Total Health Chiropractic
Dr. Timothy D Annis

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Patient Name: ______________________ Birthdate: ______________ Sex: M/F

Preferred Name ______________________ Height: ________ Weight: __________

Address: ______________ City: ______________ State: __________ Zip Code: __________

Home Phone # ______________ Cell Phone # ______________ Marital Status: ☐Single ☐Married ☐Other

Social Security #: ______________ Occupation: ______________ Employer: ______________

Employer Address: ______________ City: ______________ State: __________ Zip Code: __________

Insured Name: ______________________ Insured Birthdate: ______________

Insurance Company: ______________ Subscriber ID#: ______________ Group #: __________

Insured Employer: ______________ City: ______________ State: __________ Zip Code: __________

Primary Care Physician: ______________________ Telephone: ______________

May we share our findings with them: ☐Yes ☐No   May we text you appointment reminders and announcements: ☐Yes ☐No

Whom may we thank for your Referral? ______________________

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1. **Describe your symptoms**

   ____

   ____

   a. When did your symptoms start ______________________

   b. What caused your symptoms ______________________ ☐Unknown

2. **Is this** ☐ **Work Related** ☐ **Auto Related** ☐ **N/A**

3. **How often do you experience your symptoms?**
   - ☐ Constantly (76-100% of the day)
   - ☐ Frequently (51-75% of the day)
   - ☐ Occasionally (26-50% of the day)
   - ☐ Intermittently (0-25% of the day)

4. **What describes the nature of your symptoms?**
   - ☐ Sharp ☐ Shooting
   - ☐ Dull Ache ☐ Burning
   - ☐ Numb ☐ Tingling

5. **How are your symptoms changing?**
   - ☐ Getting Better
   - ☐ Not changing
   - ☐ Getting Worse

Indicate where you have pain or other symptoms

6. **Indicate the average intensity of your symptoms:** none 0 1 2 3 4 5 6 7 8 9 10 unbearable

7. **What makes your pain worse:** (choose all that apply, if applicable)

   ☐ Movement ☐ Standing ☐ Sitting ☐ Coughing / Sneezing ☐ Exercise ☐ Yardwork

8. **What makes your pain better:** (choose all that apply, if applicable)

   ☐ Rest ☐ Chiropractic Care ☐ Medication ☐ Movement ☐ Ice ☐ Heat ☐Stretching ☐Massage

PATIENT HEALTH QUESTIONAIRE-PHQ

Patient Name: ______________________________ Date: ______________

Have you seen anyone for your symptoms?

☐ No One ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other__________

A. What treatment did you receive and when? ______________________________

Have you had similar symptoms in the past? ☐ Yes ☐ No

If you have received treatment in the past for the same or similar symptoms, who did you see?______________

Have you had Spinal X-rays, MRI or CT Scan taken? ☐Y ☐N If Yes, circle and when were the images taken: ____________

How much have your symptoms interfered with your normal lifestyle? Please circle a number in each section to indicate how you have been affected. If one or more questions are not relevant to you please leave the question blank.

1. **driving or using public transportation**?
   0 (none) 1 2 3 4 5 6 7 8 9 10 (Unable)
2. **personal care** (washing, dressing, etc..)?
   0 (none) 1 2 3 4 5 6 7 8 9 10 (Unable)
3. **childcare**?
   0 (none) 1 2 3 4 5 6 7 8 9 10 (Unable)
4. **yardwork**?
   0 (none) 1 2 3 4 5 6 7 8 9 10 (Unable)
5. **home duties**?
   0 (none) 1 2 3 4 5 6 7 8 9 10 (Unable)
6. **recreational activities**?
   0 (none) 1 2 3 4 5 6 7 8 9 10 (Unable)
7. **sleep**?
   0 (none) 1 2 3 4 5 6 7 8 9 10 (Unable)
8. **work**?
   0 (none) 1 2 3 4 5 6 7 8 9 10 (Unable)

Please check all that apply:

☐ Arthritis	☐ Anxiety	☐ High cholesterol	☐ Painful or frequent urination
☐ Joint Pain	☐ Neuropathy	☐ Emphysema	☐ Diabetes
☐ Osteoporosis	☐ Dizziness	☐ Asthma	Abnormal Weight ☐Gain ☐ Loss
☐ History of low back pain	☐ Headaches/Migraines	☐ Constipation	☐ Rash or Hives
☐ History of neck pain	☐ Eye or vision problems	☐ Heart burn	Tobacco use ☐Current ☐Former
☐ Seizures	☐ High blood pressure	☐ Diarrhea	Alcohol use ☐Current ☐Former

Exercise Habits— ☐Unable ☐Limited ☐No Effect

☐Allergies______________________________

☐ Surgeries _(Surgery & Date)______________________________

☐Medications ______________________________

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that I will be responsible for charges deemed patient responsibility or non--covered by my insurance carrier. I authorize the release of any medical or other information necessary to process my insurance claim . . I agree to pay any and all attorney and/or collection fees incurred as part of the cost of collection. I also agree to pay a minimum finance charge of 1.5% per month (APR of 18%) or a minimum of $5.00 whichever is more on any amount not paid after 30 days. I authorize payment of medical benefits to Total Chiropractic (Dr. Timothy Annis).

