Patient Name: _____ **Date:** _____
DOB: _____ **SSN:** _____ **Patient ID:** _____
Address: _____ **City:** _____**State:** _____ **Zip:** _____
Home Phone: _____**Cell Phone:** _____**Email Address:** _____

***Cell Phone Carrier:

PLEASE PROVIDE US WITH YOUR CURRENT HEALTH INSURANCE CARD AND DRIVERS LICENSE.

IF YOU ARE NOT CURRENTLY INSURED, ASK ABOUT CHIROHEALTH USA (A $49 A YEAR DISCOUNT PLAN), CARE CREDIT OR OUR IN-HOUSE AUTOPAY PROGRAMS.

Nickname: (preferred to be called) _____
Race/Ethnicity: White ___; African American ___; Native American___; Asian ___; Pacific Islander___
Preferred language: English_____; Spanish_____; Other _____

Have you been diagnosed with: Asthma/COPD Diabetes Hypertension

Person ultimately responsible for this account?

Name: _____

Relation: _____

Billing Address: _____

SSN: _____

Driver's license #:_____

Work phone: _____

In the event of an emergency, who should we contact?

Name: _____

Relationship: _____

Cell phone: _____

Work phone: _____

Home phone: _____

Who is your Medical Doctor: _____

Medical Doctors Phone #: _____

I understand that if x-rays are necessary, there is a separate radiology fee of $40 that I must pay to Crosby Chiropractic and Acupuncture Centre at the time of service.

Acknowledgement of receipt of Notice of Privacy Practices:

I hereby consent and state my preference to have my physician, [Physician Name], and other staff at [Practice Name] communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

Signature: _____

If Legal Representative for the Patient please indicate relationship here: _____

I authorize Crosby Chiropractic & Acupuncture Centre to release to the following people access to my health record and financial record: _____

Assignment of Benefits:

I request that payment of insurance benefits for services provided to me by Jenny L Wiemann, D.C., P.C dba Crosby Chiropractic & Acupuncture Centre, be made directly to the Service Provider as appropriate. I assign any and all rights to payment of insurance benefits to the Service Provider. I acknowledge and agree that I am financially responsible for all charges relating to the services rendered to me or my dependent. If, for any reason, my insurance carrier does not pay for a portion of this bill, I understand that I am responsible for prompt (within 30 days) payment arrangements. , I understand that I am responsible for prompt (within 30 days) payment arrangements. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to this office which accepts assignment.

Signature: _____**Date/time:** _____
Patient, parent or guardian

A. Notifier: Crosby Chiropractic & Acupuncture Centre
B. Patient Name: _____C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
98940	Maintenance care not covered	$31.11
98941	Maintenance care not covered	$44.79
98942	Maintenance care not covered	$58.46

WHAT YOU NEED TO DO NOW:
Read this notice, so you can make an informed decision about your care.
Ask us any questions that you may have after you finish reading.
Choose an option below about whether to receive the D. listed above.
Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- **OPTION 1.** I want the **D.** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

- **OPTION 2.** I want the **D.** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

- **OPTION 3.** I don't want the **D.** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:
This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Patient Name: _____ **Date:** _____

ABN (excluding Medicare):

Jenny L Wiemann, D.C., P.C, dba Crosby Chiropractic & Acupuncture Centre, will file a claim on your behalf with your health insurance carrier(s) based on information that you provided during your registration process. Your carrier may not pay for part of all of the services listed below as they may determine it to be "not medically necessary." It is important that you understand your coverage as Crosby Chiropractic & Acupuncture Centre will bill you in the event that the service(s) are not covered by your insurance carrier(s) or there is a balance due after payment by your insurance carrier that is determined to be patient responsibility. Services this may apply to include: Out of network chiropractic and acupuncture care, chiropractic after 26 visits, chiropractic for self-funded or federal plans, chiropractic for maintenance/supportive care, chiropractic for minor children, acupuncture, therapy modalities, xrays, examinations, supplements.

I have read and reviewed these terms with a representative of the provider and I understand that my treatment(s) may not be covered by my health insurance carrier. I agree that I am financially responsible for the amount billed to me by Crosby Chiropractic & Acupuncture and will pay any balance due in a timely manner (less than 45 days). , I understand that I am responsible for prompt (within 30 days) payment arrangements. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to this office which accepts assignment.

