Patient Name: ______________________________

Functional Rating Index   Acct # ____________

Please Circle the Number That Best Rates Your Pain:

1. General Pain

|0----------|1----------|2----------|3----------|4

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Pain

2. While Sleeping

|0----------|1----------|2----------|3----------|4

0	1	2	3	4
Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed

3. Personal Care (washing, dressing, etc.)

|0----------|1----------|2----------|3----------|4

0	1	2	3	4
No Pain; No Restrictions	Mild Pain; Some Restrictions	Moderate Pain; need to go slow	Moderate Pain; need some assistance	Severe Pain; 100% assistance

4. Travel (while driving, etc.)

|0----------|1----------|2----------|3----------|4

0	1	2	3	4
No Pain/long trips	Mild Pain/long trips	Moderate Pain/short trips	Moderate Pain/short trips	Severe Pain

5. Does pain restrict your job functions?

|0----------|1----------|2----------|3----------|4

0	1	2	3	4
Usual work	75% Usual work	50% of Usual Work	25% of Usual Work	Cannot Work

6. Recreation

|0----------|1----------|2----------|3----------|4

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do few activities	Unable to do any activities

7. Frequency of Pain

|0----------|1----------|2----------|3----------|4

0	1	2	3	4
No Pain	Occasional; 25% of the day	Intermittent; 50% of the day	Frequent; 75% of the day	Constant; 100% of the day

8. Lifting

|0----------|1----------|2----------|3----------|4

0	1	2	3	4
No Pain w/heavy weight	↑ Pain w/heavy weight	↑ Pain w/moderate weight	↑ Pain w/light weight	↑ Pain w/any weight

9. Walking

|0----------|1----------|2----------|3----------|4

0	1	2	3	4
No Pain	↑Pain after 1 mile	↑Pain after ½ mile	↑Pain after ¼ mile	↑Pain w/all

10. Standing

|0----------|1----------|2----------|3----------|4

0	1	2	3	4
No Pain	↑ Pain after sev. hrs.	↑ Pain after 1 hr.	↑ Pain after ½ hr.	↑ Pain w/ all

X______________________________   ____________   ____________

Signature   Date   Score

AREA FOR PHYSICIAN USE ONLY

Physician Findings:

____

____

____

____

____

____

BP ________/ ________   Weight ________lbs.   Height ________   Services: ____________________

X-rays: C-spine ________   T-spine ________   L-spine ________   Other ____________________

PLEASE READ & INITIAL EACH OF THE FOLLOWING

X____ **CONSENT TO TREATMENT**

I do hereby give my consent to conservative, noninvasive treatment to the joints and soft tissues. I understand that treatments in this office may consist of manipulations, therapeutic and rehabilitative exercise, electrical therapy, muscle/soft tissue release, and other therapeutic modalities may also be used. I also voluntarily consent to receive medical care including but not limited to laboratory, diagnostic or medical/surgical treatment which may be ordered by my physicians or assistants, or designees, for emergency, or outpatient medical or surgical treatment which may be deemed necessary or advisable. The medical practice may use independent contractors who are not employees or agents of this facility. I acknowledge that no representations, warranties or guarantees as to results or cures have been made to me.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective treatments for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: Like exercise, it is common to experience muscle soreness in the first few treatments. In some cases, symptoms may get worse for a short period before they get better.

Dizziness: Temporary symptoms like dizziness, headache, and nausea can occur but are relatively rare.

Fractures/Joint Injury: In isolated cases underlying deformities or pathologies (i.e.: osteoporosis) may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormalities are detected, this office will proceed with extra caution.

Stroke: Strokes from chiropractic adjustments are extremely rare. I am aware that stroke occurs once in 1-10 million adjustments.

