AGEE
CHIROPRACTIC & WELLNESS CENTER

2811 Lurleen B. Wallace Blvd.
Suite 12, Northport Al 35476
Website: www.ageeclinic.com

Office: (205) 339-3333
Fax: (205) 339-2023

DATE _____

NEW PATIENT INFORMATION

NAME (LAST) _____ (First) _____ (MI) ____ NICKNAME" _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH: _____ AGE _____ GENDER: M F

SOCIAL SECURITY # _____ HOME PHONE ( ) _____

E-MAIL _____ CELL PHONE ( ) _____

MARITAL STATUS: S M W D WORK PHONE ( ) _____

NUMBER OF CHILDREN _____ OCCUPATION _____

PLACE OF EMPLOYMENT _____

ADDRESS OF EMPLOYMENT _____

COLLEGE STUDENT: □Full Time □Part Time Name of School _____

SPOUSE'S NAME _____ SOCIAL SECURITY # _____

SPOUSE'S EMPLOYER _____ SPOUSE DOB _____

RESPONSIBLE PARTY _____ RELATIONSHIP _____

ADDRESS _____

HOW DID YOU HEAR ABOUT US? □TV □Phonebook □Newspaper □Website □Ins. Co.

□ Sign □ Friend of Family Member _____ □ Other _____

INSURANCE: □ Medicare □ Blue Cross □ None □ Other _____

Insured Name _____ D.O.B. _____ Relationship _____

Insured ID or Policy # _____ Group # _____

IN CASE OF EMERGENCY PLEASE CONTACT _____
PHONE # _____ RELATIONSHIP _____

WHICH DOCTOR WOULD YOU PREFER TO TREAT YOU TODAY?

_____ DR. AGEE _____ DR. KENNEDY _____ DR. PATE

_____ DR. KNIGHT _____ DOES NOT MATTER

AGEE CHIROPRACTIC AND WELLNESS CENTER CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, {Name of Individual} consent to Agee Chiropractic Center's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general health care operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or the treatment of me may be conditioned upon my consent as evidenced by my signature on this document. For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of healthcare to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practices, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to restriction that I request, the restriction is binding on the Practice. I understand I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my right and the Practice's duties regarding the types of uses and disclosures of my Protective Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has active in reliance on this consent.

_____	_____	_____
Patient Signature	Date	Witness

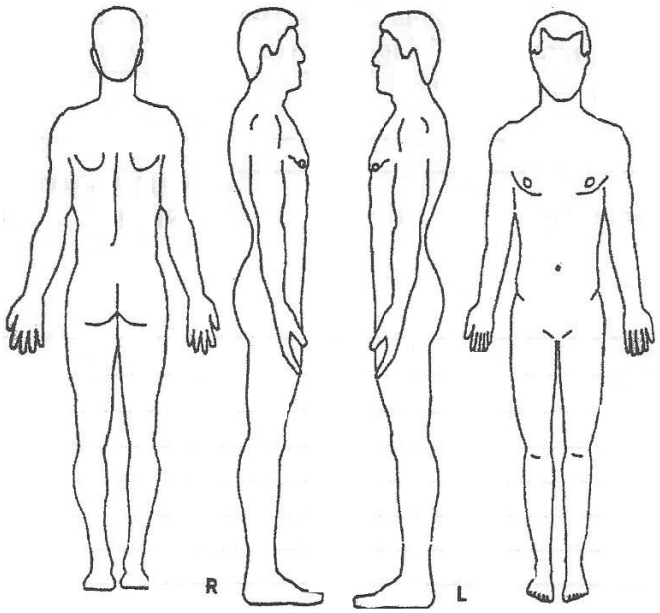
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, {Patient's Name}acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Agee Chiropractic Center, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____	_____	_____
Patient Signature	Date	Witness

PATIENT NAME: _____ DATE:_____ PN:_____

INSTRUCTIONS: Please mark the areas on your body where you feel your PAIN. If the pain radiates, draw an arrow from where the pain starts to where it stops. Please extend the arrows as far as the pain travels.



REVIEW OF SYSTEMS

Please mark an X beside any of the symptoms/conditions listed below that you CURRENTLY are experiencing.

___Weakness
___Fatigue
___Fever
___Headaches
___Sleep Loss
___Weight Loss
___Nausea
___Wheezing
___Hearing Loss
___Bowel/Bladder Problems
___Earache
___Bloody Stool
___Sinus/Hay Fever
___Heat/Cold Intolerance
___Dizziness
___Vision Problems
___Glasses/Contact Lens
___Sexual Dysfunction
___Swallowing Difficulties
___Speech Problems/Hoarseness
___Excessive Sweating

___Arthritis
___Bursitis
___Foot Trouble
___Poor Posture
___Chronic Cough
___Spinal Curvature
___Frequent Colds
___Tingling/Numbness
___Constipation
___Frequent Urination
___Inability to Control Bladder
___Memory Problems
___Fainting
___Painful Menstruation
___Joint Pain/Swelling/Stiffness
___Excessive Hunger/Thirst
___Palpitations
___Clumsiness
___Muscle Pain/Cramps
___Irritable
___Diabetes

___Heart Problems
___High Blood Pressure
___Heart Murmurs
___Poor Circulation
___Swelling of Ankles
___Chest Pain
___Depression/Nervousness
___Difficult Breathing
___Diarrhea
___Hemorrhoids
___Kidney Infection or Stones
___Loss of Appetite
___Vomiting
___Loss of Interest or Energy
___Loss of Consciousness
___Asthma
___Thyroid Problem
___Back or Neck Pain
___Stress (Emotional)
___ Seizures or Convulsions
___ Easy Bruising or Bleeding

