



Welcome to Brodows Chiropractic & Wellness Center

2606 Harwood Road

Bedford, TX 76021

817-540-1500

wellness@brodowschiropractic.com

www.brodowschiropractic.com

Date _____

Confidential Patient Information

Name _____ Social Security Number _____

Street Address _____ City _____ State _____ Zip _____

Cell Phone _____ Daytime Phone _____ Evening Phone _____

Email Address _____ Age _____ Birth Date _____

Marital Status: Married/Single/Widowed/Divorced Number of Children _____

Occupation _____ Employer _____

Employer Address _____

Employer Phone _____

Emergency Contact _____ Relationship to patient _____

Emergency Phone Number _____

I was referred to Brodows Chiropractic by: _____

Purpose of this appointment _____

Have you seen any other doctors for this condition? _____

Have you been treated by any health providers in the last year? yes no

Describe _____

Have you ever suffered from any of the following? (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Neuritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

If you have been injured in an accident, please complete the following questions

Date of Accident _____ Time of Accident _____ Location of Accident _____

What type of accident was it? Auto Collision On the job injury Other _____

Please describe the accident _____

Describe your injuries as best you can _____

If you were in an auto accident, please answer the following:

Were you wearing a seatbelt at the time of the accident? yes no

Were you the driver passenger pedestrian

Were you struck from behind right side front left side

Was your car moving or parked

Which car struck my car struck the other car the other car struck mine

As a result of the accident were any traffic citations issued ?

yes, to the driver of my car yes, to the driver of the other car no



Brodows Chiropractic

If you were in a workplace accident, did you report your injury to your supervisor? yes no
Did he/she recommend you seek care? yes no
Did you have post accident hospitalization? yes no

Have you missed any work? yes no dates _____
Have you been contacted by an insurance adjuster or company representative regarding this accident?
 yes no
Insurance Companies involved: mine other party's (provider name _____)
Do you have an attorney that has advised you on this case? yes no
If yes: Attorney Name _____
Attorney Address _____
City _____ State ____ Zip _____

Comments: _____

Payment & Insurance

Name of person responsible for payment: _____

Does patient have health insurance? yes no
Insurance Company _____ Group Number _____
Policy Number _____

I understand and agree that I am personally responsible for paying for all services rendered to me by Brodows Chiropractic. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that Brodows Chiropractic will prepare any necessary reports and forms to assist me in collecting from my insurance company, and that any amount authorized to be paid directly to Brodows Chiropractic will be credited to my account upon receipt. I also understand that if I suspend or terminate my care and treatment, any outstanding fees for services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Payment required at time of visit



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Irrevocable Assignment, Lien, and Authorization of Insurance Benefit Payments

To Whom It May Concern:

I hereby authorize and direct you, my insurance carrier, to pay directly to Brodows Chiropractic & Wellness Center such sums as may be due and owing them for services rendered me, both by reason of accident or illness and by reason of any other bills that are due Brodows Chiropractic. Furthermore I direct you to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment, or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Brodows Chiropractic. This document acts as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due to Brodows Chiropractic for services rendered. I further understand and agree that this Assignment, Lien, and Authorization does not constitute any consideration for Brodows Chiropractic to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize Brodows Chiropractic to release any information pertinent to my case to any insurance carrier or adjuster to facilitate collection under this Agreement, Lien and Authorization and authorize and direct Brodows Chiropractic to appeal denials or payments at all levels on my behalf.

I agree never to rescind this document and that a rescission will not be honored by my insurance company. I hereby instruct that in the event another insurance company is substituted in this matter, the new insurer will honor this agreement as inherent to the settlement and enforceable on the case as if it were executed by the company.

Signature _____ Date _____

Note: Your health information will be kept strictly confidential. Any information we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Medicare will in turn keep your information confidential.

Date: _____

Signature _____

Patient or legally authorized representative

Printed name of patient or legally authorized representative

Representative's relationship to patient



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Name _____ Date ____/____/____ File # _____

Low Back Disability Index

Please check the box in each section that **most clearly describes your problem:**

Section 1 – Pain Intensity

- 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 get no pain in bed
- I get pain in bed but it does not prevent me from sleeping
- Because of pain, my normal night's sleep is reduced by 25%
- Because of pain, my normal night's sleep is reduced by 50%
- Because of pain, my normal night's sleep is reduced by 75%
- Pain prevents me from sleeping at all

Section 2 – Walking

- I have no pain walking
- I have some pain walking, but it does not increase with distance
- I cannot walk more than one mile without increasing pain
- I cannot walk more than ½ mile without increasing pain
- I cannot walk more than ¼ mile without increasing pain
- I cannot walk at all because of the pain

Section 7 – Social Life

- My social life is normal and gives me no pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my energetic interests such as dancing
- Pain has restricted my social life, and I do not go out very often
- Pain has caused me to hold all of my social activities at my home
- I have hardly any social life because of the pain

Section 3 – Personal Care (Washing, Dressing, etc.)

