BETTINGER
CHIROPRACTIC CENTER
WHERE PAIN RELIEF COMES NATURALLY

Personal History

Dr. Sara Bettinger, DC
1907 Old Main Street
Maysville, KY 41056
Phone: (606)759-0090
Fax: (606) 759-0092

Name:_____ Date:_____ Age:_____

Social Security #:_____ How would you like to be addressed by our staff:_____

Address:_____ City:_____ State:_____ Zip:_____

Birth Date:_____ Sex: Male/Female/Androgynous Primary E-mail:_____

Circle One: Married Single Widowed Divorced Separated # of Children_____

Primary Phone:_____ Secondary Phone:_____

Preferred contact method: Primary Phone Secondary Phone Primary e-mail

Employment status: Employed Retired Self-employed Student Other:_____

Business/Employer:_____ Type of Work:_____

Emergency Contact (required):_____ Phone #:_____

Referred to this office by:_____ or Website Yellow Pages Other:_____

If the Patient is a Minor:

Father's Name:_____ Social Security #:_____ Date of Birth:_____

Father's Phone # (if different than patient's):_____

Father's address (if different than patient's):_____

Father's Employer:_____

Mother's Name:_____ Social Security #:_____ Date of Birth:_____

Mother's Phone # (if different than patient's):_____

Mother's address (if different than patient's):_____

Mother's Employer:_____

Race (circle one)

White Black/African American Hispanic American Indian/Alaskan Native

Asian Asian Indian Chinese Filipino Japanese

Korean Vietnamese Native Hawaiian or other Pacific Island

Samoan Guamanian or Chamorro Other I choose not to specify

Multi-Racial (circle one): Yes No Unknown

Ethnicity (circle one): Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (circle one): English Spanish Other:_____ I choose not to specify

Verification Question (**choose only one question by circling the question**, then give the answer to that question. This will only be used for your purposes to view your health information in HealthVault)

1. What is the name of your favorite pet?
2. In what city were you born?
3. What high school did you attend?
4. What is your favorite movie?
5. What is your Mother's maiden name?
6. On what street did you grow up?
7. What was the make of your first car?
8. When is your anniversary?
9. What is your favorite color?

Verification Answer:_____

Current Complaint/Reason for visit:_____

Other doctors seen for this condition:_____

When did this begin?_____ Family Physician:_____

Previous chiropractic care: None - or- Doctor's Name and approximate dates:_____

Has any doctor diagnosed you with Hypertension (High blood pressure) presently? Yes No

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind: Type I Type II

If yes to Diabetes, was your blood lab-work test for Hemoglobin A1c greater than 9.0% Yes No Unsure

Do you currently smoke tobacco of any kind? Yes Former Smoker Never been a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking? 1 2 3 4 5 6 7 8 9 10

Please list any medications, including dosage, if known:_____

_____

_____

Please check here if there are no current medications: ☐

Please list any known allergies you have had to any medications:_____

_____

Please check here if there are no known allergies to medications: ☐

Signature:_____ Date:_____

Guardian Signature (if patient is a minor):_____ Date:_____

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Review of Systems/ Social History

Do you, or any immediate family members, have or had any trouble with any of the following:

	Present	Past	No	Family History	Relationship to you
Aortic Aneurism	○	○	○	○	
Heart Disease	○	○	○	○	
Heart Attack	○	○	○	○	
High Cholesterol	○	○	○	○	
Pacemaker	○	○	○	○	
Congestive Heart Failure	○	○	○	○	
Cancer- what type_____	○	○	○	○	
High Blood Pressure	○	○	○	○	
Anemia	○	○	○	○	
Asthma	○	○	○	○	
Emphysema	○	○	○	○	
Glaucoma	○	○	○	○	
Rheumatoid Arthritis	○	○	○	○	
Osteoporosis	○	○	○	○	
Diabetes	○	○	○	○	
Depression	○	○	○	○	
Stroke	○	○	○	○	
Seizures	○	○	○	○	
Brain Aneurysm	○	○	○	○	
Parkinson's Disease	○	○	○	○	
Migraine Headaches	○	○	○	○	
Multiple Sclerosis	○	○	○	○	

Past Surgeries: (please check any past surgeries that you have had):

- ☐ Appendectomy
- ☐ Cardiovascular Procedure
- ☐ Vertebral Disc Procedures
- ☐ Gallbladder
- ☐ Hysterectomy
- ☐ Hernia
- ☐ Joint Replacement
- ☐ Laminectomies
- ☐ Rotator Cuff Repair
- ☐ Tonsillectomy
- ☐ Other_____

Signature:_____ **Date:**_____

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Cervical Bournemouth Questionnaire

Name:_____ Date:_____ Age:_____

The following scales have been designed to find out about your *NECK* pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your Neck pain?
   No Pain — Worst Pain Possible
   0 1 2 3 4 5 6 7 8 9 10
2. Over the past week, how much has your Neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?
   No Interference — Unable to carry out activity
   0 1 2 3 4 5 6 7 8 9 10
3. Over the past week, how much has your Neck pain interfered with your ability to take part in recreational, social, and family activities?
   No Interference — Unable to carry out activity
   0 1 2 3 4 5 6 7 8 9 10
4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/ relaxing) have you been feeling?
   Not anxious at all — Extremely anxious
   0 1 2 3 4 5 6 7 8 9 10
5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?
   Not at all depressed — Extremely depressed
   0 1 2 3 4 5 6 7 8 9 10
6. Over the past week, how have you felt your work (both inside and outside the home) has been affected (or would affect) your neck pain?
   Have made it no worse — Have made it much worse
   0 1 2 3 4 5 6 7 8 9 10
7. Over the past week, how much have you been able to control (reduce/help) your Neck pain on your own?
   Completely control it — No control whatsoever
   0 1 2 3 4 5 6 7 8 9 10