**If non-chiropractic or unusual findings are encountered, I will be referred to another healthcare provider.

I understand that there are beneficial effects associated with the treatment procedures used in this office however, as with any medical procedure or therapy; there is no certainty that I will achieve these benefits. I agree to the use of these procedures. Reasonable alternatives to these procedures include rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

X____ **PROTECTED HEALTH INFORMATION (PHI/HIPAA)**

I understand this office cannot release my PHI without my written consent and cannot be shared with anyone else unless I give prior written authorization. Occasionally my PHI could be overheard by other patients in the office. I understand I can request a copy of my records. My PHI may be shared in consultation with another healthcare provider. My PHI is required for billing and payments for and by third party payers. A full HIPPA manual is available to me to review in this office, at any time. All staff have been trained in the importance of patient record privacy. Information will only be available to those who need it and properly request it.

X____ **PAYMENTS, INSURANCE & IDENTIFICATION**

I understand, I am fully responsible for all fees for services and goods. I request payment from my insurance company to be made to this office. I am responsible for all deductibles, copayments and any charges not covered by my insurance company. All payments are due at time of service. My insurance is billed by this office as a courtesy to me and the benefits they quote are not a guarantee of payment. Any outstanding unpaid balance on my account may be turned over to a collection agency and I am further responsible for all costs and fees for such. This office will keep a copy of my insurance card and driver's license which will be used strictly for insurance and identification purposes. I understand my provider's schedule is very busy and agree to the office appointment policy: a $15 fee will be applied to my account for any no call/ no show appointments. I agree to make every effort to notify the office no later than 30 minutes prior to my appointment in the event that I am unable to arrive on time. This fee must be paid before I can be seen again.

Payment is due and expected at time services are rendered. I agree that I am financially responsible for the payment of all charges for services provided, regardless of insurance coverage or other responsible parties, if any. I agree and understand that I am responsible for late fees before transferring to a collection agency and/or reasonable attorney fees if my account is placed for collection. I understand that if any account goes to a collection agency, I will be unable to schedule an appointment until the balance is paid in full or reasonable arrangements are made.

CONSENT TO EVALUATE & TREAT 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 care by the doctor and /or staff.

I have read, or have had read to me, the above explanation of chiropractic treatment and office policies, and have had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician I also understand said policies. I intend this consent to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

X________________________________	________________________________	________________
Print Name	**Signature**	**Date**

Jackson Healing Arts
3130 E. Jackson Blvd.
Jackson, MO. 63755
Phone/Text: 573.243.5095
Fax: 573.243.5896

Today's Date: ________________________ Acct # _____________

Patient Information:

Patient Name: ____ Sex: **M** ☐ **F** ☐ Age: ______
(first) (middle initial) (last)

D.O.B: _______ . _______ . _______ Patient SSN: ________ . ______ . _________

Address:____ City: __________________ State: _____ Zip: __________
(street)

Primary Phone #: _______ . _______ . _______ E-Mail Address: ____

Best way to communicate: ☐ Call ☐ Text ☐ Email Occupation: ____________________________________

Who is your Primary Care Physician? ___________________ Whom may we thank for referring you? ____________________

Your Employment Information (if your insurance is from your employer):

Employer: ____ Employer's Phone: _______ . _______ . _______

Spouse Information (if your insurance is in your spouse's name):

Name: ____ D.O.B: ______. _____ . _____ SSN: ______. ____. ______

Spouse Employer: ____________________________________ Spouse Employer's Phone: _______ . _______ . _______

Payment Information: ☐ Self-Pay ☐ Insurance (please provide card to front desk) ☐ Other

Please list 2 people that can have access to your medical information, in case of an emergency:

	Name:	Relationship:	Phone #:
1:	________________________	________________	_________._________._________
2:	________________________	________________	_________._________._________

I, the undersigned certify that I (or my dependent) has insurance coverage with the above named insurance company and assign directly to the treating physician all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's Signature: X____

Chief complaint: ____ How long? __________

What caused your pain? ____

Other areas that give you pain? ____

Have you seen a doctor about this? What was the diagnosis? ____________________________

What motions/ positions/ activities make your pain:

Better: __________________ Worse: __________________

Is your pain: ☐ Sharp ☐ Dull ☐ Achy ☐ No Pain ☐ Other: _______________________

Do you have:

