10

Chiropractic Visit Notes

Google _____
UB Ex. _____
LB Ex. _____

Patient Name:_____ Date of First Visit:_____

Letter Codes(all therapies are performed for 10 minutes unless otherwise notated) (All C, T, L codes specify a Subluxation found in that area)

1. C - Cervical Spine
2. T - Thoracic Spine
3. L - Lumbar Spine
4. S - Sacral Spine
5. P - Pelvic
6. PP - Posture Pump
7. Mas - Massage
8. Mod- Modality
9. TP - Trigger Point
10. Ext - Extremity
11. NP - New Patient Exam
12. RP Rephysical Exam
13. Edu - Patient Education
14. Con - Initial Consultation
15. TEX – Therapeutic.Ex.
16. XC - X-ray Cervical Read
17. XL - X-ray Lumbar Read
18. Cox – Flexion/Distraction
19. PNF – Stretching
20. ADL – Acitivities Daily Living
21. QL – Quadratus Lumborum
22. Tub – Kinetic Activities
23. Pac – Hot or Cold Pack
24. IN - Instrumentation
25.. NE – Neuromuscular ReEd
26. Trac - Traction

#	Date	Services	Notes	Overall (Better,Worse Same)	Patient Signature	Patient Responded Well
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

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MM / PI / WC

Patient Information

Welcome to our practice! Please complete all questions. Thank you.

Name:		Date: / /
Address:		Home Phone:
City, State:	Zip:	Cell Phone:
Birth Date: / /	Age:	Sex: M F | Social Security # :
Marital Status: Married Widowed Divorced Single	Spouses Name:	Spouses Insurance:
Children's Name & Ages:	Email Address:	
Favorite Hobbies or Interests:		
Employed By:	Occupation:	
Work Address:	Work Phone:	
Who may we thank for referring you?		
Who is financially responsible for this bill?		
Method of Payment: (Check One) ❺ Cash ❺ Check ❺ Credit Card ❺ Insurance		
Health Insurance:	Policy Number:	Name policy is under:

Current Health Condition

What is your main health complaint?	
Other doctors seen for this condition? Yes No	Who?
Type of treatment:	Results:
When did this condition begin?	Has this condition occurred before? Yes No
Is condition: Job Related Auto Accident Fall Home Injury Other:	
Date of accident:	Time of accident:
Have you filed a report of your accident to your employer? Yes No	
Are you currently taking any drugs? Yes No	Drug Names:
Do you suffer from any condition other than which you are now consulting us? Yes No	
If yes, please explain:	

Past Health History

Have you had any major surgery or operations? Yes No	If yes, please list:
Major accidents or falls:	
Hospitalization:	
Previous Chiropractic Care: Yes No	Name of doctor:

X-Ray Consent

I hereby authorize x-ray/x-rays to be performed on myself on this date and to my knowledge, I am not pregnant. **Signature: _____**

I certify that the above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

Past Health Check List

Patient Name: _____ **Startup Date: _____**

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

❺ Pneumonia	❺ Mumps	❺ Influenza	❺ Epilepsy
❺ Rheumatic Fever	❺ Polio	❺ Tuberculosis	❺ Whooping Cough
❺ Anemia	❺ Measles	❺ Smallpox	❺ Chicken Pox
❺ Diabetes	❺ Cancer	❺ Heart Disease	❺ Thyroid
❺ Pleurisy	❺ Arthritis	❺ Epilepsy	❺ Mental Disorders
❺ Lumbago	❺ Eczema	❺ Colitis	❺ Other:_____

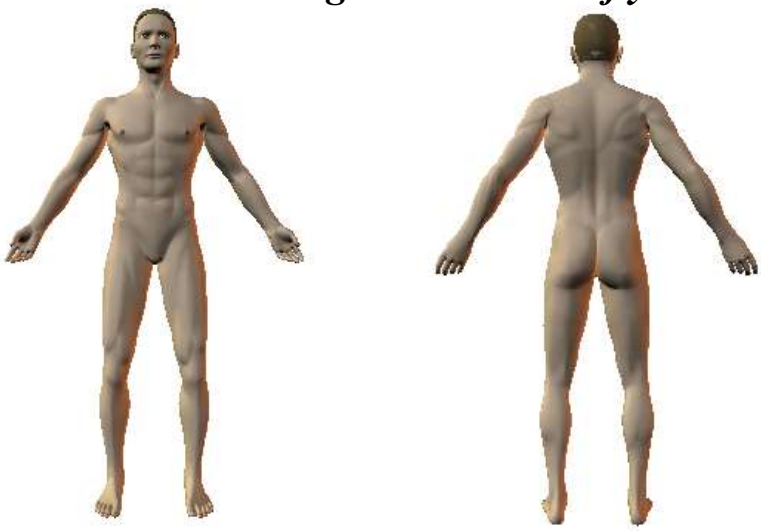
CHECK ANY OF THE FOLLOWING PROBLEMS/COMPLAINTS YOU HAVE NOW:

❺ Low Back Pain	❺ Pain Between Shoulders	❺ Neck Pain	❺Arm Pain
❺ Joint Pain/Stiffness	❺ Walking Problems	❺ Difficulty Chewing	❺General Stiffness
❺ Gas/Bloating After Meals	❺ Heartburn	❺ Black/Bloody Stools	❺ Bladder Trouble
❺ Painful/ Excessive Urination	❺ Discolored Urine	❺ Chest Pain	❺ Short Breath
❺ Irregular Blood Pressure	❺Irregular Heartbeat	❺ Lung Congestion	❺Varicose Veins
❺ Ankle Swelling	❺Stroke	❺ Fatigue	❺ Allergies
❺ Loss of Sleep	❺ Fever	❺ Headaches	❺ Sore Throat
❺ Earaches	❺ Hearing Difficulty	❺ Excessive Appetite	❺ Poor Appetite
❺ Nausea	❺ Excessive Thirst	❺ Vomiting	❺ Diarrhea
❺ Constipation	❺ Hemorrhoids	❺ Liver Problems	❺ Gall Bladder
❺ Weight Trouble	❺ Abdominal Cramps	❺Menstrual Irregularity	❺Menstrual Cramps
❺ Vaginal Pain	❺ Vaginal Infection	❺Breast Pain	❺Breast Lumps
❺ Prostate Problems	❺ Other:_____		

THE FOLLOWING MEMBERS OF MY FAMILY HAVE/HAD THE SAME OR SIMILAR PROBLEMS AS I DO:

❺Mother ❺Father ❺Brother ❺Sister ❺Spouse ❺Other_____

Please outline on the diagram the area of your discomfort.



Patient Policies

Welcome to Dr. Finkelstein's office.

The doctor's goal is to serve you with exceptionally friendly and prompt service, and to provide the best <u>family health care</u> available!

<u>Understanding Chiropractic</u> ***Initial*** _____

Chiropractic has only one goal: to eliminate misalignments within the spinal column which can cause decreased range of motion, pain and many other ailments. Dr. Finkelstein does **not** offer to **diagnose or treat** any disease or condition that is not in the realm of Chiropractic. **No promises** are made as to the outcome of your care in any form.

<u>Appointment Scheduling/Missed Appointments</u> ***Initial*** _____

Dr. Finkelstein has designed a specific course of action to allow for proper care, a must for spinal and postural correction. A personal appointment calendar has been designed for you to save time on each visit. If an appointment must be changed, you **<u>MUST</u>** give at least **<u>24 hours</u>** notice. The doctor bases his scheduling on appointments previously made for all of his patients. If appointments are repeatedly missed, regretfully, the doctor will **<u>dismiss</u>** you from his care and appoint you to another chiropractor.

<u>Terminating Your Care</u> ***Initial*** _____

In the event you choose to discontinue your care for any reason, or Dr. Finkelstein finds it necessary to discharge you from his care, **<u>any outstanding fees become immediately due and payable.</u>**

<u>Insurance Coverage</u> ***Initial*** _____

Dr. Finkelstein does not base your adjustment program on your insurance coverage and neither should you. Dr. Finkelstein's goal is to correct your problem in the shortest amount of time and in the most cost effective manner. There are limits to what the insurance company will pay. It is not uncommon for the insurance coverage to stop in the middle of your adjustment program. However, if you discontinue your adjustments you will be walking out of our office with the same problem with which you walked into the office. For this reason, Dr. Finkelstein is committed to work around any financial problems as long as **<u>YOU</u>** have the commitment to complete the program and achieve maximum health potential.

If a financial problem arises, please make this problem known to Dr. Finkelstein immediately. A payment plan will be worked out that will accommodate you. **<u>DO NOT</u>** interrupt the consistency and intensity of your adjustment schedule or you will lose the correction that you have already achieved. This would result in a loss of time, money and effort.

REMEMBER,

Dr. Finkelstein has never turned away anyone because of his or her financial situation. But, he has turned away people for not making their health a **<u>PRIORITY!</u>**

I give permission for Dr. Finkelstein to email me with any office news or monthly news letters. ***Initial*** _____

I have read and understand the above policies and agree to abide by them.

