OLYMPICO
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SPORTS MEDICINE & WELLNESS CENTER

NEW PATIENT INFORMATION

DATE:_____/_____/_____HOME PHONE:_____

NAME: *(First)*_____*(MI)*_____*(Last)*_____

ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

BIRTHDATE:_____/_____/_____ **Sex:** Male ☐ Female ☐ **Marital Status: S** ☐ **M** ☐ **D** ☐ **W** ☐

PATIENT INFORMATION:	**SPOUSE INFORMATION:**
Occupation:	Spouse Name:
Work Phone:	Occupation:
Employer:	Work Phone:
City & State:	Employer:
Social Security:	City & State:
E-Mail Address:	Social Security:
Cell Phone:	Date of Birth:

How did you find out about us?

☐ Website ☐ Internet _____ ☐ Advertisement_____ ☐ BCBS Site ☐ OTHER_____

☐ Referral from a physician _____ ☐ Referral from a friend/family_____
(Name) *(Name)*

☐ Have you had Physical Therapy this year? (Circle one) YES NO If yes, where _____

☐ Have you been or are you on Home Health Care? (Circle one) YES NO

☐ Is this related to a Workman's Comp Case or Auto Accident Case? (Circle one) YES NO
If YES, please provide Workman's Comp/Auto Accident information to Front Desk.

Primary Care Physician: (If other than the referring physician)_____

Address:_____ City:_____State:____Zip Code: _____

Specialty: _____Telephone: _____

Pharmacy:_____Phone:_____

Insurance Information:

Primary:	Group or ID#:	Insured's Name:
Secondary:	Group or ID#:	Insured's Name:

In Case of Emergency, Contact:_____Phone:_____

Assignment of Benefits/Release of Information:

I authorize payment of insurance benefits directly to Dr. Thomas George S.C. I authorize to execute any documents necessary to secure the payment of benefits and obtain any records from any other source necessary for the course of my treatment. I agree to be financially responsible for all charges incurred during treatment by Olympico Chiropractic Clinic including my insurance deductible co-payment, and services not covered by my insurance carrier or paid in full through any settlement or court case. Any remaining balances I will pay in full per the policies of Olympico Chiropractic Clinic.

Signature:_____Date:_____

Patient History

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NAME:_____**AGE**:_____**DATE:**_____

WHAT IS YOUR REASON FOR YOUR VISIT TODAY?_____

Primary Care Physician: _____DATE OF LAST PHYSICAL EXAM:_____

HEALTH STATUS (please circle):

Chills	Poor Appetite	Chest Pain	Itching
Depression	Bloating	High/Low Blood Pressure	Changes In Moles
Dizziness/Fainting	Bowel Changes	Swelling in Ankles	Rash
Fever	Constipation	Varicose Veins	Scars
Sweats	Diarrhea	Blurred/Double Vision	Sore (non-healing)
Forgetfulness	Excessive Hunger/Thirst	Earache/Ringing In Ears	Low Back Pain
Headaches/Migraines	Gas	Sinus Problems	Neck Pain
Sleep Loss	Indigestion	Allergies	Leg/Arm Pain
Weight Loss	Nausea/Vomiting	Nosebleeds	Other:_____
Nervousness	Difficulty Swallowing	Persistent Cough	_____
Numbness	Rectal Bleeding	Bruise Easily	_____

For Women

Date of Last Menstrual Period:_____Last Pap Smear:_____

Date of Last Mammogram:_____Pregnant Yes / No No. of Children_____

Complications, (if any) with childbirth?_____

Have you experienced (please circle):

Abnormal Pap Smear Abnormal Bleeding Breast Lump/Pain Vaginal Discharge

HEALTH HISTORY (please circle):

AIDS	Chicken Pox	Hernia	Polio	Tonsilitis
Alcoholism	Diabetes	High Cholesterol	Prostate Problems	Typhoid Fever
Anemia	Emphysema	Kidney/Liver Disease	Psychiatric Care	Ulcers
Appendicitis	Epilepsy	Measles	Rheumatic Fever	Vaginal Infections
Bronchitis	Gout	Miscarriage	Scarlet Fever	Venereal Disease
Cancer	Heart Disease	Pacemaker	Stroke	Other:_____
Cataracts	Hepatitis	Pneumonia	Thyroid Problems	_____

Please List *Prescriptions* and *OTC Medications*: (Use back if needed)

_____
_____
_____

Please List *Medical Allergies*:

_____
_____
_____

Family Health History

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Relation	Age	Status of Health	Age of Death	Cause of Death
Father				
Mother				
Brother (s)				
Sister (s)				

Family History (please check below if any applies)

Check	Condition	Relationship
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

Health Habits
(please mark if using the following)

_____ Caffeine: How much? _____

_____Tobacco: How much? _____

_____Drugs: How much? _____

_____Other:___ _____

Surgeries and Hospitalizations

Date	Reason for Hospitalization/Type of Surgery	Outcome/Results

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____/_____/_____

Patient Signature Date

_____ _____/_____/_____

Reviewed By Date

Name: _____ Date: _____/_____/_____

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Please state your initial problem and/or reason for visiting today?

_____

_____

_____

Date Condition/Problem began? _____

What is the frequency of your symptoms? ____Constant ____Frequent ____Intermittent ____ Occasional

SCALE of **0 to 10**; 0 representing ***no pain*** and 10 the ***most severe pain***, please circle the appropriate number below.

Please rate your pain today? 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Since your pain started, how would you rate your ***least*** pain level?

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Since your pain started, how would you rate your ***worst*** pain level?

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

If your initial pain is a pain complaint, does it radiate? _____YES _____ No

If yes, where to? _____

Please check if your initial complaint effects your movement by the following:

_____Inflexibility _____Stiffness ____Spasm _____ Cramp

If your initial complaint gives you sensations, please check from the following:

____Crawling	____Tingling	____Deadness	____Prickly
____Pins & Needles	____Stabbing	____Hurting	____Pulsating
____Burning	____Shooting	____Throbbing	____Aching
____Stinging	____Excruciating	____Dull	____Pounding

What aggravates your complaint?

____Flashing Lights	____Sneezing	____Lifting	____Exercising
____Looking Up/Down	____Coughing	____Sitting	____Stooping
____Looking side to side	____Anger	____Standing	____Depression
____Driving	____Stress	____Walking	____Getting out of Bed
____Pushing	____Emotional Upset	____Pulling	____Repetitive Movements
____Carrying	____ Straining at BM	____Climbing Stairs	____Walking up hill
____Getting in/out of Car	____Other_____		

What relieves you initial complaint?

____Resting	____Sleeping	____Cold	____Heat
____Sitting	____Shower	____Advil	____Aspirin
____Tylenol	____Pain Pills	____Treatment	____Mineral Ice

____Other_____

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Patient Name: _____ Date:_____/_____/_____

Please Circle the correct answer for each question:

1.	Have you ever had blood clots?	Yes No
2.	Have you ever had a hernia?	Yes No
	a. If yes, How long ago? _____	
3.	Do you have Spondylolisthesis?	Yes No
4.	Have you ever had a compression fracture?	Yes No
5.	Have you ever had a hip, knee or foot implant (artificial)?	Yes No
6.	Are you pregnant?	Yes No
7.	Do you have a pacemaker?	Yes No
8.	Do you have any metal in your body (Plates or screws)?	Yes No
9.	Do you have an infection?	Yes No
10.	Do you have diabetes?	Yes No
11.	Do you have any stints for your Heart or Arteries?	Yes No
12.	Do you have a severe heart problem?	Yes No
13.	Do you have epilepsy?	Yes No
14.	Do you or have you had cancer?	Yes No

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NOTICE OF PRIVACY PRACTICES

In compliance with a newly enacted Federal Law, the **Health Insurance Portability and Accountability Act (HIPAA), Olympico Chiropractic Clinic** is informing you of your privacy rights. Please review this notice carefully.

What is HIPAA?
HIPAA is a law passed by Congress in 1996 to improve the efficiency and effectiveness of the healthcare system. It requires health care professionals to adhere to privacy and security standards in order to protect their patient's Personal Health Information (PHI). *PHI is confidential information about a patient, including demographic information.*

What are my rights under HIPAA?
Under HIPAA you have a right to request the following as long as a request is made in writing to the attention of the Privacy Officer and applicable fees are paid. There is a possibility that your request may be denied. If your request is denied we will explain why it was denied in writing.