_____

Signature

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Lumbar Bournemouth Questionnaire

Name:_____ Date:_____ Age:_____

The following scales have been designed to find out about your *BACK* pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your Back pain?
   No Pain — Worst Pain Possible
   0 1 2 3 4 5 6 7 8 9 10
2. Over the past week, how much has your Back pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?
   No Interference — Unable to carry out activity
   0 1 2 3 4 5 6 7 8 9 10
3. Over the past week, how much has your Back pain interfered with your ability to take part in recreational, social, and family activities?
   No Interference — Unable to carry out activity
   0 1 2 3 4 5 6 7 8 9 10
4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/ relaxing) have you been feeling?
   Not anxious at all — Extremely anxious
   0 1 2 3 4 5 6 7 8 9 10
5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?
   Not at all depressed — Extremely depressed
   0 1 2 3 4 5 6 7 8 9 10
6. Over the past week, how have you felt your work (both inside and outside the home) has been affected (or would affect) your back pain?
   Have made it no worse — Have made it much worse
   0 1 2 3 4 5 6 7 8 9 10
7. Over the past week, how much have you been able to control (reduce/help) your Back pain on your own?
   Completely control it — No control whatsoever
   0 1 2 3 4 5 6 7 8 9 10

_____

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HIPAA- Consent for Purposes of Treatment, Payment, & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Dr. Sara Bettinger, DC or Bettinger Chiropractic Center, PLLC.

I consent to the use or disclosure of my protected health information by the 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 to the Chiropractor. I understand that analysis, diagnosis, or treatment of me by the Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand that 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. The chiropractor is not required to agree to the restrictions that I may request. However, if the Chiropractor agrees to a restriction that I request, the restriction is binding on the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except that the 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. The 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 the Chiropractor and understand that I have a right to review the 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 the Chiropractor. The Notice of Privacy Practices for the Chiropractor is also posted in the waiting room at Bettinger Chiropractic Center, PLLC. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

The 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 the 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

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Financial Policy

Chiropractic is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy *as it applies to your particular situation.*

PATIENTS WITHOUT INSURANCE- We request that 100% of the first visit be paid at the time of the visit unless other arrangements have been pre-arranged and agreed upon. A payment plan can be established in writing.

GROUP OF INDIVIDUAL INSURANCE- When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payments. Payment will be due by you at the time of service for any non-covered services, deductibles, or co-pays.

"ON THE JOB" INJURY (Worker's Compensation)- If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, and fees and services are due by you immediately.

PERSONAL INJURY- (Ohio patients only) Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.

MEDICARE- We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover, which for Chiropractors, is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%, as well as, any non-covered services. Our office completes and files the forms for Medicare at no additional charge.

SECONDARY INSURANCE- Please inform us of any secondary insurance you may have.

I understand that my insurance is an arrangement between myself and my insurance company, NOT between Dr. Bettinger and my insurance company. I request that Bettinger Chiropractic Center, PLLC, prepare the customary forms at no charge so that I may obtain insurance benefits.

Signature_____ **Date**_____

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Informed Consent

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of the bones with the doctor's hands, or with use of a machine. Frequently, adjustments create a "pop" or "click" sound in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, therapy, traction, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke is the most serious possible complication associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. Chiropractic adjustments have rarely been associated with strokes. The most recent studies (Journal of the CCA, Vol 37, No 2, June 1993) estimate that the incident of this type of stroke is 1 per every 3 million upper neck adjustments. This means that the average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniations: Occasionally chiropractic treatment will aggravate disc herniations and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles, ligaments, and tendons. Muscles move bones and ligaments limit joint movement. Rarely chiropractic treatment may tear some muscles, tendons, or ligament fibers. The result is a temporary increase in pain. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Strains/Fractures: The ribs are found in the thoracic spine, or middle back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will fracture a rib bone, or strain the rib joint. Patients who suffer from Osteoporosis or Osteopenia will be more prone to rib strains/fractures. We adjust all patients carefully and can note any conditions that we feel will make you more susceptible to rib strains/fractures on your chart. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical therapy burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering on the skin. If you ever

experience any discomfort during therapy, or a burn, please notify the doctor immediately. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic treatments to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous but please inform your doctor of it if you do experience soreness.

Other problems: There may be other problems or complications that might arise from chiropractic treatment, other than those noted above. These other problem or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Other treatments available:

Medications: As chiropractors we do not prescribe medications. If you feel these are necessary, please see your medical doctor.

Surgery: Occasionally our patients may be surgical candidates. We will gladly give you a referral to an appropriate surgeon if we feel you may be one of these candidates. You are always welcome to get a second opinion with another doctor outside of our recommendations.

Non-treatment: If you so choose, you may decide to have no treatment.

Chiropractic care is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will also give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please talk to your doctor. When you have a full understanding, please sign and date below.

_____ _____

Patient's Name Printed Today's Date

_____ _____

Patient's signature Parent or Guardian Signature

_____

Doctor's signature