

Name \_\_\_\_\_ Email: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone - Home \_\_\_\_\_ Work/Cell \_\_\_\_\_ Soc Sec. # \_\_\_\_\_

Drivers Lic. \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ M / F Status- M / S / W / D No. of Children \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Years Employed \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_

Do you have insurance? Yes  No  If yes; do you want us to bill it for you?  Yes  No

I have been queried regarding possessing insurance coverage and have declined to have my insurance billed ( ) Initial

Subscriber's Name \_\_\_\_\_ Health Plan \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Who may we thank for referring you to our office?

Friend: \_\_\_\_\_  Insurance  Google  Yelp  Other: \_\_\_\_\_

Present Weight \_\_\_\_\_ Pounds Height \_\_\_\_\_ Feet \_\_\_\_\_ Inches

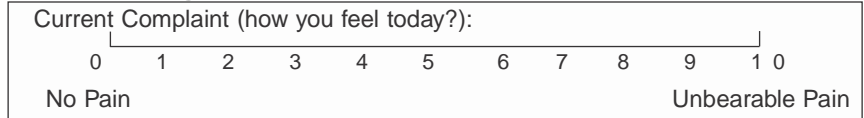
DESCRIBE YOUR PROBLEM & HOW IT BEGAN:

Headache  Neck Pain  Mid-back Pain  Low Back Pain  Other \_\_\_\_\_

Is this?  Work Related  Auto Related  N/A

Date Problem Began: \_\_\_\_\_

How Problem Began: \_\_\_\_\_



How often are your symptoms present? (Intermittent)  0-25%  26-50%  51-75%  76-100%

In the past week, how much has your pain interfered with your daily activities? (e.g., work, social activities, or household chores)

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT?  No  Yes

Date(s) taken: \_\_\_\_\_ What areas were taken? \_\_\_\_\_

Please check all of the following that apply to you:

- Recent Fever  Prostate Problems
- Diabetes  Menstrual Problems
- High Blood Pressure  Urinary Problems
- Stroke (date) \_\_\_\_\_  Currently Pregnant, # weeks \_\_\_\_\_
- Corticosteroid Use (cortisone, prednisone, etc.)  Abnormal Weight  Gain  Loss
- Taking Birth Control Pills  Marked Morning Pain/Stiffness
- Dizziness/Fainting  Pain Unrelieved by Position or Rest
- Numbness in Groin/Buttocks  Pain at night
- Cancer/Tumor (explain) \_\_\_\_\_  Visual Disturbances
- Osteoporosis  Surgeries \_\_\_\_\_
- Epilepsy/Seizures  Medications \_\_\_\_\_
- Other Health Problems (explain) \_\_\_\_\_

Family History:  Cancer  Rheumatoid Arthritis  Heart Problems / Stroke  Diabetes  High Blood Pressure

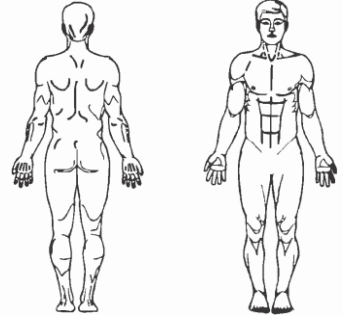
I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. (x) \_\_\_\_\_

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH HABITS**

- YES NO YES NO
Do you drink alcohol? \_\_\_Drinks/month
Do you exercise regularly?
Do you drink coffee/soda? \_\_\_/day
What type? Cardio \_\_\_ Flexibility \_\_\_ Resistance \_\_\_
Have you ever smoked?
Frequency? 1-2 times/week \_\_\_ 1-4 times/week \_\_\_ 5-6 times/week
Do you currently smoke? \_\_\_packs/day
Do you wear heel lifts or arch supports? If yes, which heel lifts \_\_\_ arch supports \_\_\_

Optional:
Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Primary Language: \_\_\_\_\_

**EXPERIENCE WITH CHIROPRACTIC**

- YES NO
Have you ever been adjusted by a Chiropractor before?
Reason for those visits: \_\_\_\_\_
Previous Chiropractors Name: \_\_\_\_\_
Approximate date of last visit: \_\_\_\_\_

**AWARENESS OF CHIROPRACTIC PRINCIPLES**

The Human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability. This interference is most commonly the result of vertebral subluxations. Stress that may be physical, chemical, or emotional may cause these subluxations. The practice of chiropractic is based on the location and reduction of nerve system interference caused by the vertebral subluxations.

