FERNANDINA
CHIROPRACTIC CENTER

463392 East State Road 200
Yulee, Fl 32097
Phone: 904-491-1345
E-Fax:904-513-9206
Email: Fernchiro@gmail.com

Appointment Letter:

Thank you for choosing Fernandina Chiropractic Center. Our chiropractors provide quality care for all ages, including pediatric patients. We understand that chiropractic care is about more than just treating neck pain and back pain – we find and correct the cause of your symptoms. If you've been injured in a car accident or are suffering from a sports injury, our chiropractors can help you get well and stay well. To prepare better for your upcoming appointment please follow these procedures.

- Please complete the following paperwork and try to arrive 15 minutes prior to your appointment time for proper processing.
- **IF YOU ARE UNABLE TO COMPLETE PAPERWORK**, you are required to arrive 30 minutes prior to allow you time to fill out paperwork. If the paperwork is not completed by your scheduled time you will be rescheduled to the next available time.
- Don't forget these following items:
  - Insurance cards
  - Government issued ID
  - List of Medications
  - Previous imaging (disks or reports if you have it)
  - Discharge Summary (if released from hospital recently)
- If Auto Accident
  - Police Report
  - **YOUR** automobile insurance card
  - **YOUR** automobile policy jacket- declaration page (you can call your insurance company to get this)
  - **YOUR** automobile claim number and Medical Adjustor Information
- Copay is due at time of service. We accept cash, check, credit and debit cards.
- If you cancel within 24 hours a $40 fee is added to your account and you will not be able to reschedule until paid.

We look forward to working with you to deliver the highest quality of chiropractic care!

Thank you,

Fernandina Chiropractic Staff

Beckerton Chiropractic PLLC. dba:
Fernandina Chiropractic Center

Patient Registration & Insurance Information

Please present insurance card and photo ID for us to copy.

Date _____ Physician _____

Person Responsible for Bill

Guarantor Name _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____
Relation to Patient _____

Patient Information

I consent to receive email/text relating to my care from your office?
YES:____
NO:____

Name _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____
Cell Phone # _____ Carrier: _____ Email _____
Date of Birth _____ Sex _____ Marital Status _____
Race: ❑ Unknown ❑ African American ❑ Asian ❑ Caucasian ❑ Chinese ❑ Filipino ❑ Hispanic ❑ Japanese ❑ Native American ❑ Native Hawaiian ❑ Pacific Islander ❑ Other _____
Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Unknown ❑ Unrecorded
Primary Language _____ Do you require an Interpreter Yes____ No____
Social Security Number _____
(If a minor): Mother's Name _____ Home Phone # _____
Father's Name _____ Home Phone # _____

Emergency Contact Information

Contact Name _____
Relationship to Patient _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____

Primary Insurance Name

Insurance Company _____
Group # _____ Policy # _____
Subscriber Name _____
Patient Relation to Subscriber _____ Date of Birth _____
Social Security Number _____
Employer _____ Work Phone # _____

Secondary Insurance Name

Insurance Company _____
Group # _____ Policy # _____
Subscriber Name _____
Patient Relation to Subscriber _____ Date of Birth _____
Social Security Number _____
Employer _____ Work Phone # _____

Referred by _____

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Insurance Assignment and Instruction for Direct Payment

I,_____ hereby instruct and direct my insurance company pursuant to F.S. 627.422 to pay directly to Beckerton Chiropractic PLLC, dba Fernandina Chiropractic Center LLC for professional or medical services by check, draft, or electronic funds transfer (EFT). The payment is not to exceed my indebtedness to the above-named provider.

I herby assign all rights and benefits that I have under any Group Health Insurance, Automobile Insurance (including PIP, UM and Med Pay benefits), Medicare and Disability benefits. I direct and assign all related policies or reimbursement plans to pay benefits for services and treatments that I have or continued to receive from the above-named provider.

Assignment includes but is not limited to all rights to collect benefits directly from Health or Auto Insurances for those services and treatments that I have received and continue to receive, including all rights to proceed against my insurance company in any action including legal suit if for any reason my insurance company fails to make payments of benefits that are due to the above-named provider. This assignment also includes the right to recover any attorney fees and costs for such action brought by the provider as my assignee.

I understand that I am financially responsible for any balance not covered by my insurance company. Ultimately, payment responsibility rests with you the patient.

All self-pay patients are expected to pay for the services in full at the time services are rendered.

I authorize the release of any information pertinent to my case or claim to the above-named provider or any attorney involved in this case. A photocopy of the assignment shall be considered as effective and valid as the original.

