	

**EMPLOYER: COMPLETE THIS SECTION AND GIVE THE EMPLOYEE A COPY IMMEDIATELY AS A RECEIPT.**

8.	Name and address of employer _____ _____	
9.	Date employer first knew of injury _____	
10.	Date claim form was provided to employee _____	
11.	Date employer received claim form _____	
12.	Name and address of insurance carrier or adjusting agency _____ _____	
13.	Signature of Employer Representative _____	
14.	Title _____	15. Telephone _____

EMPLOYER: You are required to date this form and provide copies to your insurer and to the employee, dependent or representative who filed the claim within one working day of receipt of completed form from employee.

**SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY**

STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS  
**WORKERS' COMPENSATION APPEALS BOARD**

**NOTICE AND REQUEST FOR ALLOWANCE OF LIEN**

ID OR CASE NO. \_\_\_\_\_

*(Print or type names and addresses; include ZIP Codes)*

Injured Worker	Address	
Date of Claimed Injury	Social Security Number	Date of Birth
Attorney for Injured Worker	Address	
Employer	Address	
Insurance Carrier or, if Self-Insured, Certificate Name	Address Where Claim Administered	
Adjusting Agency, if Agency Administered		
Attorney for Employer/Carrier	Address	
Lien Claimant	Address & Telephone No.:	
Attorney for Lien Claimant	Address & Telephone No.:	

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of \_\_\_\_\_ Dollars (\$\_\_\_\_\_) against any amount now due or which may hereafter become payable as compensation to the above named worker on account of the above claimed injury.

This request and claim for lien is for (Mark appropriate box):

- The reasonable expense incurred by or on behalf of said worker for medical treatment to cure or relieve from the effects of said injury; or
- The reasonable medical expense incurred to prove a contested claim; or
- The reasonable value of living expenses of said worker or of his or her dependents, subsequent to the injury, or
- The reasonable living expenses of the spouse or minor children, or both, of said worker, subsequent to the date of injury, where such worker has deserted or is neglecting his or her family; or
- The reasonable fee for interpreter's services performed on \_\_\_\_\_, 19\_\_\_\_
- 

**NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED**

FOR INJURIES OCCURRING ON OR AFTER JANUARY 1, 1990, FOR WHICH THE LIEN CLAIMANT DOES NOT HAVE A WCAB IDENTIFICATION NUMBER, the lien claimant declares under penalty of perjury that:

- a copy of the original completed Employee's Claim for Workers' Compensation Benefits (DWC Form 1) is attached, or
- the lien claimant does not have a copy of the claim form, but made the following efforts to secure one:

A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

Signature of Attorney for Lien Claimant	Signature of Lien Claimant	Date
---	----------------------------	------

**EMPLOYEE'S CONSENT TO ALLOWANCE TO LIEN**

I consent to the requested allowance of a lien against my compensation.

Signature of Attorney for Injured Worker	Signature of Injured Worker
--	-----------------------------

Performance Chiropractic & Rehabilitation Center  
Dr. Eric R. Belusa

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Insurance Company)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip)

Re: Employee:  
Employer:  
Date / Injury:  
Claim No#:

Attention: \_\_\_\_\_  
(Claim Adjuster)

**Request Change Of Physician**

Dear \_\_\_\_\_

In accordance with Labor Code Section 4601 (a), I am requesting a change of physician for treatment of my work injury. Specifically, I wish to be treated by my chiropractor,

Eric R. Belusa D.C.  
4425 Treat Blvd. #B  
Concord, Ca 94521  
925-687-5515 Voice  
925-687-5588 Fax

Please provide me with the name of an alternative physician (chiropractor), or, allow me to be treated by Dr. Belusa.

Respectfully,

\_\_\_\_\_  
Employee

\_\_\_\_\_  
Date

## PERFORMANCE CHIROPRACTIC CENTER NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Performance Chiropractic Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### **Disclosure of Your Health Care Information**

#### **Treatment**

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

*"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Performance Chiropractic Center."*

*"It is our policy to provide a substitute health care provider, authorized by Performance Chiropractic Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

#### **Payment**

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

*"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Performance Chiropractic Center for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

#### **Workers' Compensation**

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

#### **Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

#### **Public Health**

office at 925-687-5515 If Eric Belusa, D.C. is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

This notice is effective as of \_\_\_\_/\_\_\_\_/\_\_\_\_

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Performance Chiropractic Center with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date

