

Welcome To Our Office...

CASE HISTORY:

Patient's Name: _____
Street/City/State/ZIP: _____
Email Address: _____
Home Phone: _____ Work Phone: _____
Birthdate: _____ Age: _____ Sex: _____ Martial Status: M S W D
Social Security #: _____ Driver's License#: _____
Spouse's Name: _____ Number of Children/Ages: _____
Your Employer's Name/Address/Phone: _____
Your Spouse's Employer/Address/Phone: _____
Person Responsible for This Account: _____

How did you hear about or why did you choose our office? (check all that apply)

____ Another Patients (name: _____) _____ Yellow Pages _____ La Crosses Tribune Ad
____ Another Ad (name it: _____) Office Sponsored Event (where? _____)
____ My Insurance covers here. _____ Location of office. _____ Preferred Gonstead Practioner
____ Another Health Care Provider/Professional (name: _____)
Other: _____

What is your main complaint? _____

How long have you had this condition? _____ Have you had similar conditions in the past? Y N

What things aggravate your condition? _____

Is your condition getting worse? Y N Does it interfere with your activities of daily living? Y N

Are you taking medications? If yes, list _____

Any past surgeries? Y N Other doctors seen for this condition: MD DC DO PT

INSURANCE INFORMATION:

Name/Address/Phone of Insurance Carrier: _____

Are you the policyholder? Y N If no, who is? _____

Policyholder's birthdate: _____ Group#: _____

Do you have a Secondary Insurance Carrier? Y N

If yes, Name/Address/Group#./Insured Name/SS#/BDate: _____

Payment is due within 30 days of treatment or the sale of a product. A 1% per month (12% per year) late payment fee will be assessed on any unpaid balance remaining after 30 days.

****As a courtesy to our patients with insurance coverage, we will call your insurance carrier to check on your benefits for care at our office. However, insurance companies DO NOT GUARANTEE BENEFITS OVER THE PHONE, therefore the information we receive is not guarantee of payment. If you have concerns regarding your insurance benefits, please call your insurance company or refer to your benefit booklet. Your policy is an agreement between you and your insurance company, any benefits not paid by your insurance policy will be your personal responsibility.**

I verify that the information given about my condition/health is true to the best of my knowledge. I also understand and agree that I am personally responsible for all services rendered at the BENTZ CHIROPRACTIC CLINIC.

Patients Signature: _____

Today's Date: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and Dr. Bentz has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

(signature)

(date)

Bentz Chiropractic Clinic
406 Jackson St. La Crosse, WI 54601
(608) 784-2255

HEAD:

- NECK:**

- ### SHOULDERS:

- ### ARMS & HANDS:

- MID-BACK:**

- CHEST:**

- ABDOMEN:**

- LOW BACK:**

- HIPS, LEGS, & FEET:**

- WOMEN ONLY:**

- MEN ONLY:**

- GENERAL:**

- REMARKS:

[illegible]

BENTZ CHIROPRACTIC CLINIC

Dr. David M. Bentz

406 Jackson St.
La Crosse, WI 54601
608-784-2255**PATIENT NAME:** _____**DATE:** _____

P = PAST CONDITION

C = CURRENT CONDITION

| CONDITION | FATHER Age () | MOTHER Age () | SPOUSE Age () | BROTHERS Age () Age () | SISTERS Age () Age () | CHILDREN Age () Age () |
|---------------------------|-------------------|-------------------|-------------------|-----------------------------|----------------------------|-----------------------------|
| Arthritis | | | | | | |
| Asthma/Hay Fever-Sinus | | | | | | |
| Back Trouble | | | | | | |
| Bursitis | | | | | | |
| Cancer | | | | | | |
| Constipation | | | | | | |
| Diabetes | | | | | | |
| Disc Problem | | | | | | |
| Emotional | | | | | | |
| Emphysema | | | | | | |
| Headaches | | | | | | |
| Heart Trouble | | | | | | |
| High Blood Pressure | | | | | | |
| Insomnia | | | | | | |
| Kidney Trouble | | | | | | |
| Liver Trouble | | | | | | |
| Nervousness | | | | | | |
| Scoliosis | | | | | | |
| Stomach Trouble | | | | | | |
| Other | | | | | | |

Back Index

ACN Group, Inc. Form BI-100

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

Patient Name _____

Date _____

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

Pain Intensity

- ⑥ 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

- ⑥ 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

- ⑥ 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

- ⑥ 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

- ⑥ 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

- ⑥ 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

- ⑥ 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

- ⑥ 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

- ⑥ 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

- ⑥ 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.

Back
Index
Score

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|--|
| |
|--|

Neck Index

ACN Group, Inc. Form NI-100

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

Patient Name _____

Date _____

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

Pain Intensity

- ⑥ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- ⑥ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ⑥ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- ⑥ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- ⑥ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- ⑥ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ⑥ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- ⑥ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- ⑥ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- ⑥ 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.

Neck
Index
Score

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Bentz Chiropractic Insurance Agreement

Your wellness is our top priority. Based on your health history, exam and diagnostic studies, we will design a care plan specifically for you. These recommendations are based on your unique healthcare needs, not on insurance benefits.

Your insurance policy is an agreement between you and your insurance company. Insurance companies DO NOT GUARANTEE BENEFITS, therefore this is not a guarantee of payment for any or all services rendered. If the claims are not paid, you as the patient are responsible for the bill.

I have read and understand all the above information that has been presented to me. I agree to have my claims filed to my insurance company.

Patient Signature _____ Date Signed _____

Insurance Company _____