You have a ***right to inspect and obtain a copy of your PHI.*** We will respond to your request within 30 days.
In most cases your request will be honored and a copy of your PHI will be mailed to you.
You have a ***right to request an amendment of PHI.*** If you feel that your PHI is inaccurate or incomplete, you may request an amendment to your PHI. We will respond to your request within 60 days. If we honor your request we will amend your PHI and notify you and applicable parties. We will deny your request if we determine your PHI to be correct or complete, if your request was not created by us, or if PHI is not available for inspection.
You have the ***right to know what disclosure(s) of your PHI have been made***. You have a right to request a listing of who your PHI was sent to, when it was sent, what content of your PHI was sent and for what purpose. We will respond to your request within 60 days. There will be no charge to you for an initial request. Additionally, your request may not include disclosures made for national security reasons, to law enforcement officials/correctional facilities, or disclosures made prior to June 1, 2004 Updated: April 14, 2012.
You have a ***right to request confidential communications of PHI***. We will honor all reasonable requests to keep communications confidential. A reasonable request is one that specifies an alternative address, gives other means of contact and provides detailed information on how payment will be handled.
You have a ***right to request restrictions on the use and disclosure of PHI,*** however we are not required to agree to your request. Your request must state specific restrictions requested and to whom the restrictions would apply.
You have a ***right to receive a hard copy of this notice***. This notice can also be accessed on our website *www.OlympicoChiro.com*.

How will Olympico Chiropractic Clinic Use and Disclose PHI under HIPAA?
HIPAA allows us to use and disclose your PHI for the purposes of Treatment, Payment and Healthcare Operations. We will specifically use and disclose your PHI to communicate with your physician and to, upon request, assist your insurance company with the processing of your claims. Additionally, we will use your basic demographic information to notify you of new services or facilities. Your authorization is not required for Use and Disclosure of PHI for the purposes of Treatment, Payment and Healthcare Operations. Listed are other instances in which Use and Disclosure of your PHI is allowed without your authorization.

- ***Disclosure to those Involved in the Individual's Care*** – when necessary, we will make a professional decision to disclose PHI to family members, close friends or other persons involved in and assisting in your care when you approve or when are not able or present to approve.
- ***Uses and Disclosures Required by Law*** – as required by law we are required to use and disclose PHI for the following reasons:
  - Use and Disclose PHI for Public Health Activities – Examples include: communicable diseases, sexually transmitted diseases, lead poisoning, Reyes Syndrome, etc., to public health officials.
  - Disclose PHI about Victims of Abuse, Neglect, or Domestic Violence - Examples include: child abuse and neglect; an abused or neglected nursing home resident; a patient over 60 years old involved in elder abuse.
  - Uses and Disclosure of Health Oversight Activities – we may use and release PHI to be used for audits, investigations, licensure issues, etc.
  - Disclosure for Judicial and Administrative Proceedings – we may disclose limited PHI to the appropriate authorities as a result of a court order subpoena, discovery request, etc.

•Disclosure for Law Enforcement Purposes – we may disclose *reasonably necessary* PHI to law enforcement officials to identify or locate a suspect, fugitive, material witness or missing person.
•Uses and Disclosures Related to Decedents – we may use and disclose PHI to a coroner or medical examiner and funeral directors as required by law.
•Uses and Disclosures Related to Cadaveric Organ, Eye or Tissue Donations – we may use and release PHI in order to facilitate organ, eye or tissue donations.
•Uses and Disclosures to Avert a Serious Threat to Health or Safety – we may use and release PHI to public health and other authorities required by law in order to prevent a serious threat to your health or safety.
•Uses and Disclosures for Specialized Government Functions – we may use and release PHI for military/veterans activities and national security/intelligence activities.
•Use and Disclosure of PHI in Emergency Situations - in the event of an eminent threat to the safety of a patient, we may disclose PHI to prevent or lessen the threat.
•***Uses and Disclosures of PHI for Marketing Purposes*** – Olympico Chiropractic Clinic will notify you of new services and facilities unless you specify otherwise. Unless you authorize such a disclosure we will not disclose your PHI for marketing purposes.
•***Uses and Disclosures of PHI for Research Purposes*** – we do not use or disclose identifiable PHI for research purposes, unless you authorize such use and disclosure.
•***Uses and Disclosures requiring the Patients Authorization*** - we must obtain your written authorization if we are interested in using and or disclosing your PHI for reasons other than treatment, payment and health care operations. You may revoke your authorization at any time.

What does HIPAA require of The Olympico Chiropractic Clinic?
Olympico Chiropractic Clinic must maintain the privacy of PHI, abide by the terms of this notice and provide patients with a revised notice, if necessary.