_____

Signature of patient (Claimant): Date:

_____

Witness: Date:

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To whom it may concern:

I, _____, herby authorize my insurance company, _____ to release insurance benefit information to Beckerton Chiropractic PLLC/ dba Fernandina Chiropractic Center LLC.

Print:_____

Sign:_____

Date:_____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

   Initial Examination, Clinical X-Rays, Manual Manipulation, Traction, Stim, Heat/Cold Therapies, Laser, Exercises, Manual Therapy, and Ultrasound.

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand):*

Fernandina Chiropractic Center		
	Doctor Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(11)(b), Florida Statutes.

OIR-B1-1571
Pub. 1/2004

DOCTOR'S LIEN

FERNANDINA CHIROPRACTIC CENTER
Dr Thomas Beckerton
463392 East State Road
Yulee, FL 32097
Phone: 904-491-1345 Fax:904-513-9206
Email: fernchiro@gmail.com

Name of Attorney(s)

Attorney(s) Address ( ) Telephone

City State Zip

Patient's Name Birthdate

I hereby authorize the above doctor to disclose to my attorney(s) a full report of the case history, examination, diagnosis, treatment, prognosis of myself in regard to the accident in which I was involved. The purpose of this disclosure is to permit my attorney to provide me with legal services.

- This authorization has no expiration date.
- I understand that I have the right to revoke this authorization by sending a written letter to the above-named doctor, except to the extent that the above-named doctor has already taken action in reliance upon this authorization.
- I understand that the information disclosed under this authorization may be redisclosed by my attorney(s), and that the privacy of my information is no longer protected by the federal privacy rule once it is disclosed to my attorney(s).
- I understand that I may inspect or copy the information to be disclosed, except in those circumstances when inspection or copying of my information may be lawfully denied under federal law.
- I also understand that I may refuse to sign this authorization, and that the above-named doctor will not condition treatment on my providing authorization for this disclosure.

I hereby authorize and direct you, my attorney(s), to pay directly to said doctor such sums as may be due and owing him/her for professional services, supplies, items, reports, and proceedings rendered to me or on my behalf both by reason of the aforesaid accident and by reason of any other bills that are due and owing to his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor.

I hereby give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney(s), or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

- I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him/her for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of pending payment.
- I hereby waive my right to make any objections regarding the enforceability or appropriateness of this agreement. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Patient's Address ( ) Telephone

City State Zip

ATTORNEY(S): Please sign, date, and return this document to the doctor's office named above. Keep a copy for your records.

The undersigned being attorney(s) of record for the above patient does hereby agree to observe all of the terms and conditions of the above lien and agree(s) to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the said doctor named above.

Attorney(s) Signature Date

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Medical Record Release Form

Fax to: _____ **Location:** _____

Phone: _____ **Fax Number:** _____

Today's Date: _____

Patient: _____

Date of Birth: _____

Date of Testing: _____

At the request above patient, please fax medical records regarding the following:

_____

_____

_____

Patient or Guardian: _____ **(PRINT)**

Patient or Guardian: _____ **(SIGNATURE)**

_____

Date Sent: _____ **Time:** _____ **Employee Initials** _____

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Informed Consent to Care

I herby request and consent to the performance of Chiropractic adjustments and other procedures performed in office, including various modes of physical therapy and diagnostics x-rays by, any Doctor of Chiropractic or therapist, employed by Beckerton Chiropractic PLLC., dba Fernandina Chiropractic Center LLC.

I have had the opportunity to discuss with the Doctor and/or with the other office personnel the purpose and benefits of the Chiropractic adjustments and other treatments outlined below.

Though Chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injures, strokes, dislocations and sprains.

I understand that I may receive ONE or MORE of the following treatments:

- **Chiropractic Adjustment/Manipulation**
- **MLS Laser Therapy**
- **Acupuncture / Dry Needling / Cupping**
- **Electric Muscle Stimulation**
- **Heat/Cold Pack(s)**
- **Ultrasound**
- **Traction**
- **Massage/Therapeutic exercises and stretches**

I understand that Chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee the results. I understand, acknowledge, and affirm that treatments may involve direct bodily contact and touch. I acknowledge that no guarantee or assurance has been made to anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

For Treatment of Minors only:

I, as a parent/guardian of a minor receiving treatment from above named provider do and herby agree and understand that I have been advised to remain on the premises during any such treatment and waive any claim I may have resulting in failure to do so. **I consent to treatment of the minor if I am not in the office (initial) _____

Please discuss any questions or concerns with the Doctor or Therapist BEFORE signing this consent.

_____

Signature of patient, parent, guardian, or personal representative: Date:

_____

Witness Signature: Date:

_____

Doctor's Signature: Date:

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Statement of Policies

The following policies are in place for mutual convenience and benefit. Please read them carefully and sign at the bottom to indicate your agreement.

1. You are responsible for the cost of your visit at the time of service. Our office will be in network with most United Health Care plans. If you carry a health insurance plan our office is not in network with, you will be responsible for submitting your visits to insurance, which our office will provide, and the assignment of benefits will be redirected to you, the patient. Our office cannot guarantee reimbursements from the insurance company that will between you and your insurance provider.
2. Deductibles, co-Insurance and co-pays are due at the time of service, payable by cash, check or credit/debit cards. ANY previous balance on your account(s) are expected to be paid at time of service.
3. All new patient exams are $100, with the adjustment fee being $40.
4. If you schedule an appointment, and are unable to make it, please call 24 hours in advance. Failure to do so will result in a forfeit of the $40 appointment fee for new patient and massage appointments. To book your next appointment it will be an additional $40.
5. Processing disability paperwork, FMLA insurance forms, and any related forms require a $75.00 fee. This fee is to be prepaid and must coincide with an office visit.
6. Request for medical records is subject to a fee of $1.00 per page for the first 25 pages and $0.25 for each additional page after. All requests must be submitted in writing, and please allow 24-48 business hours for these requests. Please plan accordingly.
7. The above-named provider is not responsible for loss or damage to personal valuables.

I acknowledge that I have read and understand the Statement of Policies carefully and agree to abide by them.

Name (print) Signature Date

Witness (print) Signature Date

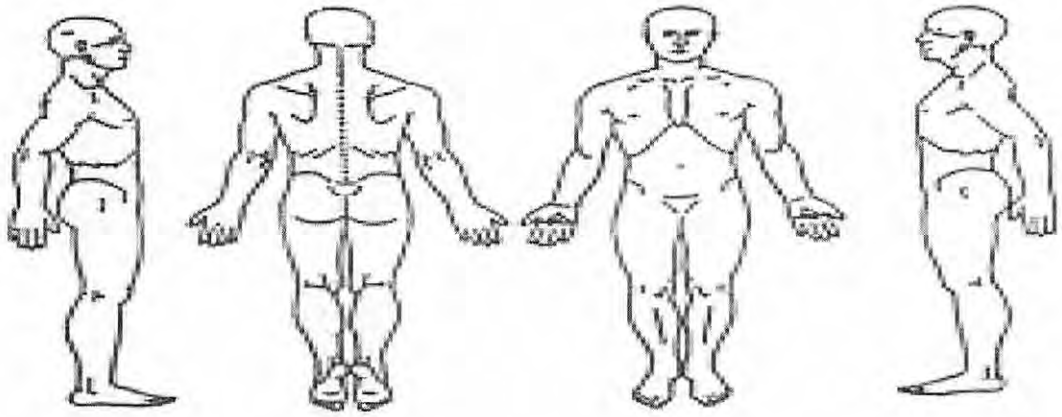
Name:_____

FERNANDINA

CHIROPRACTIC CENTER

Patient Intake Form

Please mark the area of pain:



Where is the pain located/ what side? _____

How/ When do you think the pain started? _____

_____

My pain is located on the **RIGHT** **MIDDLE** **LEFT** **BOTH SIDES**

Have you ever had problem in the past? Please circle. **YES** **NO**

Explain your pain. Please circle. **Getting Worse** **Staying the Same** **Getting Better**

How would you describe the type of pain? Please circle.

Sharp	**Numbness**	**Dull**	**Tingling**
Diffuse	**Achy**	**Burning**	**Sharp with motion**
Stiff	**Shooting**	**Stabbing**	**Electric like**
Sore	**Other:** _____		

Fill in your pain scale 0-10 (10 being most severe): ____ **(1-3 mild) (4-7 Moderate) (8-10 Severe)**

How often do you experience this pain? Please circle. **Constantly** **Frequently** **Intermittent** **Occasionally**

Does your pain radiate? **YES** **NO** If so, where? _____

Do you have Numbness? **YES** **NO** If so, where? _____

When is the pain worse? Please circle. **Morning** **Afternoon** **Evening** **Night** **Consistent**

When is pain better? Please circle. **Morning** **Afternoon** **Evening** **Night** **Consistent**

What makes the pain worse? **SITTING** **STANDING** **MOVEMENT** **SLEEPING** **WALKING** Other_____

What makes pain better? _____

Headaches **YES** **NO** If so, where? _____

Does this problem interfere with work or daily routine activities? Please circle. **YES** **NO**

Who else have you seen for the following issue? Please circle.

