

# Integrated Spinal Solutions Patient Information

<b>Patient Name:</b>		<b>Today's Date:</b>	
Address:		Home Telephone:	
City/State/Zip:		Work Telephone:	
Birth Date:	Age:	Cellular Telephone:	
Height:	Weight:	Employer's Name:	
Social Security Number:		Employer's Address:	
Email:			
Marital Status: Single Married Divorced Widowed		Primary MD Name & Address	

<b>How were you referred to our office?</b>	<input type="checkbox"/> Location	<input type="checkbox"/> Our Web Site	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Provider Manual	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Spinal Talk at: _____
	<input type="checkbox"/> Internet Search	<input type="checkbox"/> Radio / TV	<input type="checkbox"/> Existing Patient: _____

## Emergency Contact Information

Nearest Adult Relative:		Relation to Patient:
Address:		Phone #:

## Insurance Information

Does your insurance cover Chiropractic treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, we need a copy of your card
If yes, indicate Insurance Company Name.  <b>If you are being seen for a work related or car accident injury we need the Claim Number and the Claims Adjusters Name.</b>	Carrier Name:
	Address:
	Telephone Number:
	I.D. Number:
	Group Number:
Are you the insured person or a dependent?	<input type="checkbox"/> Insured <input type="checkbox"/> Dependent (wife/husband/child)
If you are the insured persons dependent (spouse or child), we need the insured persons name, date of birth, social security number, name of the insured employers business and the address of the business.	Name of Insured Person:
	Social Security Number:
	Insured Date of Birth:
	Name of Insured Company
	Insured Company Address:

*As a courtesy, our office will provide insurance billing services for you if you so desire. Please remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-pay and or any other balances not paid by your insurance carrier (except for contracted discounts). Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.*

**IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE REQUIRE PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT FOR INSURANCE PATIENTS.**

**Patient Signature (Parent or responsible party):** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>Patient Name:</b>			
<b>Patient History Integrated Spinal Solutions, pc</b> (775) 828-9665 (775) 829-8686 Fax: (775) 828-7605			
<b>When did your complaint begin?</b>			
<b>Cause:</b>	<input type="checkbox"/> Car Accident <input type="checkbox"/> Fall	<input type="checkbox"/> At home <input type="checkbox"/> Athletic injury	<input type="checkbox"/> Work related <input type="checkbox"/> After surgery
<b>Have you ever had a similar injury or complaint in the past?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes : _____		
<b>Prior Treatment:</b>	<input type="checkbox"/> ER Visits	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Surgeries <input type="checkbox"/> Other:
<b>Prior Imaging:</b>	<input type="checkbox"/> X-rays	<input type="checkbox"/> CT Scan	<input type="checkbox"/> MRI <input type="checkbox"/> EMG
<b>Quality of Pain:</b>	<input type="checkbox"/> Local <input type="checkbox"/> Radiates <input type="checkbox"/> Radiates to legs <input type="checkbox"/> Radiates to arms	<input type="checkbox"/> Electrical shock <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Burning	<input type="checkbox"/> Ache <input type="checkbox"/> Tingle <input type="checkbox"/> Cramping <input type="checkbox"/> Stinging <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
<b>What aggravates your condition?</b>	<input type="checkbox"/> Standing <input type="checkbox"/> Sitting	<input type="checkbox"/> Lay Down <input type="checkbox"/> Walk up hill	<input type="checkbox"/> Walk down hill <input type="checkbox"/> Bending <input type="checkbox"/> Lifting <input type="checkbox"/> Other:
<b>What helps?</b>	<input type="checkbox"/> Standing <input type="checkbox"/> Sitting	<input type="checkbox"/> Lay Right <input type="checkbox"/> Lay Left	<input type="checkbox"/> Bend Forward <input type="checkbox"/> Change positions <input type="checkbox"/> Other:
<b>Medical Conditions:</b>	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Ulcers <input type="checkbox"/> Lung Disease	<input type="checkbox"/> Trauma <input type="checkbox"/> Nerve Disease <input type="checkbox"/> Psychiatric Disorders <input type="checkbox"/> Depression <input type="checkbox"/> Seizures	<input type="checkbox"/> Arthritis <input type="checkbox"/> Toxin Exposure <input type="checkbox"/> Other: _____ <input type="checkbox"/> Current medications:
<b>Family History:</b>	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Ulcers <input type="checkbox"/> Trauma	<input type="checkbox"/> Nerve Disease <input type="checkbox"/> Psychiatric Disorders <input type="checkbox"/> Depression <input type="checkbox"/> Lung Disease <input type="checkbox"/> Seizures	<input type="checkbox"/> Arthritis <input type="checkbox"/> Toxin Exposure <input type="checkbox"/> Other:

Patient Name: \_\_\_\_\_

**Have you recently experienced...**

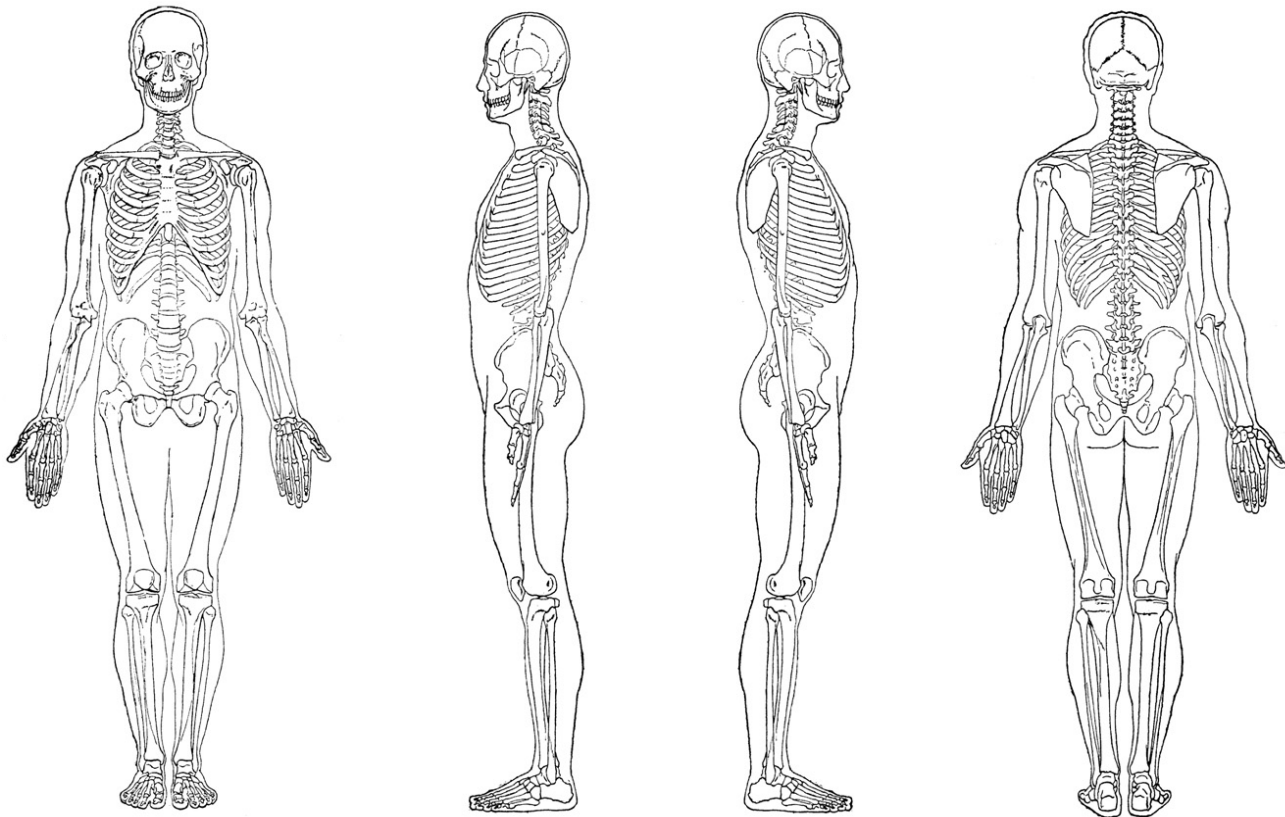
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Other Joint Pain     | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Chest Pain             |
| <input type="checkbox"/> Tightness            | <input type="checkbox"/> Sleeplessness       | <input type="checkbox"/> Sweating               |
| <input type="checkbox"/> Numbness             | <input type="checkbox"/> Decreased Energy    | <input type="checkbox"/> Vision Changes         |
| <input type="checkbox"/> Balance Loss         | <input type="checkbox"/> Nausea              | <input type="checkbox"/> Hearing Changes        |
| <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Dizziness              |
| <input type="checkbox"/> Depressed Mood       | <input type="checkbox"/> Fevers              | <input type="checkbox"/> Headaches              |
| <input type="checkbox"/> Loss of Appetite     | <input type="checkbox"/> Chills              | <input type="checkbox"/> Night Pain             |
| <input type="checkbox"/> Recent Weight Gain   | <input type="checkbox"/> Recent Weight Loss  | <input type="checkbox"/> New Lump on Body       |
| <input type="checkbox"/> Irritability         | <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Painful Bowel Movement |
| <input type="checkbox"/> Blood or dark urine  | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Painful urination      |