Where can I file a privacy complaint?
If you feel your privacy rights have been violated, contact Olympico Chiropractic Clinic's Privacy Officer, Katie Werner, 630-261-9286 or contact the regional Department of Health and Human Services at 312-886-2359 or www.hhs.gov.

Receipt of Notice of Privacy Practices Form

Effective June 1, 2004 Updated: April 14, 2012

I, _____, hereby acknowledge receipt of Olympico Chiropractic Clinic's Notice of Privacy Practices. Olympico Chiropractic Clinic will use or disclose my PHI for the purposes of carrying out treatment, payment and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand Olympico Chiropractic Clinic has reserved a right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit.
I give my consent for Olympico Chiropractic Clinic to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Olympico Chiropractic Clinic.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.

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Oswestry Pain Questionnaire

Name: **Date:**

INSTRUCTIONS: This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage your everyday activities. Please answer each section by marking the ONE CHOICE that most applies to you. We realize you may feel that more than one statement may relate to you, but PLEASE JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

Pain Intensity	**Personal Care (Washing, Dressing, Etc.)**
❑ The pain comes and goes and is very mild. ❑ The pain is mild and does not vary much. ❑ The pain comes and goes and is moderate. ❑ The pain is moderate and does not vary much. ❑ The pain comes and goes and is severe. ❑ The pain is severe and does not vary much.	❑ I would not have to change my way of washing or dressing in order to avoid pain. ❑ I do not normally change my way of washing or dressing even though it causes some pain. ❑ Washing and dressing increases the pain, but I manage not to change my way of doing it. ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it. ❑ Because of the pain, I am unable to do some washing and dressing without help. ❑ Because of the pain, I am unable to do any washing or dressing without help.
Lifting	**Walking**
❑ I can lift heavy weights without extra pain. ❑ I can lift heavy weights, but it causes extra pain. ❑ Pain prevents me from lifting heavy weights off the floor. ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table. ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. ❑ I can only lift very light weights at the most.	❑ Pain does not prevent me from walking any distance. ❑ Pain prevents me from walking more than one mile. ❑ Pain prevents me from walking more than ½ mile. ❑ Pain prevents me from walking more than ¼ mile. ❑ I can only walk while using a cane or on crutches. ❑ I am in bed most of the time and have to crawl to the toilet.
Sitting	**Standing**
❑ I can sit in any chair as long as I like without pain. ❑ I can only sit in my favorite chair as long as I like. ❑ Pain prevents me from sitting more than one hour. ❑ Pain prevents me from sitting more than ½ hour. ❑ Pain prevents me from sitting more than ten minutes. ❑ Pain prevents me from sitting at all.	❑ I can stand as long as I want without pain. ❑ I have some pain while standing, but it does not increase with time. ❑ I cannot stand for longer than one hour without increasing pain. ❑ I cannot stand for longer than ½ hour without increasing pain. ❑ I cannot stand for longer than ten minutes without increasing pain. ❑ I avoid standing because it increases the pain straight away.

Sleeping	**Social Life**
❑ I get no pain in bed. ❑ I get pain in bed, but it does not prevent me from sleeping well. ❑ Because of pain, my normal night's sleep is reduced by less than one-quarter. ❑ Because of pain, my normal night's sleep is reduced by less than one-half. ❑ Because of pain, my normal night's sleep is reduced by less than three-quarters. ❑ Pain prevents me from sleeping at all.	❑ My social life is normal and gives me no pain. ❑ My social life is normal, but increases the degree of my pain. ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc. ❑ Pain has restricted my social life and I do not go out very often. ❑ Pain has restricted my social life to my home. ❑ I have hardly any social life because of the pain.
Traveling	**Changing Degree of Pain**
❑ I get no pain while traveling. ❑ I get some pain while traveling, but none of my usual forms of travel make it any worse. ❑ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel. ❑ I get extra pain while traveling which compels me to seek alternative forms of travel. ❑ Pain restricts all forms of travel. ❑ Pain prevents all forms of travel except that done lying down.	❑ My pain is rapidly getting better. ❑ My pain fluctuates, but overall is definitely getting better. ❑ My pain seems to be getting better, but improvement is slow at present. ❑ My pain is neither getting better nor worse. ❑ My pain is gradually worsening. ❑ My pain is rapidly worsening.

Score _____ % Disability _____

Dr Signature _____

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Please Read: This questionnaire is designed to enable us to understand how much your **BACK & NECK PAIN** has affected your ability to manage 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 closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

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

A. I can look after myself 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. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

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 if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can 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 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 as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
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 work 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 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 my car 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 engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able 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 all all.

