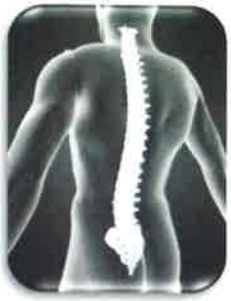
CENK
Integrated Health & Spine Centers

Functional Assessment



PERSONAL INFORMATION

DATE:_____

Name: _____

Social Security # _____ DOB:_____

Street Address: _____

City: _____State: _____ Zip: _____

Occupation: _____ Employer Name:_____

Phone No.: (CELL) _____(Work) _____ (Home) _____

E-mail Address:_____

Preferred Method of Contact: o Text o Email o Home Phone o Work Phone o Cell Phone

Married? _Y__N__ Spouse's Name: _____ Number of Children: _____

How did you become aware of Cenk Chiropractic?

- o Web Site
- o Facebook
- o Internet
- o Referral (Please tell us who made the referral)
  - o From Physician: _____
  - o From Cenk Patient: _____
  - o From other individual: _____
- o Other
  - o Please describe: _____

REASON FOR VISIT TO CENK CHIROPRACTIC

Primary Complaint (please describe): _____

_____

Secondary Complaint (please describe): _____

_____

PATIENT NAME:_____ DATE:_____

CURRENT MEDICAL CONDITIONS (please mark all yes or no)

	YES	NO		YES	NO
Asthma	o	o	Heart Disease	o	o
Chest Pain	o	o	- Family Member	o	o
Shortness of Breath	o	o	Diabetes	o	o
Stroke	o	o	- Family Member	o	o
Hernia	o	o	High Blood Pressure	o	o
Pregnancy (current)	o	o	- Family Member	o	o
Arthritis	o	o	Low Blood Pressure	o	o
Numbness or Paralysis	o	o	- Family Member	o	o
Allergies	o	o			

CURRENT OR PREVIOUS SYMPTOMS (please mark all that apply)

Pain in the following:

o Shoulders o Arms o Hands o Hips o Legs o Knees o Feet

Numbness or tingling in the following:

o Shoulders o Arms o Hands o Hips o Legs o Knees o Feet

o Low Back Pain or Stiffness
o Neck Pain or Stiffness
o Pain or Stiffness Between Shoulders
o Pain or Stiffness in Arm, Elbow, Wrist or Hand
o Mid Back Pain or Stiffness
o Muscle Pain or Stiffness
o Jaw Pain or Clicking
o Pain or Stiffness in Leg, Hip, Knee, Ankle or Foot

CURRENT OR PREVIOUS HEALTH CONDITIONS (please mark all that apply)

o Fatigue, Loss of Energy o Heartburn o Stress
o Irritability o Sleep Problems o Headaches
o Sinus Problems

Are there any injuries for which you have received treatment within the last 12 months? o Yes o No

Injury occurred o at home (details) _____
o at work (details) _____
o in auto (details) _____

Are you currently under the care of any medical doctor? o Yes o No

Medical Doctor's Name: _____ Phone No. _____

_____

Date of last visit? _____ Reason for Visit?

_____

_____

_____

Do we have your permission to send an initial report to your PCP? o Yes o No

Did you have previous chiropractic care? o Yes o No

Doctor's Name: _____ Phone No. _____

Were X-Rays Taken? o Yes o No Date Taken:_____ Date of Last Adjustment:_____

_____

Do you take any prescription medicine? o Yes o No

If yes, please list: _____

_____

_____

Condition(s) for which medicine prescribed? _____

_____

_____

Are you taking any "over the counter" medicine? o Yes o No

If yes, please list and indicate why you are taking them:

_____

_____

_____

_____

_____

Are you taking any dietary supplements? o Yes o No

For any specific activity? o Yes o No

If yes, please list and indicate why you are taking them: _____

_____

_____

_____

EXERCISE AND FITNESS GOALS

How often do you exercise? _____ per week

Do you want to lose weight? o Yes o No

How much? _____Lbs

What do you consider your "ideal" weight? _____lbs.