**If you would like the complete document (4 pages), please ask the front desk. Thank you.**

**REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE**

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><i>SECTION 1 - Pain Intensity</i></p> <p>A The pain comes and goes and is very mild.          B The pain is mild and does not vary much.          C The pain comes and goes and is moderate.          D The pain is moderate and does not vary much.          E The pain comes and goes and is severe.          F The pain is severe and does not vary much.</p>	<p><i>SECTION 6 - Standing</i></p> <p>A I can stand as long as I want without pain.          B I have some pain while standing, but it does not increase with time.          C I cannot stand for longer than one hour without increasing pain.          D I cannot stand for longer than 1/2 hour without increasing pain.          E I cannot stand for longer than ten minutes without increasing pain.          F I avoid standing, because it increases the pain straight away.</p>
<p><i>SECTION 2 - Personal Care</i></p> <p>A I would not have to change my way of washing or dressing in order to avoid pain.          B I do not normally change my way of washing or dressing even though it causes some pain.          C Washing and dressing increases the pain, but I manage not to change my way of doing it.          D Washing and dressing increases the pain and I find it necessary to change my way of doing it.          E Because of the pain, I am unable to do some washing and dressing without help.          F Because of the pain, I am unable to do any washing or dressing without help.</p>	<p><i>SECTION 7 - Sleeping</i></p> <p>A I get no pain in bed.          B I get pain in bed, but it does not prevent me from sleeping well.          C Because of pain, my normal night's sleep is reduced by less than one quarter.          D Because of pain, my normal night's sleep is reduced by less than one-half.          E Because of pain, my normal night's sleep is reduced by less than three-quarters.          F Pain prevents me from sleeping at all.</p>
<p><i>SECTION 3 - Lifting</i></p> <p>A I can lift heavy weights without extra pain.          B I can lift heavy weights, but it causes extra pain.          C Pain prevents me from lifting heavy weights off the floor.          D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.          E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.          F I can only lift very light weights, at the most.</p>	<p><i>SECTION 8 - Social Life</i></p> <p>A My social life is normal and gives me no pain.          B My social life is normal, but increases the degree of my pain.          C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.          D Pain has restricted my social life and I do not go out very often.          E Pain has restricted my social life to my home.          F I have hardly any social life because of the pain.</p>
<p><i>SECTION 4 - Walking</i></p> <p>A Pain does not prevent me from walking any distance.          B Pain prevents me from walking more than one mile.          C Pain prevents me from walking more than 1/2 mile.          D Pain prevents me from walking more than 1/4 mile.          E I can only walk while using a cane or on crutches.          F I am in bed most of the time and have to crawl to the toilet.</p>	<p><i>SECTION 9 - Traveling</i></p> <p>A I get no pain while traveling.          B I get some pain while traveling, but none of my usual forms of travel make it any worse.          C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.          D I get extra pain while traveling which compels me to seek alternative forms of travel.          E Pain restricts all forms of travel.          F Pain prevents all forms of travel except that done lying down.</p>
<p><i>SECTION 5 - Sitting</i></p> <p>A I can sit in any chair as long as I like without pain.          B I can only sit in my favorite chair as long as I like.          C Pain prevents me from sitting more than one hour.          D Pain prevents me from sitting more than 1/2 hour.          E Pain prevents me from sitting more than ten minutes.          F Pain prevents me from sitting at all.</p>	<p><i>SECTION 10 - Changing Degree of Pain</i></p> <p>A My pain is rapidly getting better.          B My pain fluctuates, but overall is definitely getting better.          C My pain seems to be getting better, but improvement is slow at present.          D My pain is neither getting better nor worse.          E My pain is gradually worsening.          F My pain is rapidly worsening.</p>