- Were you aware that: YES NO
Doctors of Chiropractic work with the nervous system?
The nervous system controls all bodily functions and systems?
Chiropractic is the largest natural healing profession in the world?
If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?

**How would you best describe your level of interest in wellness?**

\_\_\_Not very interested \_\_\_Curious \_\_\_Very Interested in greater health and wellness

On a scale of 1-5, rate the importance for you to achieve the following:
1= Not important 5= Necessary

Table with 7 columns: Activity, N/A, 1, 2, 3, 4, 5. Rows include Get fit, Eat better, Reduce stress, Stop smoking, Reduce pain, Increase my mobility, Improve my posture, Improve my sleep, Learn about wellness, Learn about wellness products that are right for me, Other.

Which of the above would you say is the most important goal for you? \_\_\_\_\_

Have you ever attempted to accomplish this goal in the past? Yes No Were you successful? Yes No

**GOALS FOR MY CARE**

People see Chiropractors for a variety of reasons. Some go for a relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief care- Symptomatic relief of pain or discomfort
Chiropractic care- Correction and relieving the cause of the problem as well as the symptoms.
Comprehensive care- Caring for the whole body, not just the symptomatic area. This works on achieving the highest state in your body.
I want the Doctor to select the type of care appropriate for my condition.

# Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

This questionnaire will give your provider information about how your **back** condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

## Pain Intensity

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

## Sleeping

- ⓪ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

## Sitting

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

## Standing

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

## Walking

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

## Personal Care

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

## Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

## Traveling

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

## Social Life

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

## Changing degree of pain

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back  
Index  
Score

# Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

*This questionnaire will give your provider information about how your **neck** condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## **Pain Intensity**

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

## **Sleeping**

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

## **Reading**

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

## **Concentration**

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

## **Work**

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

## **Personal Care**

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

## **Lifting**

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

## **Driving**

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

## **Recreation**

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

## **Headaches**

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck  
Index  
Score

# ELIGIBILITY GUARANTEE/ASSIGNMENT OF BENEFITS FORM

6010 Hidden Valley Rd Ste107, Carlsbad, CA 92011

\_\_\_\_\_  
(Chiropractor)

\_\_\_\_\_  
(Address)

## Eligibility Guarantee:

I, \_\_\_\_\_, hereby certify that I am eligible for  
(Name of Patient/Member/Guardian)

chiropractic benefits offered by \_\_\_\_\_ through my employer,  
(Name of Health Plan)

\_\_\_\_\_ as of \_\_\_\_\_.  
(Name of Employer Group) (Today's Date)

I understand that if the above is not true, or if I am not eligible under the terms of my employer's Medical and Hospital Subscriber Agreement or Insurance Policy, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a bill from the above chiropractor or health plan.

## Assignment of Benefits

I authorize the release of any health information necessary to process this claim. A photo copy of this authorization shall be as effective and valid as the original.

I authorize payment of medical benefits to the chiropractor listed above who accepts assignment through his/her contract with ASHP and/or ASHP's Health Plan.

I understand that the ASHP Chiropractor will not bill me for any charges over and above the insurance payment, other than the applicable copayments, coinsurance or deductibles, since the ASHP Chiropractor has agreed in his/her contract with ASHP and/or ASHP's Health Plan to waive all un-paid fees.

## PLEASE READ: AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

**I also understand any services rendered are with my consent and approval.**

\_\_\_\_\_  
Signature of Member (or Subscriber)

\_\_\_\_\_  
Date

# KLINE CHIROPRACTIC & WELLNESS

6010 Hidden Valley Rd Ste. 107, Carlsbad, CA 92011

Phone: (442) 232-6708 Fax: (442) 232-6732

## Privacy Right Notification Acknowledgement

By signing this form, you are granting consent to Kline Chiropractic to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at (442) 232-6708.

I hereby acknowledge receipt of the Notice of Privacy Practices.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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
- An emergency situation prevented us from obtaining acknowledgment
- Communication barriers prohibited obtaining the acknowledgment

## Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic examination, adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me, for whom I am legally responsible, by the doctor of chiropractic named below and /or their licensed doctor of chiropractic, who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, increased symptoms in the treated area, sprains and strains, dislocation, fracture, or stroke. The possibility of such injuries occurring in associations with adjustment is extremely remote. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness Signature (Office Staff)

**James D. Kline, D.C.**

Verbal Review Date \_\_\_\_\_ Doctors Initials \_\_\_\_\_