Greenwood Spine Care PLLC
11001 S. Kedzie Ave.
Chicago, IL 60655
(773)239-7777
(773)585-5550

PATIENT INFORMATION

Patient Name: ______________________ Sex: M / F Date of Birth: ___/___/_____ Age: _____

Address: ______________________ Cell Phone #: (______) ______ - ____________

City, State, Zip Code: ______________________ Cell Phone Carrier (text message reminders) __________

Email Address: ______________ @ _________ Work Phone #: (______) ______ - ____________

Emergency Contact: Name: ______________________ Phone #: (_____) ______ - ____________

PRIMARY INSURANCE CARRIER

Ins. Co Name: ______________________

(if PPO or HMO please identify plan) ______________

SECONDARY INSURANCE CARRIER

Ins. Co Name: ______________________

(if PPO or HMO please identify plan) ______________

PAST MEDICAL HISTORY – check any of the following that you have had or been treated for in the past

__ Cancer	__ Polio	__ Tuberculosis	__ High Blood Pressure	__ Heart Conditions	__ Diabetes
__ Hepatitis	__ Measles	__ Epilepsy	__ Muscular Dystrophy	__ Multiple Sclerosis	__ Dizziness
__ Arthritis	__Asthma	__ Sinus problems	__ Rheumatoid Arthritis	__ Numbness	__ Anemia

Review of Systems – Please circle Yes or No for each condition

1 General – Have you experienced any recent weight changes, weakness, night sweating or fever? Y / N
2 Skin – Have you noticed and new or abnormal skin rashes, lumps, soreness, dryness or changes in hair or nails? Y / N
3 Head – Do you have headaches or have you had any previous head injury or concussions? Y / N
4 Eyes – Have you had any change in vision, eye pain, redness, double vision, glaucoma or cataracts? Y / N
5 Ears – Any changes in hearing, dizziness, earaches, infection or discharge? Y / N
6 Nose/Sinus – Have you had frequent colds, nasal congestion, discharge, hay fever, nosebleeds or other sinus trouble? Y / N
7 Mouth/Throat – Any changes in teeth, gums, tongue, trouble swallowing or sore throats? Y / N
8 Breast – Any lumps or nipple discharge? Y / N
9 Respiratory - Have you had a persistent cough, wheezing, asthma, bronchitis, emphysema, TB or pleurisy? Y / N
10 Cardiac – Do you have any heart trouble, high blood pressure, chest pain, trouble breathing, swelling of the hands or feet? Y / N
11 GI – Have you had any problems with heartburn, appetite, nausea, vomiting, GERD, stomach pain, food or medication intolerance, jaundice, liver or gallbladder trouble, constipation, diarrhea, blood in stool, dark stools, or inability to control your bowels? Y / N
12 Urinary – Have you had frequent urination, the need to urinate during the night, inability to control your bladder, pain or burning on urination, feeling the need to urinate but you cannot, frequent urinary tract infections? Y / N
13 Reproductive - Male – Any hernias, discharge from penis, testicular pain or changes in sexual function? Y / N
Female – Any changes in periods, vaginal discharge, itching or changes in sexual function? Y / N
14 Peripheral Vascular – Any arm or leg cramps, varicose veins, leg or arm heaviness? Y / N
15 Hematologic - Have you had anemia, past transfusion or do you bruise easily? Y / N
16 Endocrine – Have you had thyroid trouble, heat or cold intolerance, excessive sweating, diabetes, excessive thirst or frequent urination? Y / N

By signing below, I authorize the release of all medical information necessary to process my insurance claim. I assign all medical benefits including major medical benefits to which I am entitled to **Greenwood Spine Care PLLC**. In the event that I am being treated for injuries sustained in a motor vehicle crash or other personal injury/litigation case, this assignment is to serve as a rescission of any attorney lien and I instruct all payments for my treatment be made directly to **Greenwood Spine Care PLLC** only.

I understand that regardless of my insurance, I am financially responsible for payment for all fees for services rendered including all collection and attorney fees if applicable. A photocopy of this assignment is considered valid as the original. This irrevocable assignment will remain in effect until payment in full is received for all services and treatment provided. If the balance is not paid in full at the time of service, for whatever reason, it is agreed that our office is extending credit to you as a courtesy. If credit is extended, you authorize our office and/or our agents to access your consumer credit report:

Patient Signature: ______________________ Date: ______________

(Parent/ Guardian)