_____ _____

Date **Patient Signature**

MM / PI / WC

Patient Exam

Patient Name: _____ **Age:**_____ **Height:**_____ **Weight:**_____ **D.O.B.:**_____

O:
P: makes worse makes better
Q:
R:
S:
T:

Previous Chiropractic Care:_____ Accidents, Falls:_____
Surgery:_____ Medication:_____
Other Health Problems:_____ Family Illness:_____

Muscle Spasm: Suboccipital, SCM, Trapezius, Paracervicle, Paradorsal, Rhomboid, Latisimus Dorsi, Paralumbar
Tenderness:_____

DATE OF EXAM 1:_____ **DATE OF EXAM 2:**_____ **DATE OF EXAM 3:**_____

Posture	1	R	L	2	R	L	3	R	L
Ears	E			E			E		
Shoulders	E			E			E		
Hips	E			E			E		

Cerebellar Tests			
Romberg	+ -	+ -	+ -
Finger to Finger	+ -	+ -	+ -
Finger to Nose	+ -	+ -	+ -

RANGE OF MOTION	**CERVICAL**	**LUMBAR**	**CERVICAL**	**LUMBAR**	**CERVICAL**	**LUMBAR**
FLEXION	(50)	(60)	(50)	(60)	(50)	(60)
EXTENSION	(60)	(25)	(60)	(25)	(60)	(25)
LEFT LATERAL FLEX	(45)	(25)	(45)	(25)	(45)	(25)
RIGHT LATERAL FLEX	(45)	(25)	(45)	(25)	(45)	(25)
LEFT ROTATION	(80)	(30)	(80)	(30)	(80)	(30)
RIGHT ROTATION	(80)	(30)	(80)	(30)	(80)	(30)

Cervical Distraction	+ - L R	+ - L R	+ - L R
Adsons	+ - L R	+ - L R	+ - L R
Allens	+ - L R	+ - L R	+ - L R
Wrights	+ - L R	+ - L R	+ - L R
Jackson's Compression	+ - L R	+ - L R	+ - L R
Dejerines	+ - L R	+ - L R	+ - L R
Soto Hall	+ - L R	+ - L R	+ - L R
Linders	+ - L R	+ - L R	+ - L R
Shoulder Depressor	+ - L R	+ - L R	+ - L R
Kemps	+ - L R	+ - L R	+ - L R
Straight Leg Raiser	+ - L R	+ - L R	+ - L R
Braggard's	+ - L R	+ - L R	+ - L R
Yeoman's	+ - L R	+ - L R	+ - L R
Ely's	+ - L R	+ - L R	+ - L R
Fabere Patrick	+ - L R	+ - L R	+ - L R

Spinal Wellness Center
Dr. Craig Finkelstein

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to "Spinal Wellness Center".

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice '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 Chiropractor. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor 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 of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority

Spinal Wellness Center
60 East State Street Ste.2
Doylestown, PA 18901
Phone (215)340-9949
Fax (215)689-0954

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____
Print 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.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____
Signature Date

Spinal Wellness Center

Dr. Craig Finkelstein
60 E. State Street Suite 2
Doylestown, PA 18901
Phone (215)340-9949
Fax (215) 689-0954

A Note From The Doctor:

Since I have opened up my Doylestown office back in 2002, I have noticed that more than a few patients have abused the appointment policy of my office with no concern for the doctor at all. My office schedules visits 1 appointment at a time. Therefore, you will find that you almost never have to wait more than 5 minutes for your appointment with the doctor. **This is almost unheard of within doctor's offices!** Unfortunately, many patients chose to miss appointments without the basic courtesy of calling at least 1 hour before their appointment time to cancel or reschedule their appointment. This is extremely aggravating and I can no longer allow this practice of missing appointments without notifying to go on. Please read the following office policies and **sign only** if you feel that you can follow these rules **without exception**!

I, _____ understand that it is my responsibility to call Dr. Finkelstein at least 1 hour before my appointment and inform him if I cannot make my appointment.

I, _____ also understand that if I do not call to inform the doctor, then the doctor's time for my appointment has been lost. This results in financial losses for the doctor that cannot be regained.

I, _____ understand and agree to pay the doctor a fee of **$30** if I fail to call the doctor within 1 hour of my visit for the doctor's lost time and financial loss.

I, _____ give permission for the doctor's office to send reminder text messages to my phone.