**Bowel or Bladder Dysfunction present?**

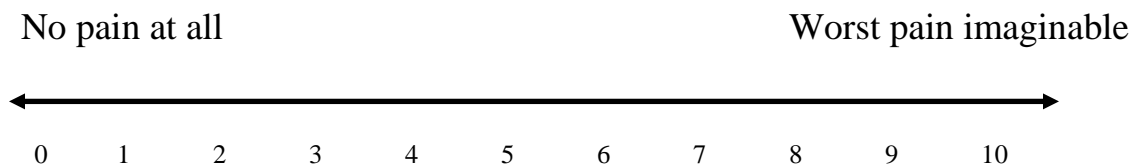
- No  
 Yes: \_\_\_\_\_

**Legend** S=Sharp Pain D=Dull Pain N=Numbness PN=Pins & Needles W=Weakness T=Tightness

Mark with an "X" where you have pain. Use lines to show how far the discomfort extends.



Indicate the severity of your current symptoms by placing an "X" on the line scale below



# INTEGRATED SPINAL SOLUTIONS, PC

## TERMS OF ACCEPTANCE

### Agreement to Financial Policy

I have agreed to pay charges at the time of service. I understand that I may pay by check, Visa or MasterCard. Emergency and after hour visits will be subject to additional charges. I agree to be charged a **missed appointment fee of \$10** if I miss an appointment without giving at least 4 hours advanced notice. I understand that as the parent or guardian, I am responsible for full payment of child's care. I further understand that for unaccompanied minors, payment in full is still required at time of service. If I have insurance coverage I hereby assign directly to Integrated Spinal Solutions, pc all medical benefits, if any, payable to me if any services rendered. I also understand that there is a 1.5% monthly interest charge on any unpaid balance over one (1) month old. It is at the discretion of the doctor to collect or waive said fee and will depend upon the payment history of the account. By signing below, I agree that should my account be referred to a collection agency or an attorney for collections, I will be directly responsible for paying all reasonable attorney's fees, other legal fees and/or any and all collection expenses.

### Patient Accepts Responsibility for Insurance Reimbursements and Approvals

I accept responsibility to know my policy limits and requirements. I further accept responsibility to seek pre-authorization, bill and collect reimbursement from my insurance carrier if applicable. I understand that my insurance policy is a contract between the insurance carrier and myself. I further understand that Integrated Spinal Solutions, pc is in no way a guarantee of coverage or reimbursement from my insurance carrier. I further understand that my health insurance will be billed as a courtesy but that I am ultimately responsible for payment. I understand that some of perhaps all of the services that I receive may not be considered reasonable and necessary under the Medicare program and/or other insurance plans. I understand that insurance claims that are over 90 days old and unpaid, will become my responsibility. By my presence and continuation of appointments, I consent and elect care provided by Dr. Xavier Martinez and/or his staff.