Chiropractor	**Primary Care**	**ER physician**	**Orthopedist**
Physical Therapist	**Massage Therapist**	**None**	**Other:**_____

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

(If applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

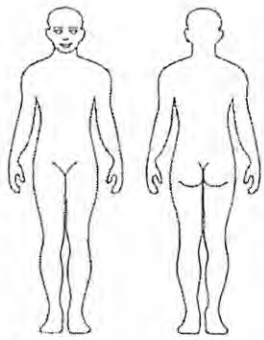
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling
☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Medications (Please attach list if available):

Medication or Vitamin Name:	Dosage:	Reason For Taking:
1.		
2.		
3.		
4.		
5.		

Drug Allergies (please also list reaction):

_____

_____

Past Surgical History:

_____

_____

Medical History (Please circle what condition applies to you):

AIDS/HIV	Coronary Artery Disease	Hepatitis	Obesity	Spinal Stenosis
Alcoholism	Crohn's disease	High Cholesterol	Osteoarthritis	Spondyloarthropathy
Anemia	Degenerative Joint Disease	Hypertension	Osteoporosis	Thyroid Disease
Angina (Chest Pain)	Depression	Inflammatory Bowel Disease	Parkinson's Disease	Valvular Disease
Arthritis	Diabetes	Rheumatoid Arthritis	Peptic Ulcer	
A Fib	Drug abuse	Kidney Disease	PVD	Other: _____
Enlarged Prostate	DVT (Blood Clot)	Liver Disease	Renal Disease	
Cancer: _____	Fibromyalgia	Lyme Disease	Scoliosis	
CVA (Stroke)	Gallbladder Disease	Migraines	Seizure Disorder	
Congestive Heart Failure	Gerd	Multiple Sclerosis	Sleep Apnea	
COPD	Gout	Myocardial Infarction	SLE- Lupus	

Family History (Please select which applies):

	Father	Mother	Sibling	Grandparent
Arthritis	O	O	O	O
Cancer	O	O	O	O
Colitis	O	O	O	O
Diabetes	O	O	O	O
Epilepsy	O	O	O	O
Heart Disease	O	O	O	O
Hypertension	O	O	O	O
Kidney Disease	O	O	O	O
Osteoporosis	O	O	O	O
Psoriasis	O	O	O	O
Stroke	O	O	O	O
Thyroid Disease	O	O	O	O

Review of Symptoms

Please CIRLCE current symptoms that apply.

Constitutional:

Chills
Fatigue
Malaise
Night Swears
Weakness
Weight Loss

HEENT

Blurred vision
Double vision
Dysphasia
Ear Drainage
Facial Pain
Headache
Hearing loss
Hoarseness
Nasal congestion
Ringing in ears
Vertigo
Vision loss

Cardiovascular

Chest Pain
Cyanosis
Heart Murmur
Irregular Heartbeat
Leg Swelling
Syncope (fainting)

Gastrointestinal

Abdominal Pain
Constipation
Diarrhea
Heartburn
Jaundice
Loss of appetite
Nausea
Vomiting

Genitourinary

Dysuria
Frequent urination
Blood in urine
Urge incontinence
Urinary incontinence

Skin/ Integumentary

Contact allergy
Itchy skin
Rash
Skin infection
Skin lesion

Neurological

Difficulty walking
Dizziness
Poor coordination
Memory loss
Muscle weakness
Paresthesia
Seizures
Tremors

Immunological

Asthma
Bee sting allergies
Contact dermatitis
Seasonal allergies
Food allergies
Environmental allergies

Metabolic / Endocrine

Cold intolerant
Heat intolerant
Hair loss

Psychiatric

Anxiety
Depression
Insomnia

Respiratory

Painful breathing
Cough
Shortness of breath
Recent infections
Known TB exposure
Wheezing

Hematologic

Bleeding
Bruising

FEMALES ONLY:

Pregnant? YES NO
WEEKS:_____

Office staff only past this point:

Height:_____

Weight:_____

BP: _____/_____

BOURNEMOUTH QUESTIONNAIRE

PRINT NAME: _____ DATE: _____

First, consider the location of your main complaint. Is it low back pain, neck pain, shoulder pain? Tell me the one location that is your main complaint: _____

Please circle ONE number for each question related to your MAIN complaint.