- I do not have to change my way of washing or dressing to avoid pain
- I do not normally change my way of washing or dressing even though it causes me some pain
- Washing and dressing increase the pain but I manage not to change my way of doing them
- Washing and dressing increase the pain, and I find it necessary to change my way of doing them
- Because of the pain, I am unable to do some washing and dressing tasks without help
- Because of the pain, I am unable to wash and dress myself

Section 8 – Traveling

- I experience no pain from 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 causes me to do all traveling lying down
- Pain prevents me from traveling

Section 4 – Standing

- I can stand as long as I want without pain
- I have some pain standing, but the pain does not increase over time
- The pain increases if I stand longer than one hour
- I cannot stand for longer than ½ hour without increasing pain
- I cannot stand for longer than 10 minutes without increasing pain
- I avoid standing because it increases the pain immediately

Section 9 – Lifting

- I can lift heavy objects without extra pain
- I can lift heavy objects but it causes me extra pain
- Pain prevents me from lifting heavy objects off the floor, but I can lift them if they are conveniently positioned
- Pain prevents me from lifting heavy objects, but I can lift light to medium weights if they are conveniently positioned
- I can only lift very light objects
- I cannot lift any objects

Section 5 – Sitting

- 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 10 minutes
- I avoid standing because it increases the pain immediately

Section 10 – Changing Degree of Pain

- 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
- My pain is staying about the same
- My pain is gradually getting worse
- My pain is rapidly getting worse

Section 6 – Sleeping



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Neck Disability Index

Please check the box in each section that **most clearly describes your problem**:

Section 1 – Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is unbearable at the moment

Section 2 – Personal Care (Washing, Dressing, etc)

- I can care for myself normally without extra pain
- I can care for myself normally but it causes extra pain
- It is painful to care for myself but I am slow and careful
- I need some help but manage most of my personal care
- I need help everyday in most aspects of self care
- I do not get dressed, I wash with difficulty, and I stay in bed

Section 3 – Lifting

- I can lift heavy objects without extra pain
- I can lift heavy objects but it causes me extra pain
- Pain prevents me from lifting heavy objects off the floor, but I can lift them if they are conveniently positioned
- Pain prevents me from lifting heavy objects, but I can lift light to medium weights if they are conveniently positioned
- I can only lift very light objects
- I cannot lift any objects

Section 4 - Reading

- I can read as much as I want without any pain in my neck
- I can read as much as I want with slight pain in my neck
- I can read as much as I want with moderate pain in my neck
- I cannot read as much as I want to because of moderate pain in my neck
- I can hardly read at all because of severe neck pain
- I cannot read at all because of severe neck pain

Section 5 - Headaches

- I have no headaches at all
- I have slight headaches which come infrequently
- I have moderate headaches which come infrequently
- I have moderate headaches which come frequently
- I have severe headaches which come frequently
- I have severe headaches almost all the time

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty concentrating when I try to
- I have a lot of difficulty concentrating when I try to
- I have severe difficulty concentrating when I try to do so
- I cannot concentrate at all

Section 7 – Work

- I can do as much work as I want to
- I can only do my usual work but no more
- I can do most of my usual work
- I cannot do my usual work
- I can hardly do any work
- I cannot work

Section 8 – Recreation

- I am able to engage in all my recreational activities with no neck pain
- I am able to engage in all my recreational activities with some neck pain
- I am able to engage in most but not all of my usual recreational activities because of neck pain
- I can hardly do any recreational activities because of neck pain
- I cannot do any recreational activities at all

Section 9 – Driving

- I can drive my car without neck pain
- I can drive my car as long as I want with slight neck pain
- I can drive my car as long as I want with moderate neck pain
- I can't drive my car as long as I want because of severe neck pain
- I cannot drive my car at all because of the neck pain

Section 10 – Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (< 1 hr sleepless)
- My sleep is moderately disturbed (1-3 hrs sleepless)
- My sleep is greatly disturbed (3-5 hrs sleepless)
- I sleep very little
- I cannot sleep at all



Health Care Authorization Form

Patient's Name _____
Patient's SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES BRODOWS CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to Brodows Chiropractic to use my address, phone number, e-mail address, and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.
- I give Brodows Chiropractic permission to treat me in a open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving Brodows Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Brodows Chiropractic. The written notice must contain the following information:

- Your name, Social Security number and Date of Birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature.

The revocation is not effective until it is received by the Privacy Official.

The AUTHORIZATION is requested by Brodows Chiropractic for its own use/disclosure of PHI.
(Minimum necessary standards apply)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Brodows Chiropractic will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

PLEASE SEE OTHER SIDE

- ***A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU****

Print Name of Patient

Signature of Patient

Date

Signature of Personal Representative

Description of Representative's Authority To Act for Patient: