Yerkey Chiropractic Patient Questionnaire

Circle your answer or fill out. Thanks

1. What is/are your goal/s of your treatment here at Yerkey Chiropractic?
   a. Get out of Pain
   b. Get out of Pain and improve function
   c. Get out of Pain and improve function and prevent reoccurrences
   d. I am not in Pain I just want wellness care
2. Would you consider yourself….
   a. always on time to your appointments
   b. sometimes on time, sometimes late, and needs a reminder call
   c. always late, need a reminder call
   d. an individual who reschedules often, and needs a reminder call
3. Do you prefer appointments…
   a. In the morning
   b. In the lunch hour
   c. In the evening
   d. On Saturday Mornings
4. Would you consider yourself…
   a. The individual in charge of healthcare decisions in your household
   b. My spouse takes care of the healthcare decisions
   c. My parents take care of healthcare
5. How long is your ideal Chiropractic treatment length. (do not consider the waiting room, Just the treatment)
   a. Less than 15minutes
   b. 30 minutes
   c. one hour
   d. it does not matter
6. Please put the following, in order of importance (put a 1 for most important, 2 for next and so on)
   a. Treatment time
   b. Price out of pocket
   c. Knowledge and competence of Doctor
   d. Courtesy of office staff
   e. Having available appointment that fits your schedule
7. What is your biggest fear of Chiropractic?
   a. Have to keep coming back for a long period of time
   b. Pain that may be induced by the treatment (side affects)
   c. Not having a good outcome
   d. Don't know never been to a Chiropractor
8. What influences your willingness to refer friends and family to a Doctor
   a. Does not matter I never usually refer
   b. I refer only when the conversation permits
   c. I actively try to get my friends and family to see doctors I see
   d. I refer only if appointments are convienent, staff is friendly& I get better

REGISTRATION

Date: ________________________ Home Phone: ____________________________

Additional Contact Numbers: Cell______________________, Pager_________________, Work_____________

Patient: ____________________________ Street Address _______________________________________

Last Name First Name Initial

City: ________________________ State: _________ Zip Code: ________ Age ____ D.O.B. ______

Sex: ◻ M ◻ F ◻ Single ◻ Married ◻ Widowed ◻ Separated ◻ Divorced

Social Security Number: __________________ Email address_____________________________________

Insured's Name: __________________ Nearest Relative: __________ Phone: ______________________

Last First Initial

Relationship ◻ Self ◻ Spouse ◻ Child ◻ Other Condition Related to ◻ Illness ◻ Employment ◻ Auto ◻ Other

SPOUSE IF INSURED

Name____

Last Name First Name Initial

Birth date ______________________ _____ Social Security______________________

Employer Name______________________ _____ Occupation________________________

Address____________________________________ Phone______________________

City______________________________ State_______ Zip_________________

ASSIGNMENT OF INSURANCE BENEFITS

I authorize and direct that payment be made directly to:

Yerkey Chiropractic Health Center, Inc.
727 E. Western Reserve Road, Suite B
Poland, Ohio 44514

Yerkey Chiropractic Health Center, Inc.
8 Union Street
Columbiana, Ohio 44408

For any and all insurance benefits or reimbursement for services rendered by Yerkey Chiropractic Health Center, Inc. which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

RELEASE OF INFORMATION: I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare, BWC, Current Provider with Signature.

PAYMENT AGREEMENT: I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Not withstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

______________________________ ______________________________

Date Patient Signature

Patient Name ______________________________ **Date** _________________________________

Family Physician ____

Do you smoke? ☐Yes ☐No Packs Per Day: ________ For _________ Years

Do you drink alcohol? ☐Yes ☐No If so, how much per week? _________________________

Is there a possibility you are pregnant? ☐Yes ☐No

Allergies: ____

Have you lost or gained weight in the past year? ☐Yes ☐No If so, how much? _______________

Have you ever had cancer? ☐Yes ☐No Are you losing weight without trying? ☐Yes ☐No

Does your pain ever wake you from a sound sleep? ☐Yes ☐No

Are you coughing up blood or noticing blood in your urine or stools? ☐Yes ☐No

Have you lost consciousness or memory recently? ☐Yes ☐No

Are you seeing any other Doctor(s) now for any reason? ☐Yes ☐No Doctor _____________

PLEASE DESCRIBE YOUR CONDITION OR PAIN: ____________________________________

HOW DO YOU BELIEVE YOUR PROBLEM (PAIN) BEGAN? ___________________________

____

When did you first notice this pain (problem)? ______________________________________

IS THIS CONDITION DUE TO AN INJURY? ☐Yes ☐No If yes, the injury occurred at:
☐Home ☐Work ☐Automobile Accident ☐Other ____