### Patient Will Truthfully and Fully Disclose Health Status and History

I hereby state that all information that I hereby give Integrated Spinal Solutions, pc and/or it's staff will be complete and truthful. I will not misrepresent my presence, nature, severity or cause of my injuries. I further state that I will fully disclose my health history and authorize the release of all past medical records to Integrated Spinal Solutions, pc. I present myself for health reasons only and it is not my intent to mislead, defraud or coerce this office or any third party or misrepresent myself in any manner.

### Patient Consents to Care and Accepts Responsibility

I consent to recommendations and care by the Doctor(s) of Integrated Spinal Solutions, pc for myself (or my children if minors) including, but not limited to examinations, x-rays, chiropractic adjustments, rehabilitative and physical therapy. I understand that my care will be individualized to me and therefore may not be comparable to standards or guidelines used or required by insurance companies, professional associates, and/or consensus groups. I understand that my treatment will comply with the inherent risks. These risks, though rare, could occur ranging from minor aggravation of current condition to serious conditions such as cerebral vascular accident or death. I am signing this consent after having been fully informed to my satisfaction by the Doctor(s) of Integrated Spinal Solutions, pc and/or his staff of the risks and benefits of the care and the risks and benefits of not having the recommended treatment. I have been informed and fully understand that there are no guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Doctor(s) of Integrated Spinal Solutions, pc and/or his staff.

### Medicare Limits and Responsibilities Advance Notice

**The only charge for Chiropractic that is covered by Medicare is manual manipulation of the spine.** I accept responsibility to know the current Medicare guidelines and limits for covered services. I accept responsibility to pay for all covered non-covered or denied services. I have been notified by my physician that he believes that in my case Medicare is likely to deny payment for some services. If Medicare denies payment, I agree to be personally and fully responsible for payment. I understand that I must pay for services at the time of treatment. I also understand that Integrated Spinal Solutions, pc will bill all charges directly to Medicare as required by law. I authorize the release of my records as necessary for Medicare Billing.

I have read, understand and agree to the provisions and terms of acceptance. This agreement shall become effective upon signing and be irrevocable for the full extent of my treatment by the doctor.