COMMENTS: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ SCORE: \_\_\_\_\_

## NECK PAIN DISABILITY INDEX QUESTIONNAIRE

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><i>SECTION 1 - Pain Intensity</i></p> <p>A I have no pain at the moment.            B The pain is very mild at the moment.            C The pain is moderate at the moment.            D The pain is fairly severe at the moment.            E The pain is very severe at the moment.            F The pain is the worst imaginable at the moment.</p>	<p><i>SECTION 6 - Concentration</i></p> <p>A I can concentrate fully when I want to with no difficulty.            B I can concentrate fully when I want to with slight difficulty.            C I have a fair degree of difficulty in concentrating when I want to.            D I have a lot of difficulty in concentrating when I want to.            E I have a great deal of difficulty in concentrating when I want to.            F I cannot concentrate at all.</p>
<p><i>SECTION 2 - Personal Care (Washing, Dressing, etc.)</i></p> <p>A I can look after myself normally without causing extra pain.            B I can look after myself normally, but it causes extra pain.            C It is painful to look after myself and I am slow and careful.            D I need some help, but manage most of my personal care.            E I need help every day in most aspects of self care.            F I do not get dressed, I wash with difficulty and stay in bed</p>	<p><i>SECTION 7 - Work</i></p> <p>A I can do as much work as I want to.            B I can only do my usual work, but no more.            C I can do most of my usual work, but no more.            D I cannot do my usual work.            E I can hardly do any work at all.            F I cannot do any work at all.</p>
<p><i>SECTION 3 - Lifting</i></p> <p>A I can lift heavy weights without extra pain.            B I can lift heavy weights, but it gives extra pain.            C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.            D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.            E I can lift very light weights.            F I cannot lift or carry anything at all.</p>	<p><i>SECTION 8 - Driving</i></p> <p>A I can drive my car without any neck pain.            B I can drive my car as long as I want with slight pain in my neck.            C I can drive my car as long as I want with moderate pain in my neck.            D I cannot drive my car as long as I want because of moderate pain in my neck.            E I can hardly drive at all because of severe pain in my neck.            F I cannot drive my car at all.</p>
<p><i>SECTION 4 - Reading</i></p> <p>A I can read as much as I want to with no pain in my neck.            B I can read as much as I want to with slight pain in my neck.            C I can read as much as I want to with moderate pain in my neck.            D I cannot read as much as I want because of moderate pain in my neck.            E I cannot read as much as I want because of severe pain in my neck.            F I cannot read at all.</p>	<p><i>SECTION 9 - Sleeping</i></p> <p>A I have no trouble sleeping.            B My sleep is slightly disturbed (less than 1 hour sleepless).            C My sleep is mildly disturbed (1-2 hours sleepless).            D My sleep is moderately disturbed (2-3 hours sleepless).            E My sleep is greatly disturbed (3-5 hours sleepless).            F My sleep is completely disturbed (5-7 hours)</p>
<p><i>SECTION 5 - Headaches</i></p> <p>A I have no headaches at all.            B I have slight headaches which come infrequently.            C I have moderate headaches which come infrequently.            D I have moderate headaches which come frequently.            E I have severe headaches which come frequently.            F I have headaches almost all the time.</p>	<p><i>SECTION 10 - Recreation</i></p> <p>A I am able to engage in all of my recreational activities with no neck pain at all.            B I am able to engage in all of my recreational activities with some pain in my neck.            C I am able to engage in most, but not all of my recreational activities because of pain in my neck.            D I am able to engage in a few of my recreational activities because of pain in my neck.            E I can hardly do any recreational activities because of pain in my neck.            F I cannot do any recreational activities at all.</p>

COMMENTS: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_ Score \_\_\_\_\_

## Disclosure of Fees/ Payment Policy

99201	Brief Initial History and Consultation	60.00
99202	Brief Initial History and Exam	75.00
99203	Intermediate Initial History and Exam	100.00
99204	Comprehensive History and Exam	140.00
99211	Min. Office Visit/ Re-evaluation (not needing doctors presence)	35.00
99212	Brief Office Visit/ Re-evaluation	45.00
99213	Limited Office Visit/ Re-evaluation	55.00
99214	Intermediate Office Visit/ Re-evaluation	80.00
97026	Infrared Hot/ Cold	35.00
97035	Ultrasound/ Iontophoresis 15 minutes or less	45.00
97032	Muscular Stimulation 15 minutes or less	55.00
97124	Vibromassage	15.00
97124	Massage Therapy 15 minutes or less	30.00
97250	Myofascial Release 15 minutes	50.00
99012	Mechanical Traction	30.00
98940	Manipulation 1-2 Areas	60.00
98941	Manipulation 3-4 Areas	75.00
98943	Extra Spinal Manipulation	60.00
98940-52	Office Visit/ Manipulation	55.00
98940-52	Family Wellness Plan	
98940	Medicare Spinal Manipulation 1-2 Areas	29.48
98941	Medicare Spinal Manipulation 3-4 Areas	41.12
98942	Medicare Spinal Manipulation 5 Regions	52.82
72040	X-rays Cervical 2 Views	90.00
72050	X-rays Cervical 5 Views	130.00
72100	X-rays Lumbar 2 Views	100.00
72070	X-rays Thoracic 2 Views	100.00
99070	Brace and Supports	Varies
	Supplements	Varies

I have read the above codes and fees and understand and know the cost of my care with my treating doctor. I understand that I am responsible for payment of all deductibles and co-payments of my care. I further understand that it is my responsibility to know my own insurance benefits and that Performance Chiropractic is not responsible for any discrepancy between what my coverage is and what was reported to us. I understand that if I have a balance for medical services not paid, I will make a minimum payment of \$50.00 each month or 20% (auto debit) of the outstanding balance whichever is greater. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collection, court and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of the case. I understand that if a check or debit is returned for insufficient funds, I will be charged a \$25.00 service charge.

**I have read and fully understand the above financial terms and prices.**

Signed \_\_\_\_\_ Date \_\_\_\_\_.