West Chiropractic
& Neuropathy Center — Dr. Nathan Lea

Pain Questionnaire

Name: _____ DOB _____ Date _____

0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

None/not severe **The worst/very severe**

1 - Does your pain interfere with your normal work inside and outside the home?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

2 - Does your pain interfere with personal care such as washing, dressing, etc.?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

3 - Does your pain interfere with your traveling?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

4 - Does your pain interfere with your ability to sit or stand?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

5 - Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

6 - Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

7 - Does your pain affect your ability to walk or run?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

8 - Has your income declined since your pain began?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

9 - Do you have to take pain medication every day to control your pain?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

10 - Does your pain force you to see Doctors more often than when your pain began?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

11 - Does your pain interfere with your ability to see the people who are important to you?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

12 - Does your pain interfere with recreational activities and hobbies that are important to you?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

13 - Do you need the help of your family/friends to complete everyday tasks? (including housework/work outside the home.)

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

14 - Do you feel more depressed, tense, or anxious now than when your pain began?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

15 - Are there emotional problems, caused by your pain, that interfere with your family, social, or work activities?

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

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Personal Information: Date_____

Name _____ Cell: _____ Home: _____

Address _____

City/State/Zip _____

Date of Birth _____ SSN_____ Occupation _____

Email _____

Primary Insurance _____ Member ID: _____

Secondary Insurance _____ Member ID: _____

❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Live In Partner

Emergency Contact _____ Phone _____

Please check any and all insurance that may be applicable in this case ❑ Health Insurance ❑ Workmans Comp ❑ Auto (PIP)

If you are not a Florida resident - Date you arrived _____ Date you leave _____

How did you hear about us? _____

The following information will be used to help determine safe and effective treatment.
Please answer to the best of your ability.

Major complaints and symptoms: ***Please be specific.***: _____

_____

_____

_____

How did this problem begin? _____

When did you first notice this problem/pain? _____

What makes this condition worse? _____

What relieves this condition? _____

Date you last worked? _____

Have you ever had this condition, or a similar condition before? _____

Have you ever had Chiropractic care before? ❑ Yes ❑ No - When? _____

Chiropractors Name / Location? _____

Have you seen anyone else for this condition? _____

If yes - Where?_____ When?_____

Primary Care Physician's Name _____ Phone#: _____

Authorization and release: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the Dr. to release all information necessary to communicate with personal physicians, other healthcare providers and payers; and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of Insurance Coverage. I also understand that if I suspend or terminate my schedule of care, as determined by my treating Dr., any fees for these services will be immediately due and payable. _____ **Please Initial**

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Medical History

Have you ever been in an accident? ❑ auto ❑slip & fall ❑ workmans comp

_____

If yes, please describe (dates & treatment received) _____

Are you currently under medical supervision? ❑ YES ❑ NO - If yes, please explain

_____

Have you gained/lost weight in the last year? ❑ YES ❑ NO - How much? _____ ❑ Gained ❑ Lost

Are you allergic to any medications? ❑ Yes ❑ No - If yes, what medications _____

Are you taking any medication? ❑ Yes ❑ No - please

list:_____

Date of last X Ray? _____ Urinalysis? _____ Blood Work? _____

Habits - ❑ Tea *quantity:_____per day* ❑ Coffee *quantity:____per day* ❑ Alcohol *quantity:____per day* ❑ Cigarettes *quantity:____per day* ❑ Vape

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For Women (MUST BE COMPLETED)

Pregnancy Release/X-Ray Consent form

Date of last menstrual period _____ Possibility of Pregnancy? ❑ Yes ❑ No - # of Pregnancies ____

Are you trying to get pregnant currently? Y: ___ N: ___

Please sign the release form to acknowledge that you do not feel it is necessary to undergo a pregnancy test before the imaging procedures, understanding the potential risks associated with radiation exposure to yourself and your unborn child if you were pregnant. Your health and well-being are important to us, and we are here to support your informed decisions.

_____ _____/_____/_____

Patient Signature Date

Please check any condition listed below that applies to you?

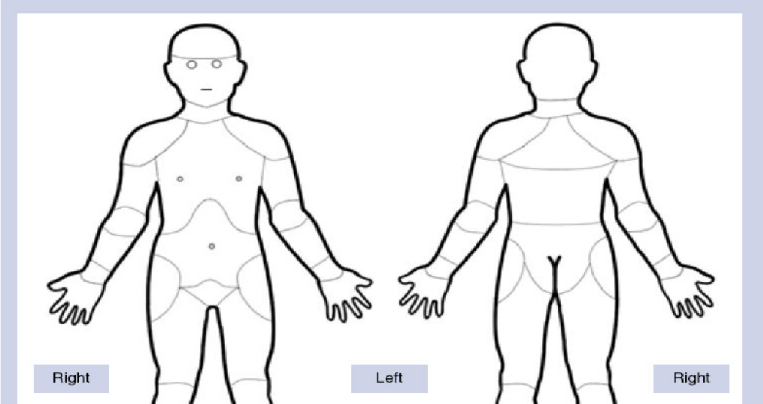
❑ Headache ❑ Ringing in the Ears ❑ Memory Loss ❑ Dizziness ❑ Irritability ❑ Arm Pain ❑ Loss of smell ❑ Loss of Taste ❑ Pins & Needles in Arms or Legs ❑ Cold Hands ❑ Cold Feet ❑ Muscle Spasms ❑ Difficulty Urinating ❑ Difficulty Breathing ❑ Depression ❑ Vomiting ❑ Swelling joints ❑ Knee pain ❑ Tension ❑ Chest Pain ❑ Weakness ❑ Loss of Balance ❑ High Blood Pressure ❑ Low Blood Pressure ❑ Sick Frequently ❑ Sinus Problems ❑ Foot Pain ❑ Neck Pain ❑ Trouble Sleeping ❑ Menstrual Issues ❑ Shoulder Pain ❑ Hip Pain ❑ Back Pain ❑ Swelling ❑ Cancer ❑ HIV ❑ AIDS ❑ Diabetes ❑ Colitis ❑ Stroke

Family Medical History _____

_____

_____

Please Circle the Areas of Pain



Consent for chiropractic care: A patient coming into the chiropractic clinic gives the doctor permission and authority to care for said patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments and/or other clinical procedures are usually beneficial to the patient and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies, may render the patient susceptible to injury. The doctor will not give any treatment or healthcare if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures, whatever latent pathological defects, illnesses, or deformities; which would otherwise not come to the attention of the doctor: he/she is suffering from. The Chiropractor provides a specialized, non duplicating, health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regime.

I understand that if I am accepted as a patient by a doctor at West Chiropractic Clinic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved regarding chiropractic treatment, will be explained to me upon my request. _____ **Please Initial**

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Your medical information is the information gathered by your healthcare providers during the time you are being treated. It is private, and no one without a legitimate need to know, may have access to it. West Chiropractic Clinic is required by law to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. We will promptly notify affected individuals following a breach of protected health information. West Chiropractic Clinic will not use or disclose your health information, except as described in this Notice of Privacy Practices. This "Notice" applies to all of the medical records generated during your participation in our programs and services.

Patient Health Information: Under federal law, your patient health information is protected and confidential. Patient health information includes: information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes: payment, billing, and insurance information.

How we use Patient Health Information: We use patient health information about you for treatment, to obtain payment, and for health care operations including: administrative purposes and evaluation of quality of care received. Under some circumstances, we may be required to use or disclose health information without prior authorization from you.

The following categories describe the ways that West Chiropractic Clinic may use and disclose your health information:

Treatment: West Chiropractic Clinic will use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your medical record information to your physician, consulting physician(s), nurses and other healthcare providers who have a legitimate need for such information in your care and continued treatment.

Payment: West Chiropractic Clinic may release medical information about you for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. The information may be released to an insurance company, third-party payor or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record that are necessary for payment of your account. For example, a bill sent to a third party payor may include information that identifies you, your diagnosis, the procedures and supplies used.

Routine Healthcare Operations: West Chiropractic Clinic may use and disclose your medical information during routine healthcare operations, including quality assurance, utilization review, internal auditing, licensing or credentialing activities, research and educational purposes.

Business Associates: West Chiropractic Clinic may use and disclose certain medical information about you to its business associates. A business associate is an individual or entity under contract with West Chiropractic Clinic to perform or assist in a function or activity that necessitates the use or disclosure of medical information. Examples of business associates include but are not limited to: a medical records copy service, consultants, accountants, lawyers, medical transcriptionists and third-party billing companies. West Chiropractic Clinic requires the business associate to protect the confidentiality of your medical information. In addition, West Chiropractic Clinic requires any subcontractor of West Chiropractic Clinics business associate, to protect the confidentiality of your medical information.

Required by Law: West Chiropractic Clinic will disclose medical information about you when required to do so by law.

Public Health Activities: West Chiropractic Clinic may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Victims of Abuse, Neglect or Domestic Violence: West Chiropractic Clinic may disclose your health information to a public health authority that is authorized to receive reports of abuse, neglect, or domestic violence. We may make an effort to obtain your permission before releasing this information, but in some cases, may be required or authorized to act without your permission. _____**Please Initial**

Health Oversight, Licensing, Accreditation and Regulatory Activities: West Chiropractic Clinic may disclose your health information to health oversight agencies authorized to conduct audits, investigations, and inspections of our facility. For example, billing practices may be audited by the State Auditor and records are subject to review by the Secretary of Health and Human Services and his/her authorized representatives.

Judicial or Administrative Proceedings: West Chiropractic Clinic may disclose your health information if we are ordered to do so by a court or an administrative hearing officer that is handling a lawsuit or other dispute or provided with a valid subpoena.
Disclosures for Law Enforcement Purposes: West Chiropractic Clinic may disclose your identity to law enforcement. Instances which may result in a disclosure of protected health information to law enforcement include: compliance with court orders or assisting with ongoing investigations
Coroners, Medical Examiners and Funeral Directors: West Chiropractic Clinic may disclose protected health information to a coroner, medical examiner or funeral director for the purposes of identifying a deceased person or other duties as authorized by the law.
Organ and Tissue Donation: West Chiropractic Clinic may share health information about you with organ procurement organizations.
Research; In some instances, West Chiropractic Clinic can use or share your health information for health research.
To Avert a Serious and Imminent Threat to Health or Safety: West Chiropractic Clinic may use or disclose your protected health information when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety or another person or the public.
Specialized Government Functions: If you are an inmate of a correctional institution or under custody of law enforcement, West Chiropractic Clinic may release your health information to the correctional institution or law enforcement official. West Chiropractic Clinic may also disclose your health information as required by military command authorities if you are a member of the armed forces.
Workers' Compensation: West Chiropractic Clinic may release medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illnesses.
You have the right and choice to tell us which information to share with your family, close friends, or others involved in your care, and if you would like us to share your information in a disaster relief situation. If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information, when needed, to lessen a serious and imminent threat to health or safety. In the case of fundraising, West Chiropractic Clinic may contact you for fundraising efforts, but you can tell us not to contact you again.
Except for the situations and exceptions described in this Notice, we will need to obtain your written authorization before using or disclosing your protected health information for other purposes. For example, except as otherwise set forth under State and Federal law, we must obtain your written authorization for most uses or disclosures of any psychotherapy notes related to you, for the use or disclosure of your protected health information for marketing purposes, or for the sale of your protected health information.
Special Uses: We may use your information to contact you with appointment reminders. We may do this by way of text message, email, automated call, or direct call.

Patient Information Rights

Although all records concerning your treatment obtained at West Chiropractic Clinic are the property of West Chiropractic Clinic, you have the following rights concerning your medical information:
Right to Confidential Communications: You have the right to receive confidential communications of your medical information by alternative means or at alternative locations. For example, you may request that West Chiropractic Clinic contact you only at work or by mail.
Right to Inspect and Copy: You have the right to inspect and copy your medical information.
Right to Amend: You have the right to amend your medical information. Any request for amendment should be submitted to West Chiropractic Clinic in writing, stating a reason in support of the amendment.
Right to an Accounting: You have the right to obtain an accounting of the disclosures of your medical information made during the preceding six (6) year period.
Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your medical information. West Chiropractic Clinic is not required to honor your request except where: (I) the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law, and (II) the medical information pertains solely to a healthcare item or service for which you, or person other than the health plan on your behalf, has paid West Chiropractic Clinic in full.
Right to Receive a Paper Copy: You have the right to receive a paper copy of this Notice, even if you have previously agreed to receive the Notice electronically.
Right to Receive Electronic Copies: You have the right to receive electronic copies of your medical information.
Right to Transfer Records: You may initiate the transfer of your records to another person by completing a written authorization form.
Right to Revoke Authorization: You have the right to revoke your authorization to use or disclose your medical information, except to the extent that action has already been taken in reliance on your authorization. A request to exercise any of these rights must be submitted, in writing, to West Chiropractic Clinic at 8855 9th Street. North/St. Petersburg, FL 33702 or faxed to (727) 576-5829. _____ **Please Initial**
If you have questions and would like additional information, you may contact our office at (727) 577-0004. If you believe your privacy rights have been violated, or if you disagree with a decision we made concerning your records, you may file a written complaint to West Chiropractic Clinic, or with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint. West Chiropractic Clinic will abide by the terms of the Notice currently in effect. West Chiropractic Clinic reserves the right to change the terms of its Notice and to make the new Notice available to you.

I, _____, hereby acknowledge receipt of the Notice of Privacy Practice.
Print/Type Patient Name

_____ _____

Patient Signature **Date:**

_____ _____

Staff Signature/Witness Signature **Date:**

If not signed, what was the reason for not obtaining the signature: _____