# Dr. Danielle R. Rice

----------Worthington Family Chiropractic----------

## CONFIDENTIAL PATIENT INFORMATION

Please complete this questionnaire and the following forms. Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. This information will also help us to get to know you as a person and will help us determine how we can best meet your needs.

Name_____Social Security #_____-_____-_____

How do you wished to be addressed in our office? ☐First name ☐Dr. ☐Mr. ☐ Mrs. ☐Miss. ☐Ms.

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

E-Mail Address_____Age____ Birthday_____Marital Status: M S D W

Employer_____Address _____ City_____

State _____ Zip_____.Occupation_____

Spouse's Name _____ Birth Date _____ Employer _____

Number of Children _____ How did you learn about our office?_____

Name of nearest relative not living with you _____

Name:_____Phone_____

Health Information: Family Physician _____Dentist _____

Other (massage therapist, etc.) _____

**YOUR PRESENT COMPLAINT(S):** _____

_____

List other Doctors seen for this condition: _____

_____

Personal Medical history (if any of the following are relevant to your medical history, please check box)

| | | | | |
|---|---|---|---|---|
| ☐Cancer | ☐Muscular Dystrophy | ☐Rheumatic Fever | ☐Digestive Disorders | ☐Polio |
| ☐Multiple Sclerosis | ☐Scarlet Fever | ☐Sinus Trouble | ☐Tuberculosis | ☐Convulsions |
| ☐Nervousness | ☐Backaches | ☐Arthritis | ☐Epilepsy | ☐Asthma |
| ☐Numbness | ☐Heart Trouble | ☐Concussion | ☐Dizziness | ☐Diabetes |
| ☐High Blood Pressure | ☐Hepatitis | ☐German Measles | ☐Venereal Disease | |

Describe any operations you've had and the dates: _____

Have you been treated for any health condition in the last year? ☐ Yes ☐ No. _____

Describe Condition _____ Date of last physical _____

List medications you are taking _____

Are you allergic to any medication? ☐ Yes ☐No. What kind? _____

Are you pregnant? ☐ Yes ☐ No. Date of last menstrual period: _____

Do you have insurance? ☐ Yes ☐ No. Company _____ ID# _____ Group # _____

I hereby authorize Worthington Family Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

SIGNATURE AUTHORIZING CARE _____ DATE _____

57 E. Wilson Bridge Road Suite 200 * Worthington, Ohio 43085 * Phone: (614) 785-9999 * Fax: (614) 785-9995
Website: www.drdaniellerice.com * Email: drdaniellerice@yahoo.com

**Worthington Family Chiropractic**
57 E. Wilson Bridge Rd. Ste 200 Worthington, OH 43085
(p) 614 785-9999 (f) 614-785-9995

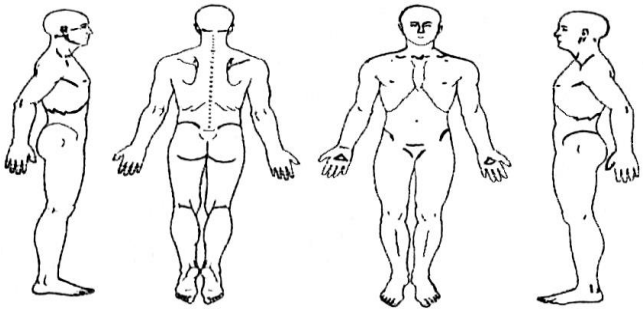
# CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

| Condition / Problem | Severity (Minimal → Severe) | Frequency (% of week) (Occasional → Constant) |
|---|---|---|
| a. _____ | 0 1 2 3 4 5 6 7 8 9 10 | 0 10 20 30 40 50 60 70 80 90 100 |
| b. _____ | 0 1 2 3 4 5 6 7 8 9 10 | 0 10 20 30 40 50 60 70 80 90 100 |
| c. _____ | 0 1 2 3 4 5 6 7 8 9 10 | 0 10 20 30 40 50 60 70 80 90 100 |
| d. _____ | 0 1 2 3 4 5 6 7 8 9 10 | 0 10 20 30 40 50 60 70 80 90 100 |
| e. _____ | 0 1 2 3 4 5 6 7 8 9 10 | 0 10 20 30 40 50 60 70 80 90 100 |

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any other major injuries you have had, other than those mentioned above: _____