PATIENT SIGNATURE: ______________________________ DATE: ______________

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires that you give us this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy for our privacy notices.

I authorized Total Health Chiropractic Center to contact me with information related to my personal health needs and interests. The physician's office may use any phone number in my personal records to contact me. If contact is made by phone and I am unable to respond, a message may be left with my home answering machine or voice mail service. I may be contacted about the following:

- Appointment reminders or schedule changes.
- Information about alternative treatments, presentations or events
- Other health related information that may be of interest to me

To contact me, I authorize Back Total Health Chiropractic Center to use and disclose the following information:

- My Name, Address and Phone Numbers
- The Name of my Physician and the Clinic where I was treated

NOTE: NO DIAGNOSIS OR TREATMENT INFORMATION WILL BE USED OR DISCLOSED.

Patient Name: ______________________________ Date of Birth: ______________
(PLEASE PRINT)

Address of Patient: ______________________________ Phone: ______________
(STREET)

____
(CITY, STATE, ZIP CODE)

Total Health Chiropractic Center fully supports the protection of health information. Only the physician and office staff will use this information to contact you. While we retain the standard rights of disclosure as provided under HIPAA , this authorization allows us to access only the above authorized information for contact purposes. Failure to sign this authorization will not affect you treatment, payment or eligibility for benefits in any way. This authorization will remain valid for ten (10) years from the date of signature. You may revoke this authorization at any time or request to receive a copy of the protected health information to be used by writing to Total Health Chiropractic 460 E 2nd St Suite B Ogden, UT 84404. In this case, every effort will be made to discontinue future communications.

______________________________ ______________
Signature (Patient or person authorized) Date

Total Health Chiropractic

Dr. Timothy B. Annis
460 E. 2nd St. Suite B
Ogden UT 84404
621-2541

Informed Consent for Chiropractic Care

A patient in coming to the doctor of chiropractic gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. While the risk of injury from chiropractic care is extremely low you may experience some all or none of the following symptoms: headache, stiffness, pain, or in extremely rare cases damage to blood vessels. The best estimate of the most noteworthy negative effects is in the range of 1 in 3 million to 10 million adjustments rendered. The doctor, of course will not give the chiropractic adjustment, or health care if he is aware that such care may be contraindicated. Acupuncture may pose a minute risk of infection.

It is the responsibility of the patient to make known what he/she are suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the physician. The patient should look to the correct specialist for the proper diagnostic or clinical procedures. The doctor of chiropractic provides a specialized, non duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

Results

The goal of chiropractic care is to promote natural health for the reduction of the VSS or VSC. Since there are so many variables it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal, in most cases there is a gradual but satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which did not respond chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain control of disease.

Please discuss any questions or problems with the doctor before signing the statement of policy.

I have read understand and agree to the foregoing.

______________________________	________________
Signature	Date

Cancellation Policy

We make every effort to respect your time by staying on time and we request the same from you. We reserve the right to charge for missed appointments when no notice is given. We understand that life is busy but request that you call to reschedule if you cannot make your appointment. Please initial ____.

Appointments for **massage therapy require 24 hours notice for cancellation**. Missed appoints WILL be charged. Please initial ____.

Consent to Treat a Minor

Permission is hereby given by me to the doctor(s) of this office and whomever they designate to treat the patient. I am his/her legal guardian.

______________________	________________	______________________
Guardian Signature	Date	Witness Signature

Pregnancy Waiver

I hereby Certify that I am not Pregnant nor do I have reason to believe that I am pregnant at this time.

______________________________	________________
Patient Signature	Date

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name ______________________________ Date ____________________

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the 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 at all anxious — 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 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

____
Examiner

OTHER COMMENTS: ____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name ______________________________ Date ____________________

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the 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, walking, climbing stairs, getting in/out of bed/chair)?

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 at all anxious — 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 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

____
Examiner

OTHER COMMENTS: ______________________________

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

We pride ourselves in educating our patients on their condition with 20 short daily emails. So that you receive this important information, provide us with your email address here:

*Email Address:*__________________

For Office Use Only:

Patient Name:________________________

Chief Complaint:_______________________