1. Over the past week, on average, how would you rate your complaint?

No Pain									Worst pain possible
0	1	2	3	4	5	6	7	8	9	10

2. Over the past week, how much has your complaint interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No Interference								Unable to carry out activity		
0	1	2	3	4	5	6	7	8	9	10

3. Over the past week, how much has your complaint interfered with your ability to take part in recreational, social, and family activities?

No Interference								Unable to carry out activity		
0	1	2	3	4	5	6	7	8	9	10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious									Extremely anxious
0	1	2	3	4	5	6	7	8	9	10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling

Not at all depressed									Extremely depressed
0	1	2	3	4	5	6	7	8	9	10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your complaint?

Has made it no worse									Has made it much worse
0	1	2	3	4	5	6	7	8	9	10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it									No control whatsoever
0	1	2	3	4	5	6	7	8	9	10

Is there is a second region that you want to have evaluated? Please turn this form over or ask the receptionist for the additional Bournemouth Questionnaire.

BOURNEMOUTH QUESTIONNAIRE

PRINT NAME: _____ DATE: _____

Now, consider where your SECONDARY complaint/location. Is it low back pain, neck pain, shoulder pain?
Tell me the one area that is your secondary complaint: _____

Please circle ONE number for each question related to your SECONDARY complaint:

1. Over the past week, on average, how would you rate your complaint?

No Pain									Worst pain possible
0	1	2	3	4	5	6	7	8	9	10

2. Over the past week, how much has your complaint interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No Interference								Unable to carry out activity		
0	1	2	3	4	5	6	7	8	9	10

3. Over the past week, how much has your complaint interfered with your ability to take part in recreational, social, and family activities?

No Interference								Unable to carry out activity		
0	1	2	3	4	5	6	7	8	9	10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious									Extremely anxious	
0	1	2	3	4	5	6	7	8	9	10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling

Not at all depressed								Extremely depressed		
0	1	2	3	4	5	6	7	8	9	10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your complaint?

Has made it no worse								Has made it much worse		
0	1	2	3	4	5	6	7	8	9	10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it								No control whatsoever		
0	1	2	3	4	5	6	7	8	9	10

Neck Index

Form N1-100

DOB:

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.

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.

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).

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.

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.

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.

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.

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.

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.

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

Back Index

Form BI100

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

FERNANDINA
CHIROPRACTIC CENTER

Phone: 904-491-1345
E-fax: 1- 904-513-9206
email: fernchiro@gmail.com

463392 East State Road 200
Yulee, Florida 32097

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTICE TAKES EFFECT ON YOUR FIRST DATE OF TREATMENT AND REMAINS IN EFFECT UNTIL WE REPLACE IT, PLEASE REVIEW IT CAREFULLY.

1) **OUR PLEDGE REGAURDING MEDICAL INFORMATION**

The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe the rights and certain duties we have regarding the use and disclosure of medical information.

2) **OUR LEGAL DUTY**

LAW REQURES US TO:

I. Keep your medical information private.
II. Give you this notice describing our legal duties, privacy practices, and your right regarding your medical information.
III. Follow the terms of the notice.

WE HAVE THE RIGHT TO:

I. Change our privacy practice and the terms of this notice at any time, provided the changes are all permitted by law.
II. Make the changes in our privacy practice and new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

NOTICE OF CHANGE TO PRIVACY PRACTICES:

I. Before we make any important change in our new privacy practices, we will change this notice and make the new notice available upon request.

3) **USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. Not every use or discloser will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your written authorization. Any specific written authorization you provide may be revoked any time by writing to us at the address provided at the top of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technician, medical students, or other people who are taking care of you. We may also share medical information about you to other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information. Initial:_____

FERNANDINA
CHIROPRACTIC CENTER

Phone: 904-491-1345
E-fax: 1- 904-513-9206
email:fernchiro@gmail.com

463392 East State Road 200
Yulee, Florida 32097

Release of Medical Information

I, _____ give permission for my protected heath information to be disclosed for the purposes of communicating results, findings, care decisions and billing inquires to the family members and others listed below.

FAMILY/FRIENDS:

Name :	Relation to Patient:	Release information: YES NO
Name:	Relation to Patient:	Release Information: YES NO

Primary Care Provider:

Name:	Phone:_____ Fax:_____ Email:_____	Address:_____ _____ _____

Attorney (if applicable):

Name:_____ Case Manager:_____	Phone:_____ Email:_____	**Address:**_____ _____ _____

*If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from discloser.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patients Signature:_____ **Date:**_____

Rev 11/16/22