Signature: _____
Patient, parent or guardian

Informed Consent:

I request and consent to any diagnostic testing or treatment from the Doctors/staff of Crosby Chiropractic. I understand that the practice of chiropractic, acupuncture and massage are not exact sciences and I acknowledge that no guarantees have been made to me as a results of medical treatments, diagnostic procedures or examinations that occur within this facility. I further understand that, as in the practice of medicine, there are some risks to treatment including fracture, disc injury, stroke, dislocation and sprains although these are very rare (1 in 4 million). I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise those procedures that the doctor feels, at the time are in my best interest.

In the event I need x-rays I authorize them **1)** to be taken, and **2)** to be sent to Radiology Consultants Midwest, to be read. (initial) _____ and state that to the best of my knowledge I am not pregnant (female only) _____(initial).

Signature: _____
Patient, parent or guardian

CONSENT TO TREAT A MINOR
I hereby authorize the doctors at Crosby Chiropractic & Acupuncture Centre to administer treatment as they so deem necessary to my son/daughter Patient->FirstName Patient->LastName.

Parent/Guardian Signature: _____

I have read or have had read to me, the above and have had opportunities to ask about the content. By signing below I agree to care for this condition and for any future conditions for which I seek treatment.

- Our policy requires payment in full for all services rendered at the time of each visit unless other arrangements have been made. If insurance has not paid within 90 days of the date of service, you will be responsible for the bill. Any legal fees, collection agency, attorney fees, interest fees and any other fees incurred attempting to recoup your account balance are your responsibility.
- I authorize the staff to perform any necessary services needed during my diagnosis and treatment including x-rays and I understand there is an associated radiology fee of $40, that I am personally responsible for. I also authorize the provider to release any information required to ensure payment of insurance claims.
- I hereby appoint Jenny L Wiemann, D.C., P.C., including its authorized agents, as my attorney in fact to collect any and all data required to satisfy my financial obligations to this office. I hereby give and grant to my said attorney full power and authority to do and perform all and every act and thing whatsoever to be done. In order to fully carry out and effectuate the authority granted herein, as fully to all intents and purposes as I might or could do if personally present and personally acting and I hereby ratify and confirm all that my said attorney may do pursuant to this power.
- I understand the above information and guarantee that my information, provided electronically and on paper was completed correctly to the best of my knowledge and I know it is my responsibility to inform this office of any changes in the information I have provided

Signature: _____ **Date/time:** _____

Witness: _____ **Date:** _____

CROSBY CHIROPRACTIC & ACUPUNCTURE CENTRE

PATIENT HISTORY FORM

Date: _____

NAME: _____ Birthdate: _____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Orthotics: Y/N Mattress age: Comfortable? Last Spinal Xrays?

Hospitalizations:

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		

Living status: alone /not alone

Smoking status:

Alcohol use:

Caffeine use:

Soda consumption:

Exercise:

Patient Name: _____ **Date:** _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High/low blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism/hyperthyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems/disease/murmur
- ❑ Gout
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma/bronchitis
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Celiac/Crohn's
- ❑ Kidney disease/stones
- ❑ Arteriosclerosis
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Chicken Pox

Other medical conditions (please list):

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

Female: ❑ BCP/IUD/ ❑ miscarriages

Male: ❑ Impotency ❑ Pain on erection/ejaculation

Patient Name: _____ **Date:** _____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Loss/gain of weight
- ❑ Low back pain
- ❑ Fatigue
- ❑ Weakness
- ❑ Polio/Rheumatic Fever/Scarlet fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain/numbness
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears/Ear pain
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Asthma/Bronchitis/wheezing
- ❑ Swollen legs or feet
- ❑ Cough (chronic)

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss
- ❑ Multiple sclerosis

STOMACH AND INTESTINES
- ❑ Nausea/vomiting
- ❑ Heartburn/GERD
- ❑ Stomach pain/abdominal pain
- ❑ Gas/belching/difficult digestion
- ❑ Liver trouble/jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea/colitis
- ❑ Blood in stools/black stools
- ❑ Ulcers
- ❑ Hemorrhoids

SKIN
- ❑ Redness/rash
- ❑ Bruise easily
- ❑ Nodules/bumps/sores
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots/phlebitis
- ❑ Poor circulation/Reynauds