Date of Injury __________________ Please describe the incident ___________________________

Have you previously injured or had similar symptoms to this body part before? _________________

In the past have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc? _______
When ___________________ Give details: ____

Name___________

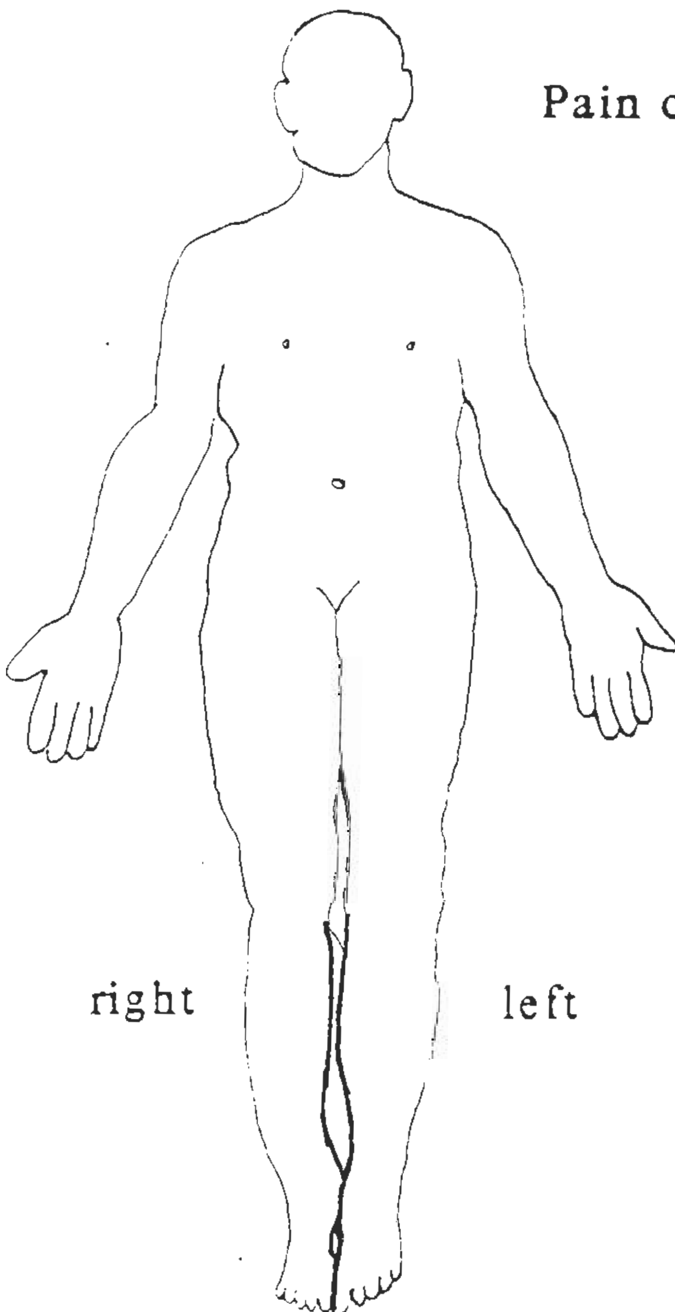
File___________

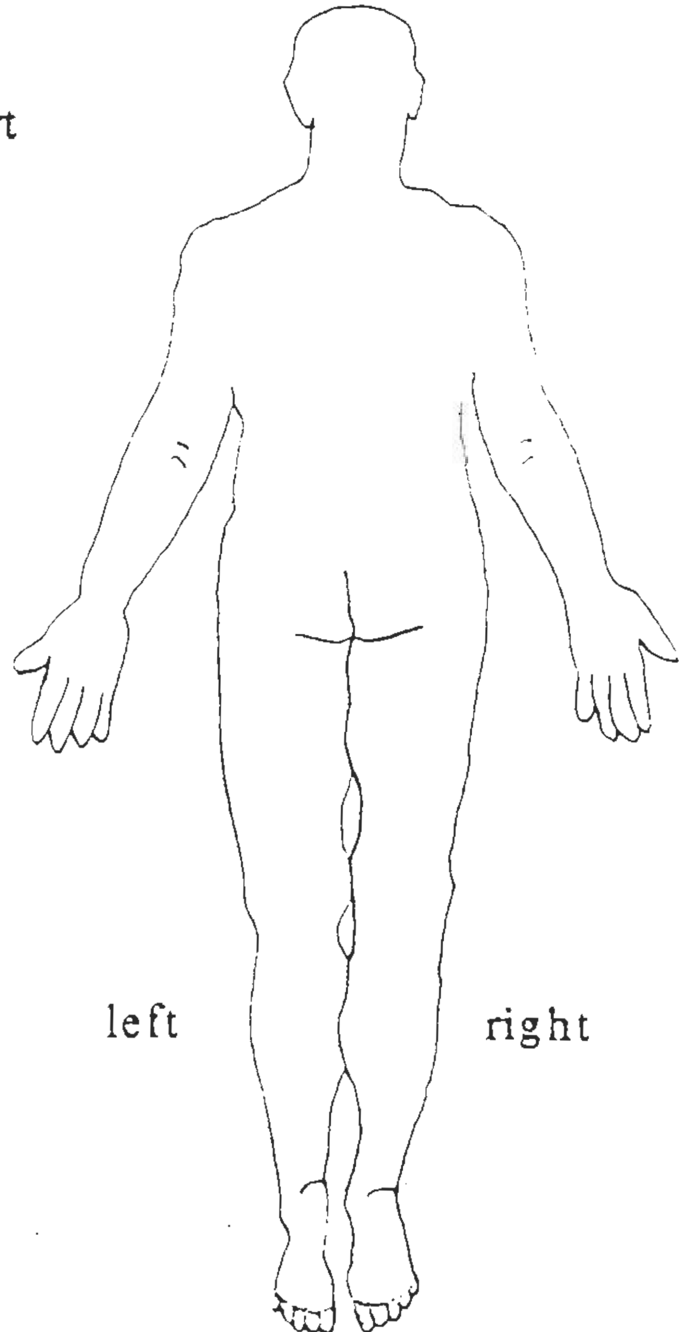
Date___________

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////

Pain chart





NCC 1001

QUADRUPLE VISUAL ANALOG SCALE

INSTRUCTIONS: Please mark an X at the position on the line which indicates how much pain you feel. NOTE: If you have more than one complaint, please answer each question for each individual complaint. Please indicate your pain levels using the last 3 months as your reference.

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1. Please mark an "X" on the line to indicate what your pain level is RIGHT NOW?

   no pain ____ worst possible pain
   0 10

2. Please mark an "X" on the line to indicate what your TYPICAL or AVERAGE pain level is?

   no pain ____ worst possible pain
   0 10

3. Please mark an "X" on the line to indicate what your pain level is AT ITS BEST? (How close to "0" does your pain get at its best?)

   no pain ____ worst possible pain
   0 10

   What percentage of your awake hours is your pain at its best? ______%

4. Please mark an "X" on the line to indiate what your pain level is AT ITS WORST? (How close to "0" does your pain get at its worst?)

   no pain ____ worst possible pain
   0 10

   What percentage of your awake hours is your pain at its worst? ______%