PAST HISTORY

I. PAST MEDICAL HISTORY:

Prior MAJOR Illnesses: _____

_____

Prior Surgeries/Operations: _____

_____

_____

Prior Hospitalizations: _____

_____

Current Medications: _____

_____

Allergies (Drug/Food): _____

Prior MAJOR Injuries (MVA, WC, SLIP/FALL, BROKEN BONES): _____

_____

_____

II. FAMILY HISTORY:

*** Please tell us if there is a History of Cancer, Diabetes, Cardiac Problems, Stroke, Blood Pressure Problems, Headaches, Neck Pain, Back Pain or Surgeries in your FAMILY.**

Family History	Living? Medical problems if any:	Deceased? Cause of death:	Age
Mother			
Father			
Brother			
Brother			
Sister			
Sister			
Children			
Children			

III. SOCIAL HISTORY:

Marital Status (Circle): Single Married Divorced Widowed

Current Employment/Occupational History: _____

_____

Exercise: Type: _____ **Freq. ____/wk; Duration _____ Min. / Hrs;___**

Tobacco: NO / YES _____ pk / _____day, wk. for _____ yrs; Chew _____ yrs; Pipe_____yrs

Caffeine: NO / YES _____ glasses per day, week or month

Alcohol: NO / YES _____ glasses per day, week or month

Sleep Interrupted? NO / YES _____ x's / night for _____ mo, yrs

Patient Signature: _____ **Date:** _____

REVISED OSWESTRY BACK AND DISABILITY QUESTIONNAIRE

Name _____ Date _____

Please read carefully: *This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only* ***ONE CHOICE*** *which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one box which most closely describes your problem right now.*

SECTION 1 – Pain Intensity
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.

SECTION 2 – Personal Care
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.

SECTION 3 – Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me 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-(ex. 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.

SECTION 4 – Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting
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 sitting more than 1 hour.
D. Pain prevents me sitting more than ½ hour.
E. Pain prevents me sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

OTHER COMMENTS:

_____
_____

_____
Examiner

SECTION 6 – Standing
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 1 hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7 – Sleeping
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.

SECTION 8 – Social Life
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, eg, 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.

SECTION 9 – Traveling
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.

SECTION 10 – Changing Degree of Pain
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.

NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name _____ Date_____

Please read carefully: *This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ONE CHOICE which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one box which most closely describes your problem right now.*

SECTION 1 – Pain Intensity
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.

SECTION 2 – Personal Care (washing, dressing, etc.)
A. I can look after myself 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, wash with difficulty and stay in bed.

SECTION 3 – Lifting
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 objects off the floor, but I can manage if they are conveniently positioned (ex. 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.

SECTION 4 – Reading
A. I can read as much as I want with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 – Headaches
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.

Other Comments: _____
_____

_____
Examiner

SECTION 6 – Concentration
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.

SECTION 7 – Work
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.

SECTION 8 – Driving
A. I can drive without any neck pain.
B. I can drive as long as I want with slight pain in my neck.
C. I can drive as long as I want with moderate pain in my neck.
D. I cannot drive 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.

SECTION 9 – Sleeping
A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr. sleepless).
C. My sleep is mildly disturbed (1-2 hrs. sleepless).
D. My sleep is moderately disturbed (2-3 hrs. sleepless).
E. My sleep is greatly disturbed (3-5 hrs. sleepless).
F. My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – Recreation
A. I am able to engage in all my recreation activities with no neck pain at all.
B. I am able to engage in all my recreation activities with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
E. I can hardly do any recreation activities because of pain in my neck.
F. I cannot do any recreation activities at all.

ASSIGNMENT, LIEN AND AUTHORIZATION

I, _____, {Patient's Name} hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to AGEE CHIROPRACTIC CENTER, P.C. (The "Center") such sums as may be due and owing the Center for services rendered me, and to withhold such sums from any medical payments benefits, health and accident, benefits, workman's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Center. I understand that I remain personally responsible for the total amounts due the Center for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Center to await payments and they may demand payments from me immediately upon rendering services at their option. I understand that I am financially responsible to the Center for all charges not covered by my insurance company. I further agree that in the event of non-payment, I will bear the cost of collection, and/or court costs and reasonable legal fees, should this be required. I authorize the Center to release any information pertinent to my case to my insurance company, adjustor or attorney, or 3rd party – review board, employer – to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Center may be given power of attorney to endorse/sign my name on any and all checks for payment of services rendered. I hereby authorize the Center (or whomever they may designate as assistants), to administer such treatment as is necessary, and to perform the appropriate therapy, manipulation, and additional diagnostic procedures as considered chiropractically necessary on the basis of findings. This serves as a long term authorization that applies to all occasions of service until it is revoked.

_____ _____ _____

Patient Signature Date Witness Signature

COMMUNICATIONS REGARDING MY ACCOUNTS

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

_____ _____

Responsible Party Signature Date

AGEE CHIROPRACTICE CENTER, P. C. CONTACT INFORMATION

Listed below are the persons, including all of my medical doctors, who are involved in my care with whom you may share my protected health information regarding my treatment or payment issues:

Name:_____

I wish to be contacted in the following manner (check all that apply):

1) _____ Home Telephone _____ Okay to leave message
2) _____ Cell Telephone _____ Okay to leave message
3) _____Work Telephone _____ Okay to leave message
4) _____Written Communication _____ Okay to mail to home/work/office

X_____ Date: _____

Patient Signature (*or Parent if Minor Child*)