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine
- ❑ Bed wetting
- ❑ Urinary tract infection
- ❑ Nighttime urination
- ❑ PMS

CHIROPRACTIC
- ❑ Headaches
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Muscle or Ligament Tears
- ❑ Neck Pain/Stiffness
- ❑ Pain between shoulder blades
- ❑ Pain with coughing/sneezing
- ❑ Pain on swallowing
- ❑ Poor concentration
- ❑ Arthritis/Bursitis
- ❑ Sciatica
- ❑ Jaw pain/TMJ issues
- ❑ Foot issues
- ❑ Hernia
- ❑ Mood swings
- ❑ Anxiety/Nervousness
- ❑ Sinus issues
- ❑ Depression
- ❑ Irritability/Stress

OTHER PROBLEMS:
- ❑ get sick easily
- ❑ loss of smell
- ❑ no appetite
- ❑ gall bladder troubles

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS
- ❑ Excess flow/vaginal discharge

Modified Oswestry Low Back Pain Disability Questionnaire

Patient Name: _____**Date:** _____

Please Read:

This questionnaire has been designed to give your doctor/therapist information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the **one** box that best describes your condition today.

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition

Section 1 – Pain Intensity
0 I can tolerate the pain I have without having to use pain medication.
1 The pain is bad but I manage without having to take pain medication.
2 Pain medication provides me complete relief from pain.
3 Pain medication provides me moderate relief from pain.
4 Pain medication provides me little relief from pain.
5 Pain medication has no effect on the pain

Section 2 – Personal Care (Washing, Dressing, etc.)
0 I can take care of myself normally without causing increased pain.
1 I can take care of myself normally but it increases my pain.
2 It is painful to take care of myself and I am slow and careful.
3 I need help but I am able to manage most of my personal care.
4 I need help every day in most aspects of my care.
5 I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting
0 I can lift heavy weights without increased pain.
1 I can lift heavy weights but it causes increased pain.
2 Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.
3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
4 I can lift only very light weights.
5 I cannot lift or carry anything at all.

Section 4 - Walking
0 Pain does not prevent me walking any distance.
1 Pain prevents me walking more than 1 mile.
2 Pain prevents me walking more than ½ mile
3 Pain prevents me walking more than ¼ mile
4 I can only walk using crutches or a cane.
5 I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting
0 I can it in any chair as long as I like.
1 I can only sit in my favorite chair as long as I like.
2 Pain prevents me sitting more than 1 hour.
3 Pain prevents me from sitting more than ½ hour.
4 Pain prevents me from sitting more than 10 mins.
5 Pain prevents me from sitting at all.

Score _____ (50) **Benchmark -5=_____**

Section 6 – Standing
0 I can stand as long as I want without increased pain.
1 I can stand as long as I want but increases my pain.
2 Pain prevents me from standing for more than 1 hour.
3 Pain prevents me from standing for more than ½ hour.
4 Pain prevents me from standing for more than 10 mins.
5 Pain prevents me from standing at all.

Section 7 – Sleeping
0 Pain does not prevent me from sleeping well.
1 I can sleep well only by using pain medication.
2 Even when I take pain medication, I sleep less than 6 hours.
3 Even when I take pain medication, I sleep less than 4 hours.
4 Even when I take pain medication, I sleep less than 2 hours.
5 Pain prevents me from sleeping at all

Section 8 – Social Life
0 My social life is normal and does not increase my pain.
1 My social life is normal, but it increases my level of pain.
2 Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.
3 Pain prevents me from going out very often.
4 Pain has restricted my social life to my home.
5 I have hardly any social life because of my pain.

Section 9 – Traveling
0 I can travel anywhere without increased pain.
1 I can travel anywhere but it increases my pain.
2 Pain restricts travel over 2 hours.
3 Pain restricts travel over 1 hour.
4 Pain restricts my travel to short necessary journeys under ½ hour.
5 Pain prevents all travel except for visits to the doctor/therapist or hospital.

Section 10 – Employment/Homemaking
0 My normal homemaking/job activities do not cause pain.
1 My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
2 I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming).
3 Pain prevents me from doing anything but light duties.
4 Pain prevents me from doing even light duties.
5 Pain prevents me from performing any job/homemaking chores.