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HEALTHCARE CONSENT

1) **To Treat:** I, for myself (or the patient named below), hereby consent to diagnostic procedures, chiropractic treatment, physical therapy and any other treatment deemed appropriate and necessary for my condition or illness by Greenwood Spine Care PLLC, or outpatient treatment in the judgement of my physicians, to be performed by Greenwood Spine Care PLLC's physicians, therapists and other healthcare providers/staff. I understand that the physicians and other healthcare providers may participate in my treatment and I consent to such involvement in my care. By signing I agree that all risks and potential negative outcomes of my treatment have been explained to me.
2) **Responsibility for Payment:** In consideration of services to be rendered by/at Greenwood Spine Care PLLC, the undersigned agrees, as patient or guarantor for the patient, to pay Greenwood Spine Care PLLC for all services and supplies provided to me or the patient at the established rates, including any deductible, copayment or charges not covered by third party payers. I as the undersigned accept all responsibility for any collections costs, including attorney fees incurred in the collection of these charges. I understand that if I do not consent to release of record or later revoke such consent, I am fully responsible for payment of all charges for diagnosis and treatment received. I certify that the information given by me for purposes of payment for this treatment is, to the best of my knowledge, complete and accurate. I understand that if I am having difficulty in meeting my payment responsibilities to Greenwood Spine Care PLLC, financial contract arrangements are available upon request.
3) **Irrevocable Assignment of Benefits:** In consideration of services rendered by/at Greenwood Spine Care PLLC , I hereby irrevocably assign and authorize direct payment to Greenwood Spine Care PLLC, by any insurance, health plan, or third party payer benefits otherwise payable to me or on my behalf for those services. This irrevocable assignment is to also serve as a rescission of any attorney lien for payment of services received at Greenwood Spine Care PLLC. I instruct all insurance carriers to pay Greenwood Spine Care PLLC directly for all treatment provided.
4) **Medicare Payment & Assignment of Benefits** (if applicable): I request that all payments of authorized Medicare benefits be made on my behalf for services provided to me at Greenwood Spine Care PLLC and I assign such benefits to Greenwood Spine Care PLLC. I certify that the information given by me in applying for such benefits is correct. I authorize any holder of medical or other information about me to be released to the Centers for Medicare and Medicaid Services and its agents any information needed for payment of such benefits. I authorize the Social Security Administration to release information about my entitlement of benefits to Greenwood Chiropractic providing services to me.
5) **Release of Medical Information for Payment:**
   A) General Release for Payment: I hereby authorize Greenwood Spine Care PLLC to release any and all information obtained in my medical records including HIV, mental health, and/or substance abuse to third party payers responsible for payment of patient charges including but not limited to; insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies or intermediaries representing any of the above.
   B) By initialing in the space below, I do not consent to the release of medical information concerning HIV, mental health, substance abuse diagnoses or treatment, if any, to third party payers and I understand that I am personally responsible for all payment for all services provided. __________ Initials.
6) **Duration and Revocation of Authorization for release of information for billing.** This authorization to release information related to payment expires upon satisfactory payment of all outstanding bills/charges for treatment in this office. This authorization (or the refusal under paragraph 5B) may be revoked at any time by written notice with no effect on prior disclosures. If I revoke this authorization prior to satisfactory payment, I understand and accept that I am personally responsible for payment of all outstanding charges.
7) **Credit Card Payment Authorization:** I hereby authorize Greenwood Spine Care PLLC to use my credit card for all copays, co-insurance, non-covered services, or other balances that are my financial responsibility if not paid within 60 of first bill/statement/notice.
   Credit Card Type (circle) Visa MC Amex Discover Card # ________-________-________-________ Exp: ___/_____
8) **Interest:** 1.5% interest will be accrued per month on past due balances as described above, beyond 60 days past due.
9) **Radiology Fee:** I understand that my x-rays will be sent for interpretation by a board certified radiologist. I understand that there is a fee for this service and my insurance will be billed. I also agree that by signing below, I as the patient am responsible for any unpaid portion or non-covered portion of the radiology fee. I authorize and assign direct payments to be paid directly to Gregerson Radiology consultants. **By signing below, I acknowledge that I have read and agree to all terms listed above. I also confirm that I am the patient or I am authorized to sign on the patient's behalf.**

Patient Name: ______________________________ **Date:** ____________________

Patient Signature: ______________________________ **Witness Signature:** ____________________

Patient Health Questionnaire - PHQ

Form PHQ-202

Health Plan Use Only rev 7/18/05

Patient Name________________ **Date**________________

1. Describe your symptoms ________________

____

a. When did your symptoms start? ________________

b. How did your symptoms begin? ________________

2. How often do you experience your symptoms?
- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms

3. What describes the nature of your symptoms?
- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?
- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)Plan

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?
- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when? ________________

b. What tests have you had for your symptoms and when were they performed?
- ① Xrays date: ________
- ② MRI date: ________
- ③ CT Scan date: ________
- ④ Other date: ________

9. Have you had similar symptoms in the past?
- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?
- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?
____
- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?
- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature________________ **Date**________________

Patient's Name____ Number____________ Date____________________

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5-Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = ____________ %ADL______

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7—Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Comments____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Patient's Name______________________ Number__________ Date______________

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = __________ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments______________________________

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204