Patient Name (please print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**Please read:** This questionnaire is designed to enable us to understand how much your **LOW BACK** pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><b>SECTION 1 - Pain Intensity</b></p> <p><input type="checkbox"/> I can tolerate the pain without having to use painkillers.</p> <p><input type="checkbox"/> The pain is bad but I can manage without taking painkillers.</p> <p><input type="checkbox"/> Painkillers give complete relief from pain.</p> <p><input type="checkbox"/> Painkillers give moderate relief from pain.</p> <p><input type="checkbox"/> Painkillers give very little relief from pain.</p> <p><input type="checkbox"/> Painkillers have no effect on the pain and I do not use them.</p>	<p><b>SECTION 6 -Standing</b></p> <p><input type="checkbox"/> I can stand as long as I want without extra pain.</p> <p><input type="checkbox"/> I can stand as long as I want but it gives extra pain.</p> <p><input type="checkbox"/> Pain prevents me from standing more than 1 hour.</p> <p><input type="checkbox"/> Pain prevents me from standing more than 30 minutes.</p> <p><input type="checkbox"/> Pain prevents me from standing more than 10 minutes.</p> <p><input type="checkbox"/> Pain prevents me from standing at all.</p>
<p><b>SECTION 2 - Personal Care</b></p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain.</p> <p><input type="checkbox"/> I can look after myself normally but it causes extra pain.</p> <p><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</p> <p><input type="checkbox"/> I need some help but manage most of my personal care.</p> <p><input type="checkbox"/> I need help every day in most aspects of self care.</p> <p><input type="checkbox"/> I do not get dressed; I wash with difficulty and stay in bed.</p>	<p><b>SECTION 7 -Sleeping</b></p> <p><input type="checkbox"/> I get no pain in bed.</p> <p><input type="checkbox"/> I get pain in bed but it does not prevent me from sleeping well.</p> <p><input type="checkbox"/> Because of pain my normal night's sleep is reduced by less than 1/4.</p> <p><input type="checkbox"/> Because of pain my normal night's sleep is reduced by less than 1/2.</p> <p><input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than 3/4.</p> <p><input type="checkbox"/> Pain prevents me from sleeping at all.</p>
<p><b>SECTION 3 - Lifting</b></p> <p><input type="checkbox"/> I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> I can lift heavy weights but it causes extra pain</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/> I can only lift very light weights at the most.</p>	<p><b>SECTION 8 - Social Life</b></p> <p><input type="checkbox"/> My social life is normal and gives me no pain.</p> <p><input type="checkbox"/> My social life is normal but increases the degree of my pain.</p> <p><input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.</p> <p><input type="checkbox"/> Pain has restricted my social life, and I do not go out very often.</p> <p><input type="checkbox"/> Pain has restricted my social life to my home.</p> <p><input type="checkbox"/> I have no social life because of the pain.</p>
<p><b>SECTION 4 - Walking</b></p> <p><input type="checkbox"/> Pain does not prevent me from walking any distance.</p> <p><input type="checkbox"/> Pain prevents me from walking more than one mile.</p> <p><input type="checkbox"/> Pain prevents me from walking more than one-half mile.</p> <p><input type="checkbox"/> Pain prevents me from walking more than one-quarter mile</p> <p><input type="checkbox"/> I can only walk using a stick or crutches.</p> <p><input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.</p>	<p><b>SECTION 9 - Travel</b></p> <p><input type="checkbox"/> I get no pain while traveling.</p> <p><input type="checkbox"/> I get some pain while traveling, but none of my usual forms of travel make it any worse.</p> <p><input type="checkbox"/> I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.</p> <p><input type="checkbox"/> I get extra pain while traveling, which compels me to seek alternative forms of travel.</p> <p><input type="checkbox"/> Pain restricts all forms of travel.</p> <p><input type="checkbox"/> Pain prevents all forms of travel except that done lying down.</p>
<p><b>SECTION 5 -Sitting</b></p> <p><input type="checkbox"/> I can sit in any chair as long as I like</p> <p><input type="checkbox"/> I can only sit in my favorite chair as long as I like</p> <p><input type="checkbox"/> Pain prevents me from sitting more than one hour.</p> <p><input type="checkbox"/> Pain prevents me from sitting more than 30 minutes.</p> <p><input type="checkbox"/> Pain prevents me from sitting more than 10 minutes.</p> <p><input type="checkbox"/> Pain prevents me from sitting almost all the time.</p>	<p><b>SECTION 10 - Changing degree of pain</b></p> <p>†</p> <p><input type="checkbox"/> My pain is rapidly getting better.</p> <p><input type="checkbox"/> My pain fluctuates but overall is definitely getting better.</p> <p><input type="checkbox"/> My pain seems to be getting better but improvement is slow at the present.</p> <p><input type="checkbox"/> My pain is neither getting better nor worse.</p> <p><input type="checkbox"/> My pain is gradually worsening.</p> <p><input type="checkbox"/> My pain is rapidly worsening.</p>

Patient Signature: \_\_\_\_\_

# OSWESTRY NECK DISABILITY INDEX

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Please read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

<p><b>SECTION 1 - Pain Intensity</b></p> <p><input type="checkbox"/> 0 I have no pain at the moment.</p> <p><input type="checkbox"/> 1 The pain is very mild at the moment.</p> <p><input type="checkbox"/> 2 The pain is moderate at the moment.</p> <p><input type="checkbox"/> 3 The pain is fairly severe at the moment.</p> <p><input type="checkbox"/> 4 The pain is very severe at the moment.</p> <p><input type="checkbox"/> 5 The pain is the worst imaginable at the moment.</p>	<p><b>SECTION 6 -Concentration</b></p> <p><input type="checkbox"/> 0 I can concentrate fully when I want to with no difficulty.</p> <p><input type="checkbox"/> 1 I can concentrate fully when I want to with slight difficulty.</p> <p><input type="checkbox"/> 2 I have a fair degree of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> 3 I have a lot of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> 4 I have a great deal of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> 5 I cannot concentrate at all.</p>
<p><b>SECTION 2 - Personal Care (washing, dressing, etc)</b></p> <p><input type="checkbox"/> 0 I can look after myself normally without causing extra pain.</p> <p><input type="checkbox"/> 1 I can look after myself normally, but it causes extra pain.</p> <p><input type="checkbox"/> 2 It is painful to look after myself; I am slow and careful.</p> <p><input type="checkbox"/> 3 I need some help but manage most of my personal care.</p> <p><input type="checkbox"/> 4 I need help every day in most aspects of self-care.</p> <p><input type="checkbox"/> 5 I do not get dressed; I wash with difficulty and stay in bed.</p>	<p><b>SECTION 7 -Work</b></p> <p><input type="checkbox"/> 0 I can do as much work as I want to.</p> <p><input type="checkbox"/> 1 I can only do my usual work, but no more.</p> <p><input type="checkbox"/> 2 I can do most of my usual work, but no more.</p> <p><input type="checkbox"/> 3 I cannot do my usual work.</p> <p><input type="checkbox"/> 4 I can hardly do any work at all.</p> <p><input type="checkbox"/> 5 I can't do any work at all.</p>
<p><b>SECTION 3 - Lifting</b></p> <p><input type="checkbox"/> 0 I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> 1 I can lift heavy weights, but it gives me extra pain.</p> <p><input type="checkbox"/> 2 pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned for example on a table.</p> <p><input type="checkbox"/> 3 pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/> 4 I can with only very light weights.</p> <p><input type="checkbox"/> 5 I cannot lift or carry anything at all.</p>	<p><b>SECTION 8 - Driving</b></p> <p><input type="checkbox"/> 0 I can drive my car without any neck pain.</p> <p><input type="checkbox"/> 1 I can drive my car as long as I want with slight pain in my neck.</p> <p><input type="checkbox"/> 2 I can drive my car as long as I want with moderate pain in my neck.</p> <p><input type="checkbox"/> 3 I can't drive my car as long as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> 4 I can hardly drive at all because of severe pain in my neck.</p> <p><input type="checkbox"/> 5 I can't drive my car at all.</p>
<p><b>SECTION 4 - Reading</b></p> <p><input type="checkbox"/> 0 I can read as much as I want to with no pain in my neck.</p> <p><input type="checkbox"/> 1 I can read as much as I want to with slight pain in my neck.</p> <p><input type="checkbox"/> 2 I can read as much as I want with moderate neck pain.</p> <p><input type="checkbox"/> 3 I can't read as much as I want because of moderate neck pain.</p> <p><input type="checkbox"/> 4 I can hardly read at all because of severe pain in my neck.</p> <p><input type="checkbox"/> 5 I cannot read at all.</p>	<p><b>SECTION 9 - Sleeping</b></p> <p><input type="checkbox"/> 0 I have no trouble sleeping.</p> <p><input type="checkbox"/> 1 My sleep is slightly disturbed (less than one hour sleeplessness).</p> <p><input type="checkbox"/> 2 My sleep is mildly disturbed (1-2 hours sleepless).</p> <p><input type="checkbox"/> 3 My sleep is moderately disturbed (2-3 hours sleepless).</p> <p><input type="checkbox"/> 4 My sleep is greatly disturbed (3-5 hours sleepless).</p> <p><input type="checkbox"/> 5 My sleep is completely disturbed (5-7 hours sleepless).</p>
<p><b>SECTION 5 -Headaches</b></p> <p><input type="checkbox"/> 0 I have no headaches at all.</p> <p><input type="checkbox"/> 1 I have slight headaches that come infrequently.</p> <p><input type="checkbox"/> 2 I have slight headaches that come frequently.</p> <p><input type="checkbox"/> 3 I have moderate headaches that come infrequently.</p> <p><input type="checkbox"/> 4 I have moderate headaches that come frequently.</p> <p><input type="checkbox"/> 5 I have headaches almost all the time.</p>	<p><b>SECTION 10 -Recreation</b></p> <p><input type="checkbox"/> 0 I am able to engage in all my recreation activities with no neck pain at all.</p> <p><input type="checkbox"/> 1 I am able to engage in all my recreational activities, with some pain in my neck.</p> <p><input type="checkbox"/> 2 I am able to engage in most, but not all of my usual of recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> 3 I am able to engage in a few of my recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> 4 I can hardly do any recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> 5 I can't do any recreational activities at all.</p>

Patient Signature: \_\_\_\_\_