_____

18. Any other Musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes

*******Additional information on back side of sheet.

19. How do these following activities impact your condition?

a. Walking: Increase / Decrease Symptoms. I can walk _____ min. before symptoms begin / increase
additional notes for walking: _____

b. Sleeping I have problems falling asleep / staying asleep / wake up stiff & sore in mornings.
additional notes for sleeping: _____

c. Standing: Increase / Decrease Symptoms: I can stand unassisted _____ min. before symptoms begin /increase
additional notes for standing: _____

d Lifting: Increase /Decrease Symptoms: I can lift _____ lb. with ease / without symptoms
additional notes for lifting: _____

e. Bending: Increase / Decrease Symptoms: I can bend easily / have to use assistance / sit to bend
additional notes for bending: _____

f. Lying Flat: Increase / Decrease Symptoms: I can lay on Right Side / Back / Left Side Symptom Free
additional notes for lying: _____

g. Sitting: Increase / Decrease Symptoms: I can sit _____ min. before symptoms begin
I go sitting to standing easily / using my hands to walk up legs / use assistance / no pain / moderate pain / severe pain
additional notes for sitting: _____

h. Any other activity that you currently can't do or that aggravates your symptoms: _____
_____

20. I am currently utilizing the following activities also to help:

Massage Nutritional Supplements Prescription Medication Over the Counter Medications Exercise Physical Therapy
additional notes: _____

21. Current Medications: _____
_____

22. Current Medical Diagnosis: _____

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

# Dr. Danielle R. Rice

Worthington Family Chiropractic

## Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

The goal of chiropractic care in our office is to correct spinal misalignments, to reduce nerve system stress, and to promote normal healing and body function. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment**: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine utilizing the NUCCA system of spinal correction.

**Health**: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

**Vertebral Subluxation**: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

**Our only practice objective** is to eliminate a major interference to the expression of the body's innate ability to function properly. Our only method is specific adjustments to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(Please Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

57 E. Wilson Bridge Road, Suite 200 ▪ Worthington, Ohio 43085 ▪ Phone: (614) 785-9999 ▪ Fax (614) 785-9995
Website: www.drdaniellerice.com ▪ Email: drdaniellerice@yahoo.com

# Dr. Danielle R. Rice

Worthington Family Chiropractic

*Pain Relief and Wellness Care using the gentle & safe*
*N.U.C.C.A. Chiropractic Technique*

## INSURANCE AND FINANCIAL POLICY

At times, dealing with insurance can be somewhat confusing and frustrating. It is very important to remember that your insurance company is *your* insurer. Your policy is a contract between yourself or the company you work for and your insurance company. It is the responsibility of your insurance company to *reimburse* you for the fees you have paid in this office to the extent of your "healthcare" policy. You are responsible for contacting your insurance company to determine your benefits. It is your responsibility to file claims with your insurance company. *We will assist you in filing your claim by printing any insurance claim for you upon your request.* We have found that patients are reimbursed much quicker when they send in their own insurance claim forms. This form merely needs to be mailed or faxed to your insurance company for reimbursement. According to Ohio's Prompt Pay Law (ORC Sec. 3901.38B), your insurance company has to pay completed claims within 24 days. If we are not "providers" for your insurance company, we have no contract with your insurance company and therefore can not accept "co-pays" or contracted percentages. There is a $10.00 fee for the doctor to fill out extra insurance forms or papers requested by your insurance company.

Payment is expected at the time of service. We collect fees so that we may continue to provide service. We do not provide service so that we may collect fees. Any outstanding balances over 60 days are assessed interest at 20% ARP.

I have read and understand the above statement concerning my insurance coverage.

_____ _____

(Please Print Name) (Date)

_____

(Signature)

57 E. Wilson Bridge Road, Suite 200 ▪ Worthington, Ohio 43085 ▪ Phone: (614) 785-9999 ▪ Fax (614) 785-9995
Website: www.drdaniellerice.com ▪ Email: drdaniellerice@yahoo.com

Worthington family chiropractic
57 E. Wilson Bridge Rd. Ste 200 Worthington, oh 43085
O: 614-785-9999 F: 614-785-995

# ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

## For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgment
- ☐ An emergency situation prevented us from obtaining Acknowledgment
- ☐ Other (Please Specify)

_____

_____

_____

Staff signature Date