Do you want to improve your balance and coordination? o Yes o No

For any specific activity? o Yes o No

If yes, please describe: _____

_____

NUTRITION AND DIETARY INFORMATION

How often do you drink the following beverages?

Water: _____ oz. per day

Coffee/ Tea: _____cups per week

Soda: _____ cans per day

Diet Soda: _____ cans per day

Additional Patient Information (Females only)

Is there a possibility that you may be pregnant? □ Yes □No

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy, and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient health Information will be used, and I agree to these policies and procedures.

Name of Patient Date

SUBJECTIVE ANALYSIS

Patient Name _____
Attending Dr: _____

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Date: _____
(Initial / Re-exam)

VISUAL ANALOG SCALE

(Please indicate the pain level you are currently experiencing
by writing each involved body area on the scale below)

0----------10

1 2 3 4 5 6 7 8 9

(no pain) **(unbearable pain)**

Total of all pain levels: _____

Circle all activities that you find difficult to do <u>now</u>:

- **Sleep through the night**
- **Get out of bed**
- **Make your bed**
- **Bathe yourself**
- **Wash, comb or dry hair**
- **Bend over a sink for 10 minutes**
- **Go to the bathroom**
- **Put on socks, shoes or clothing**
- **Walk up one flight of stairs**
- **Walk down one flight of stairs**
- **Crawl on all fours**
- **Turn a door knob**
- **Open a heavy door**
- **Sit in a chair for 30 minutes**
- **Sit and work at a desk for one hour**
- **Get up from a low seat**
- **Cross legs**
- **Walk one mile**
- **Stand for 30 minutes**
- **Travel on journeys that take over one hour**
- **Push or pull vacuum cleaner or lawn mower**
- **Carry laundry basket, groceries or a small child**
- **Wash windows or walls**
- **Bend over to clean bathtub**
- **Shovel snow or dirt**
- **Use pencil, scissors, screwdriver, or pliers**
- **Lift heavy suitcase (about 40 pounds)**
- **Reach in front or overhead to high shelves**
- **Enjoy hobbies or social activities'**
- **Enjoy sexual activates**

Total # ADL items circled_____
Subjective total _____

Circle any of the following conditions you are currently experiencing:

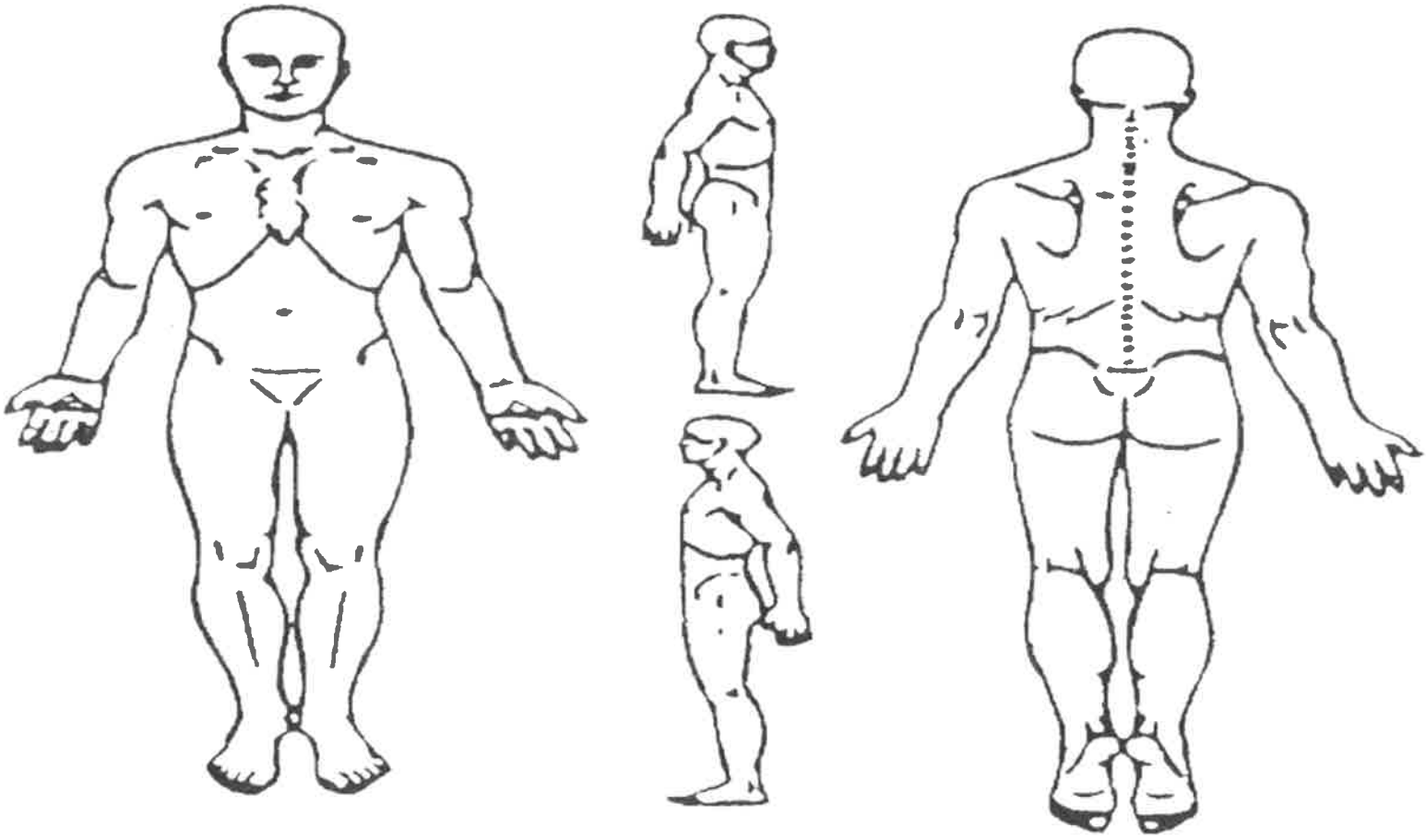
- **Neck or back weakness**
- **Restricted movement of neck or back**
- **Persistent tender areas in muscles around neck or back**
- **"Catch" or "kink" in neck or back**

Patient Signature: _____
Date: _____

Name: _____ **Date:** _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type (s) of pain:

D = Dull	S = Stabbing/Cutting
B = Burning	T = Tingling (Pins & Needles)
N = Numb	C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right now:

No Pain — Unbearable Pain

0 — 10

Rate your pain at is best in the past week:

No Pain — Unbearable Pain

0 — 10

Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain

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Massage Information and Policy Form

-Our massage rates are $65 per hour and $50 per ½ hour for current patients. In order to qualify for the patient rate, you must have had an adjustment in the last 45 days.

- Our massage rates for non-patients are $75 per hour and $60 per half hour.

- Massage appointments must be cancelled with at least 24 hours notice. If you do not cancel your massage before the 24 cancellation period, or if you fail to show up for your massage, you will be charged the full fee for the appointment. If you are a no-show for three appointments, we will no longer accept massage appointments from you.

-All massages are to be paid for, in full, on the date of service.

-Please arrive on time for your appointment. If you arrive late, your appointment may be shortened to accommodate those with appointments after you. Full payment will be expected.

I have read and agree to the policies above.

Patient Name: _____

Signature:_____ Date:_____

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Letter of Protection

I understand that my primary health insurance company is being billed for services rendered during each of my visits. If at any time during my care my insurance company denies care or discontinues coverage, I become responsible for covering the cost of my treatment. If I refuse to pay my outstanding amount due, I understand that my account will be sent to a collection agency.

_____
Patient Name (Printed)

_____ _____
Patient Signature Date

_____
Cenk Chiropractic Staff (printed)

_____ _____
Cenk Chiropractic Staff Signature Date