De Groot Chiropractic

New Patient Intake

Date__________________

Name:_____________________ ______________________________ ______________________________
First Middle Last

Nickname:_________________________

Spouse:___________________________ Your SSN:______________________________

Contact Information

Email:____________________________ Sex: Male Female

Address:__________________________ Date of Birth:_____/_____/_______Age____________

City:_____________________________ Occupation:________________________

State:___________ Zip:______________ Employer:__________________________

Home(_________)__________-________________ Marital Status: Single
Partnered
Work (________)__________-________________ Married
Separated
Cell (_________)__________-________________ Divorced
Widowed
Referred By________________________ Other

Reason For Visit

Have you ever been treated by a Chiropractor before: Yes No
If so, please explain:____
The reason for this visit is a result of: work, sports, auto, trauma, chronic
Explain what happened:____

____

Please describe the pain and it=s location:____

____
When did the condition begin:_____/_____/________
Is the condition getting worse? Yes No Constant Comes and goes
Is this condition interfering with your: Work, Sleep, Daily Routine
If so, please explain:____
Have you had this or similar conditions in the past? Yes No
If so, please explain:____
Have you been treated by a Medical Physician for this condition? Yes No
If so, where?____

In the Event of an Emergency

Who should we contact?________________________________Relation__________________________________
Home Phone(__________)______________________-_______Work Phone(__________)_______-_____________
Cell Phone:(__________)_____________________-____

Health History:

Are you taking any of the following medications?

Nerve Pills   Pain Killers (including aspirin)   Muscle Relaxers   >Pep= Pills

Blood Thinners   Tranquilizers   Insulin   Others ______________________________

Have you ever had any of the following diseases/medical condition(s)? (Please check all that apply)

Heart Attack/ Stroke	Heart Surgery/ Pacemaker	Heart Murmur
Congenital Heart Defect	Mitral Valve Prolapse	Artificial Valves
Alcohol/ Drug Abuse	Venereal Disease	Hepatitis
HIV+/AIDS	Shingles	Cancer
Frequent Neck Pain	Emphysema/ Glaucoma	Anemia
High/ Low Blood Pressure	Psychiatric Problems	Rheumatic Fever
Severe/ Frequent Headaches	Kidney Problems	Ulcers/ Colitis
Fainting/ Seizures/ Epilepsy	Sinus Problems	Asthma
Diabetes/ Tuberculosis	Difficulty Breathing	Chemotherapy
Lower Back Problems	Artificial Bones/ Joints	Arthritis

Please list any other serious medical condition(s) you have or have ever had:______________________________

____

Please list anything that you may be allergic to:______________________________________

List previous surgeries/treatments with dates:______________________________________

____

List any past serious accidents with dates:______________________________________

____

Do you smoke?   No   Yes/ How much?______________________ How Long?______________

Are you wearing: Heel lifts   Sole lifts   Inner soles   Arch supports

What is the age of your mattress? ______________ Is it comfortable?   Yes   No

For Women: Are you taking Birth Control?   Yes   No

Are you pregnant?   No   Yes/ How Long?____________   Nursing?   Yes   No

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

I authorize any doctor, hospital, employer, or other person to whom a signed or photocopy of this authorization is delivered, to furnish any information, reports or copies of records which may be requested by Kenneth E. deGroot, D.C.

Signature ______________________________   Date ______________________

The Doctor-Patient Relationship

Chiropractic treatment seeks to restore health through natural means, without the use of dangerous drugs or surgery. Your success under our care depends on your body's ability to respond, and on your willingness to follow the doctor's recommendations closely.

Informed Consent

There always is some danger associated with any activity, for example, like driving a car or stepping out of the shower. The same is true of any type of treatment. We will not perform any procedure that we feel has a significant health risk to you or any other patient. It is your duty to fully make known the details of your health history; we welcome interaction with your other doctors.

Results

We only accept a patient for treatment if we feel it is likely they will respond satisfactorily. It is impossible to guarantee how quickly an individual will respond to treatment. Those who are not chiropractic cases, or do not respond to treatment, will be referred elsewhere for treatment.

Agreement

I have read, understand and agree to the provisions outlined above.

____________ ____

Date Signature

We feel that it is very important to coordinate with your other doctors and keep them up to date on your treatment in our office. Please fill in all available information.

General Physician			
Address			
City	**State**	**Zip**	**Phone number**

Other			
Address			
City	**State**	**Zip**	**Phone number**

I give authorization to de Groot Chiropractic & Orthopedic Center to release my health care information to the above doctors.

Print Name	
Sign Name	**Date**

Kenneth E. De Groot, D.C., P.A.
1401 Silverside Rd., Suite 1
Wilmington, DE 19810

Patient=s Name and Address: ____
____
____
____

Assignment of Benefits To Physician:

I hereby assign payments made by my insurance company (or third party who might be responsible for paying for services), directly to Kenneth de Groot, D.C.

I understand that I am financially responsible to Kenneth E. De Groot, D.C. for charges not covered by this agreement, and that credit checks may be required through various credit agencies. I also acknowledge that I am liable for any charges not paid by my insurance company that were incurred by children or dependents of mine over the age of eighteen who are listed or covered under my health insurance. I furthermore agree to be liable for at least 50% of remaining balance for collection fees and/or court costs and attorney fees incurred by the provider in the event I fail to pay the amounts due for services rendered and this account is sent to anyone for collection. I also agree to pay interest of the rate of 1 2 percent per month on the unpaid balance commencing 60 days after the services have been rendered or 30 days after my insurance carrier has been billed; whichever is later.