CROSBY CHIROPRACTIC & ACUPUNCTURE CENTRE

Patient Name: _____ **Date:** _____

OSWESTRY NECK DISABILITY INDEX

SECTION 1: Pain Intensity
A. 0 I have no pain at the moment.
B. 1 The pain is mild at the moment.
C. 2 The pain comes & goes & is moderate
D. 3 The pain is moderate & does not vary much.
E. 4 The pain is severe but comes & goes.
F. 5 The pain is severe & does not vary much.

SECTION 2: Personal Care (Washing, Dressing etc.)
A. 0 I can look after myself without causing extra pain.
B. 1 I can look after myself normally but it causes extra pain.
C. 2 It is painful to look after myself and I am slow & careful.
D. 3 I need some help but manage most of my personal care.
E. 4 I need help every day in most aspects of self-care.
F. 5 I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3: Lifting
A. 0 I can lift heavy weights without extra pain.
B. 1 I can lift heavy weights, but it causes extra pain.
C. 2 Pain prevents me from lifing heavy weights off the floor, but I can if they are conveniently positioned, for example on a table.
D. 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. 4 I can only lift very light weights.
F. 5 I cannot lift or carry anything at all.

SECTION 4: Reading
A. 0 I can read as much as I want to with no pain in my neck.
B. 1 I can read as much as I want with slight pain in my neck.
C. 2 I can read as much as I want with moderate pain in my neck.
D. 3 I cannot read as much as I want because of moderate pain in my neck.
E. 4 I cannot read as much as I want because of severe pain in my neck.
F. 5 I can not read at all because of neck pain.

SECTION 5: Headache
A. 0 I have no headaches at all.
B. 1 I have slight headaches that come infrequently.
C. 2 I have moderate headaches that come in-frequently.
D. 3 I have moderate headaches that come frequently.
E. 4 I have severe headaches that come frequently.
F. 5 I have headaches almost all the time.

Score _____ (50) **Benchmark -5=_____**

SECTION 6: Concentration
A. 0 I can concentrate fully when I want to with no difficulty.
B. 1 I can concentrate fully when I want to with slight difficulty.
C. 2 I have a fair degree of difficulty in concentrating when I want to.
D. 3 I have a lot of difficulty in concentrating when I want to.
E. 4 I have a great deal of difficulty in concentrating when I want to.
F. 5 I cannot concentrate at all.

SECTION 7: Work
A. 0 I can do as much work as I want to.
B. 1 I can only do my usual work but no more.
C. 2 I can don most of my usual work but no more.
D. 3 I cannot do my usual work.
E. 4 I can hardly do any work at all.
F. 5 I cannot do any work at all.

SECTION 8: Driving
A. 0 I can drive my car without neck pain.
B. 1 I can drive my car as long as I want with slight pain in my neck.
C. 2 I can drive my car as long as I want with moderate pain in my neck.
D. 3 I cannot drive my car as long as I want because of moderate pain in my neck.
E. 4 I can hardly drive my car at all because of severe pain in my neck.
F. 5 I cannot drive my car at all.

SECTION 9: Sleeping
A. 0 I have no trouble sleeping.
B. 1 My sleep is slightly disturbed (less than 1 hour sleepless).
C. 2 My sleep is mildly disturbed (1-2 hours sleepless).
D. 3 My sleep is moderately disturbed (2-3 hours sleepless).
E. 4 My sleep is greatly disturbed (3-5 hours sleepless).
F. 5 My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10: Recreation
A. 0 I am able to engage in all recreational activities with no pain in my neck at all.
B. 1 A am able to engage in all recreational activities with some pain in my neck.
C. 2 I am able to engage in most, but not all, recreational activities because of pain in my neck.
D. 3 I am able to engage in only a few of my usual recreational activities because of pain in my neck.
E. 4 I can hardly do any recreational activiites because of pain in my neck.
F. 5 I cannot do any recreational activities at all.

Revise Date 4/3/2021

Do any of the following apply to you today:

- ___Open Cuts ___Injury ___Cold/Flu ___Anything Contagious?

- Have you had a fever in the last 24 hours of 100°F or above? _____
- Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? _____
- Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? _____
- Have you travelled out of state in the last 14 days? _____

I understand that, because chiropractic, acupuncture and passive modality therapies involve touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive treatment from this clinic and its employees.

Signature_____
Date_____