SIGNATURE:_____ **DATE:**_____

DISABILITY INDEX SCORE: **%**_____

DR SIGNATURE:_____

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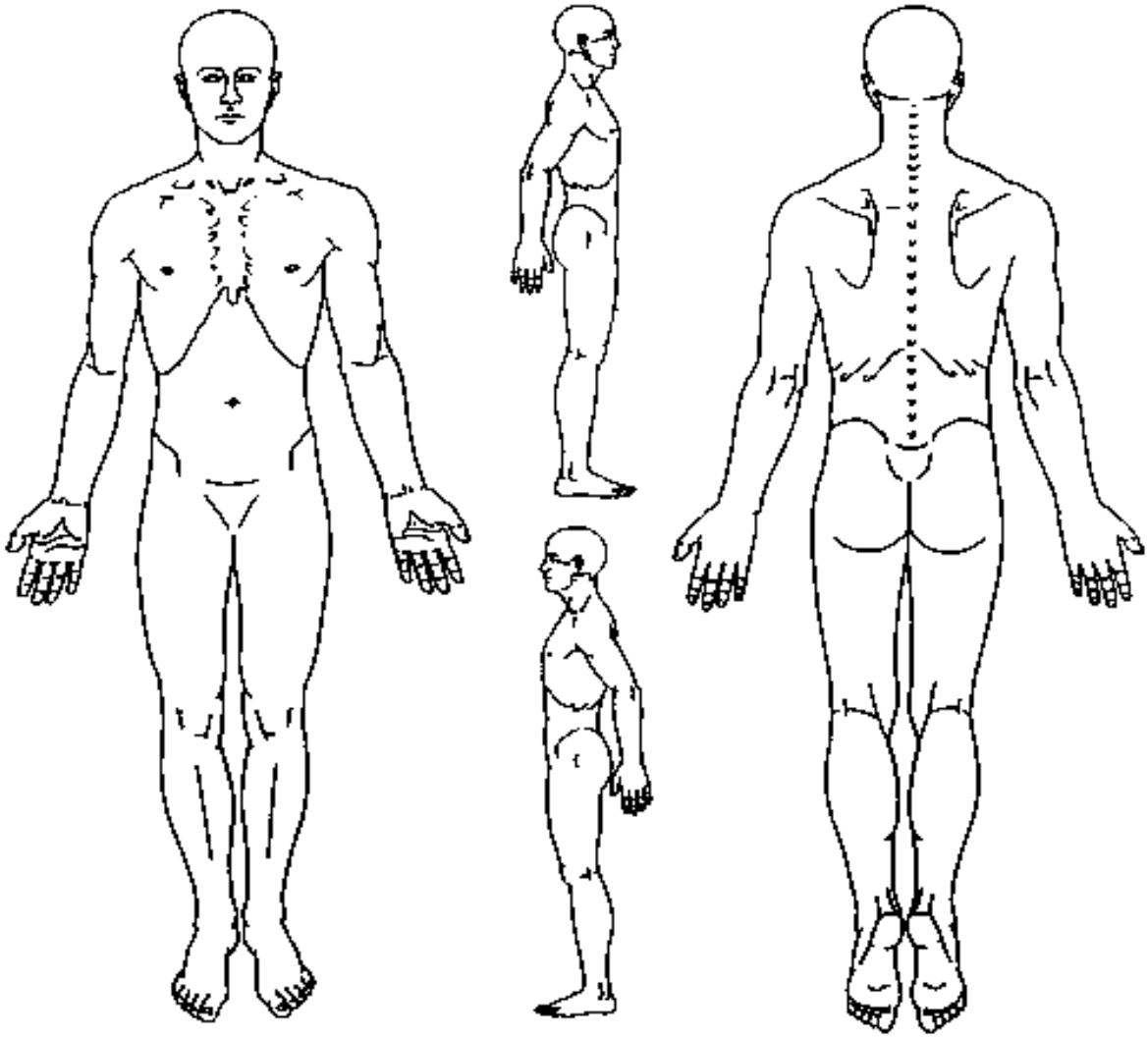
THE BACK & NECK DISABILITY INDEX QUESTIONNAIRE

NAME _____ DATE _____

How long have you had Back/Neck pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE	**B = BURNING**	**N = NUMBNESS**
P = PINS & NEEDLES	**S = STABBING**	**O = OTHER**

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