NAME: ______________________ AGE: ____ DATE: ______________ SCORE: ______

SCORE: 1 ____ + 2 ____ + 4 ____ = ____/ 3 x 10 = ____ (Low Intensity = <50; High Intensity = >50)

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Patient Information

Please list all medications you are currently taking:

MEDICATION	CONDITION (i.e., Diabetes)	HOW OFTEN	DOSAGE

Please list all surgeries:

BODY PART (i.e., Knee)	DOCTOR	DATE	HOSPITAL

Please list all past illnesses: (i.e., Diabetes, High Blood Pressure, etc.)

ILLNESS	DOCTOR	DATE DIAGNOSED	DOCTORS LOCATION

Please indicate any injuries that you have had in the past (i.e., sprains, fractures, dislocations, auto or work injuries)

TYPE OF INJURY	DATE OF INJURY	REMAINING COMPLAINTS

Please list all ***BLOOD*** relatives who have had the following:

CONDITION	BLOOD RELATIVE	PRESENT AGE	DECEASED AGE
DIABETES			
CANCER			
HIGH BLOOD PRESSURE			
HEART DISEASE			
TUBERCULOSIS			
THYROID DISEASE			
ARTHRITIS			
STROKE			
OTHER			

NAME ______________________________ *DATE*______________________________

Below are listed some common symptoms which may suggest the presence of an ailment involving a particular body system. If you have ever had a listed symptom in the **past**, please check that symptom in the **left hand column.** If you are **presently** troubled by a particular symptom, check that symptom in the **right hand column.**

Past	***Musculoskeletal***	Present
☐	Neck Pain	☐
☐	Shoulder Pain	☐
☐	Pain in Upper Arm or Elbow	☐
☐	Hand Pain	☐
☐	Upper Back Pain	☐
☐	Lower Back Pain	☐
☐	Pain in Upper Leg or Hip	☐
☐	Pain in Ankle or Foot	☐
☐	Jaw Pain	☐
☐	Swelling of Joints	☐

Past	***Nervous System***	Present
☐	Stiffness of Joints	☐
☐	Depression	☐
☐	Insomnia (trouble sleeping)	☐
☐	Bed Wetting	☐
☐	Fainting	☐
☐	Convulsions	☐
☐	Dizziness	☐
☐	Headache	☐
☐	Muscular Incoordination	☐
☐	Hearing Loss	☐
☐	Tinnitus (ear noises)	☐
☐	Ear Pain	☐
☐	Impaired Vision	☐
☐	Eye Pain	☐

Past	***Cardiovascular***	Present
☐	Rapid Heart Beat	☐
☐	Chest Pains	☐

Past	***Endocrine***	Present
☐	Loss of Appetite	☐
☐	Abnormal Weight Gain	☐
☐	Abnormal Weight Loss	☐

Past	***Respiratory***	Present
☐	Shortness of Breath	☐
☐	Chronic Pain	☐
☐	Chronic Cough	☐
☐	Chronic Sinusitis	☐

Past	***Gynecologic***	Present
☐	Pain During Menstruation	☐
☐	Irregular Menstrual Flow	☐
☐	Spotting	☐
☐	Menopausal Symptoms	☐

Past	***Genito -Urinary***	Present
☐	Painful Urination	☐
☐	Loss of Bladder Control	☐
☐	Frequent Urination	☐
☐	Urethral Discharge	☐

Past	***GI Tract***	Present
☐	Abdominal Pain	☐
☐	Difficulty in Swallowing	☐
☐	Heartburn/Indigestion	☐
☐	Constipation	☐

Past	***Skin***	Present
☐	Rash	☐
☐	Dermatitis or Eczema	☐
☐	Persistent Itching	☐

Please check any of the following that apply to you:

Past	***Miscellaneous***	Present
☐	Tobacco	☐
☐	Alcohol	☐
☐	Tranquilizers/Sedatives	☐
☐	Laxatives	☐
☐	Other________________	☐
☐	Coffee, cups per day ___	☐

Past	***Condition***	Present
☐	Hemorrhoids	☐
☐	Rheumatic Heart Disease	☐
☐	High Blood Pressure	☐
☐	Angina	☐
☐	Heart Attack	☐
☐	Stroke	☐
☐	Asthma	☐
☐	Cancer	☐
☐	Emphysema	☐
☐	Arthritis	☐
☐	Drug or Alcohol Dependency	☐
☐	Diabetes	☐
☐	Ulcer	☐
☐	Kidney Stones	☐
☐	Bladder Infection	☐

Past	***Other***	Present
☐	____________________	☐
☐	____________________	☐

Office Visits and Payment Options

We **emphasize the importance of a treatment plan and scheduled visits**. In doing so, this puts you in the position to get the best results for your condition, and at the same time reserves a place for you in our schedule. This usually means you will not wait in the waiting area and you will always be moving through the clinic, we value your time as well as ours, and try not to waste it.

In order to process people efficiently we have a strict office policy in place due to missed appointments we experience. If you do not **reschedule** your appointment with at least 24 hour notice we will charge 15.00 to your account.

A **No Show** for a scheduled appointment will be charged the 15.00 to the account, as well as inform you that one additional No Show will result in you paying toward your next visit/s ahead of time.

I apologize if this policy offends you, it is only in place for individuals that take advantage of our schedule and as always when special circumstances arise we will be understanding.

Payment Options

We always try to accommodate most financial situations. We have several ways to make getting treatment affordable for most. If you need additional options due to certain circumstances please notify Dr. Yerkey early in your treatment schedule.

Credit cards are accepted, we can do monthly scheduled payments with your card on file
Cash payments at time of service are discounted
Pay co-payments weekly
Make arrangements for monthly installments on your account balance.
We do not charge up front for most deductibles, or for Personal injury cases
If any of these do not fit your situation please speak to us privately.

Patient Signature________________________________ Date:__________________

PRACTICE'S REQUIREMENTS
YERKEY CHIROPRACTIC
HEALTH CENTER, INC.

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this PRIVACY NOTICE detailing the PRACTICE'S legal duties and privacy practices with respect to your PHI.

(b) Adheres to OHIO laws in those instances where OHIO law does not conflict with federal law. See explanation of OHIO law attached.

(c) Is required to abide by the terms of this PRIVACY NOTICE.

(d) Reserve the right to change the terms of this PRIVACY NOTICE and to make the new PRIVACY NOTICE provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised PRIVACY NOTICE to you prior to implementation.

(f) Will not retaliate you for filing a complaint.

EFFECTIVE DATE

This NOTICE is in effect as of 4/15/03

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this NOTICE, and my understanding and my agreement to its terms.

Patient ____________________________

Date ____________________________