______________________________ ______________________________________
Date Patient Signature (Parent or guardian, if minor)

Authorization to Release Information:

I hereby authorize Dr. Kenneth E. de Groot to release any informaiton acquired in the course of examination or treatment to my insurance company (or any third party who might be responsible for paying services rendered).

______________________________ ______________________________________
Date Patient Signature (Parent of guardian, if minor)

TOMORROW'S HEALTHCARE TODAY@

DEGROOT CHIROPRACTIC HEALTHCARE

Kenneth E. de Groot, D.C 1401 Silverside Rd. Wilmington, DE 19810 Phone (302)475-5600 Fax(302)475-5940 (302)475-5940

PRACTICE'S REQUIREMENTS

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. Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use and release of your PHI than that which is provided under federal law.
c. Is required to abide by the terms of this Privacy Notice.
d. Reserves 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 and revised Privacy Notice to you prior to implementation.
f. Will not retaliate against you for filing a complaint.

*PHI - Protected Health Information

EFFECTIVE DATE

This Notice is in effect as of 4/15/03.

PATIENT ACKNOWLEDGMENT

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

_______________________________ _______________________

Patient Signature Date

____

Printed Name

AUTHORIZATION

I authorize any doctor, hospital, employer, or other person to whom a signed or photocopy of this authorization is delivered, to furnish any information, reports or copies of records which may be requested by Kenneth E. de Groot, D.C.

_______________________________ _______________________

Patient Signature Date

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

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 CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1- Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2- Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3- Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4- Walking

A Pain does not prevent me from walking any distance
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than ½ mile.
D Pain prevents me from walking more than ¼ mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5- Sitting

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than ½ hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

SECTION 6- Standing

A I can stand as long as I want without pain
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain
D I cannot stand for longer than ½ hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain
F I avoid standing, because it increases the pain straight away.

SECTION 7-Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one-quarter
D Because of pain, my normal night's sleep is reduced by less than one-half
E Because of pain, my normal night's sleep is reduced by less than three-quarters
F Pain prevents me from sleeping at all.

SECTION 8-Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9-Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10-Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E My pain is gradually worsening
F My pain is rapidly worsening.

Comments:____

Patient Signature:________________________ Date:______________

ROLAND-MORRIS LOW BACK PAIN DISABILITY QUESTIONNAIRE

When your back hurts, you may find it difficult to do some of the things you normally do.
This list contains some sentences that people have used describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you *today*. As you read the list, think of yourself *today*. Check the box next to any sentence that describes you *today*. If the sentence does not describe you then leave the space blank and go on to the next one. Remember, only check the sentence if you are sure that it describes you today.

1. ☐ I stay at home most of the time because of my back.
2. ☐ I change position frequently to try and get my back comfortable.
3. ☐ I walk more slowly than usual because of my back.
4. ☐ Because of my back I am not doing any of the jobs that I usually do around the house.
5. ☐ Because of my back, I use a handrail to get upstairs.
6. ☐ Because of my back, I lie down to rest more often.
7. ☐ Because of my back, I have to hold on to something to get out of an easy chair.
8. ☐ Because of my back, I try to get other people to do things for me.
9. ☐ I get dressed more slowly than usual because of my back
10. ☐ I only stand up for short periods of time because of my back.
11. ☐ Because of my back, I try not to bend or kneel down.
12. ☐ I find it difficult to get out of a chair because of my back.
13. ☐ My back is painful almost all the time.
14. ☐ I find it difficult to turn over in bed because of my back.
15. ☐ My appetite is not very good because of my back pain.
16. ☐ I have trouble putting on my socks (or stockings) because of the pain in my back.
17. ☐ I only walk short distances because of my back pain.
18. ☐ I sleep less well because of my back.
19. ☐ Because of my back pain, I get dressed with help from someone else.
20. ☐ I sit down for most of the day because of my back.
21. ☐ I avoid heavy jobs around the house because of my back.
22. ☐ Because of my back pain, I am more irritable and bad tempered with people than usual.
23. ☐ Because of my back, I go upstairs more slowly than usual.
24. ☐ I stay in bed most of the time because of my back

SIGNATURE____ **DATE**______________________

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much 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 CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1- Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

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

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D Washing and dressing increases the pain and I find it necessary to change my way of doi
E Because of the pain, I am unable to do some washing and dressing without help
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3- Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4- Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read at all.

SECTION 5- Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6- Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7-Work

A I can do as much as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more
D I cannot do my usual work
E I can hardly do any work at all
F I cannot do any work at all.

SECTION 8-Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9-Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10-Recreation

A I am able to engage in all of my recreational activities, with no neck pain at all.
B I am able to engage in all of my recreational activities, with some pain in my neck.
C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck
F I cannot do any recreational activities at all.

Comments:____

Patient Signature:__________________________ Date:________________

Kenneth de Groot, DC, DABCO, DABDA
1401 Silverside Road, Ste. 1
Wilmington, DE, 19810

302-475-5600
fax 302-475-5940

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:__________________________ **Last Name**:__________________________

Email address: __________________@_________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ___________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date:_________________

For office use only

Height: _________ Weight:____________ Blood Pressure:______ /______