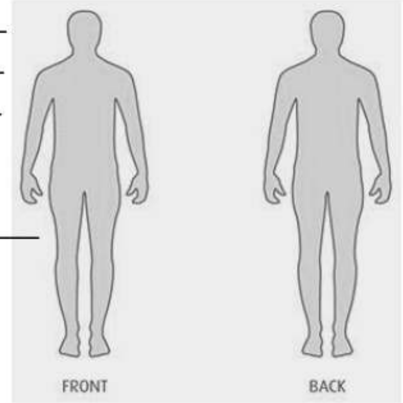
☐ Numbness Arm: R / L Hand: R / L Leg: R / L Foot: R / L

☐ Tingling Arm: R / L Hand: R / L Leg: R / L Foot: R / L

☐ Weakness Arm: R / L Hand: R / L Leg: R / L Foot: R / L

Is your pain worse in the: ☐ morning ☐ evening ☐ activity dependent

Please circle area of pain in diagram below:



Constitutional

- ☐ Night Sweats
- ☐ Recurrent Fevers
- ☐ Insomnia/sleeping disorder
- ☐ Sleep Apnea
- ☐ Weight loss/gain

Eyes

- ☐ Double Vision
- ☐ Injuries
- ☐ Glaucoma
- ☐ Glasses/Contacts

Cardiovascular

- ☐ Chest Pain/Angina
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular Heart beat
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Abnormal heart anatomy

Respiratory

- ☐ Asthma
- ☐ Allergies
- ☐ Chronic cough
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Bronchitis/Pneumonia
- ☐ Lung Cancer
- ☐ Bloody Sputum
- ☐ COPD

Gastrointestinal

- ☐ Indigestion/pain with eating
- ☐ Chronic nausea/vomiting
- ☐ Liver disease/hepatitis/jaundice
- ☐ Ulcers/ gastritis
- ☐ Colon/stomach cancer

Genitourinary

- ☐ Recurrent UTI
- ☐ Blood in Urine
- ☐ Prostate cancer
- ☐ Uterine/cervical cancer
- ☐ Frequent urination
- ☐ Renal cystic disease
- ☐ Kidney failure

Musculoskeletal

- ☐ Broken bones/fractures

____

____

____

- ☐ Chronic arm/leg weakness
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Back Pain
- ☐ Carpal tunnel
- ☐ Joint swelling/redness
- ☐ Bone cancer

Integumentary

- ☐ Skin Cancer
- ☐ Skin Disease

Neurological

- ☐ Fainting Spells
- ☐ Seizures/Epilepsy
- ☐ Difficulty with speech
- ☐ Frequent headaches/migraines
- ☐ Stroke
- ☐ Neuromuscular disease

(ALS, MS, Myasthenia gravis)

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ PTSD

Endocrine

- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Hormone Problems
- ☐ Pregnant/breastfeeding

AutoImmune

- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Psoriasis

Hematologic/Lymphatic

- ☐ Anemia
- ☐ Hemophilia/easy bleeding
- ☐ Thrombocytopenia
- ☐ Platelet syndrome
- ☐ HIV/AIDS
- ☐ Blood Clots
- ☐ Persistent swollen glands/lymph nodes
- ☐ Blood Transfusions: when ____________________________

Immunologic

- ☐ Immune deficiency
- ☐ Radiation treatment

when: ___________

Social

- ☐ Tobacco use

________/ day

- ☐ Alcohol use

________/ day

- ☐ Use of steroids

oral or injection

- ☐ Use of NSAIDs

Other

Allergies (sulfa/iodine)

____

____

Surgeries

____

____

____

____

Tumorous Cancers

____

Medications/Vitamins

____

Blood Thinner Clearance:

____

____

____

____

What have you tried to relieve/get rid of the pain? ☐ Medications ☐ Exercise ☐ Physical Therapy ☐ Nutrition ☐ Chiropractic Care ☐ Stretching ☐ Nothing ☐ Other ______________________

I certify the above information to be complete and accurate **X** ____

Signature Date