Welcome to Hoffmann Chiropractic LLC

Patient Information

Thank you for choosing Hoffmann Chiropractic LLC for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

(please print clearly)

Name: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: ❑ Female ❑ Male Birthdate: _____ E-mail: _____

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for ____ years

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

Cell Phone Provider _____ ❑ Check if you do NOT want to receive text message reminder

Patient Employer/School: _____Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip Code: _____

Spouse or parent's name: _____ Employer: _____ Work Phone: (_____)_____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone: (_____)_____

Responsible Party

Name of person responsible for this account: _____

Relationship to patient:_____ Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

Name of employer: _____ Work Phone: (_____)_____

Payment Information

❑ Auto Accident

Attorney Name/Firm: _____ Phone: _____ Address: _____

Claim # _____ Policy # _____

❑ Worker's Compensation

Name of employer: _____ Work Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

Claim # _____ Policy # _____

❑ Health Insurance ❑ Medicare ❑ Medicaid

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security#:: _____ Effective date: _____

Insurance Co.: _____ Phone: (_____)_____ Address: _____

Group #: _____ Member #: _____

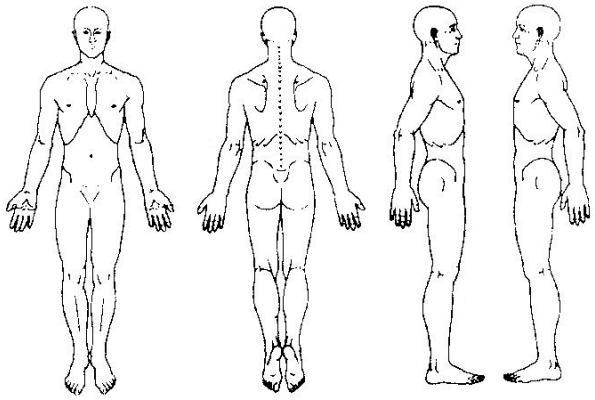
Do you have additional insurance? ❑ Yes ❑ No If Yes, please provide information:_____

Symptoms_____

Reason for visit: _____ When did you first notice the symptoms? _____

Is the condition getting progressively worse? _____ Where specifically is the problem(s) located? _____

Mark areas of complaint:



Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Radiating (where?)_____ ❑ Other_____

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Sleeping ❑ Lifting ❑ Running ❑ Working ❑ Pushing/Pulling ❑ Climbing ❑ Lying down ❑ Physical Activity ❑ Personal Care ❑ Other_____

Have you lost any days of work? ❑ Yes ❑ No Dates:_____

What treatment have you received for your condition? ❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Other _____

Name and address of other doctor(s) who have treated you for your condition: _____

_____

Have you had similar symptoms or injuries before? ❑ Yes ❑ No If yes, please explain _____

_____

Health History *Check only those conditions which are applicable:*_____

❑ AIDS/HIV	❑ Cataracts	❑ Hepatitis	❑ Osteoporosis	❑ Suicide Attempt
❑ Alcoholism	❑ Chemical Dependency	❑ Hernia	❑ Pacemaker	❑ Thyroid Problems
❑ Allergy Shots	❑ Chicken Pox	❑ Herniated Disc	❑ Parkinson's Disease	❑ Tonsillitis
❑ Anemia	❑ Depression	❑ Herpes	❑ Pinched Nerve	❑ Tuberculosis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tumors, Growths
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Typhoid Fever
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostrate Problems	❑ Ulcers
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Vaginal Infections
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraine Headaches	❑ Psychiatric Care	❑ Venereal Disease
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Whooping Cough
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Other _____
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever _____	
❑ Cancer	❑ Heart Disease	❑ Mumps	❑ Stroke _____	

Primary Care Physician:_____ Date of last exam: _____

List any types of surgeries which you have had and the dates which they occurred: _____

_____

Please list all medications you are currently taking: _____

Allergies: _____

Family History

Parents: Father (age)_____Mother (age)_____ Siblings (ages)_____

Family Diseases

❑ Tuberculosis	❑ Cancer	❑ Mental Illness	❑ Diabetes
❑ Asthma	❑ Heart Disease	❑ Stroke	❑ Kidney Disease
❑ Lung Disease	❑ Arthritis	❑ Liver Disease	❑ Other _____

Remarks or other information you would like the doctor to know:

_____

_____

(Woman Only):

Are you pregnant? ❑Yes ❑No Nursing? ❑Yes ❑No Birth Control Methods? ❑Yes ❑ No LMP_____

Daily Habits_____

What type of exercise do you perform on a daily/weekly basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? _____

What vitamins do you currently take? _____ Nutritional supplements (if any)? _____

Do you smoke? ❑ Yes ❑ No How much per day? _____

How much liquor do you consume weekly? _____ How many caffeinated beverages do you consume daily? _____

How much water do you consume daily?_____

Certification and Assignment

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.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Hoffmann Chiropractic LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Hoffmann Chiropractic LLC may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

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

_____ _____

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

HOFFMANN CHIROPRACTIC LLC

Personal / Home Injury History

Patient Name: _____ Date: _____

Age: _____ Birth Date: _____/ _____ / _____ ❑ M ❑ F S.S.#: _____ Address:

_____ City:

_____ State: ___ Zip: _____Driver's License #: _____

Insured: _____Address: _____

Name of Insurance Company: _____

City: _____ State: _____Zip: _____ Telephone #: _____

(If home injury, Home Owner's Policy may be responsible for payment.)

Have you retained an attorney? ❑ Yes❑ No Name of Attorney: _____ Address/

Phone # of Attorney: _____

Date of Accident: _____ / _____ / _____ Time of Accident: _____ ❑ A.M. ❑ P.M.

Where did the accident happen? _____

Where were you taken after the accident? _____

Where did you feel pain? _____ Were you unconscious? ❑ Yes❑ No

What are your present symptoms? _____

Are your symptoms: ❑ Improving? ❑ Getting Worse? ❑ Same? ❑ Other? _____

Name(s) of any other doctors consulted since your accident: _____

Treatment received: _____

How often did you receive treatment from the other doctor? _____

Have you previously been injured in a similar manner? ❑ Yes❑ No

PLEASE EXPLAIN FULLY HOW YOUR ACCIDENT HAPPENED: _____

_____

_____

_____

_____

_____

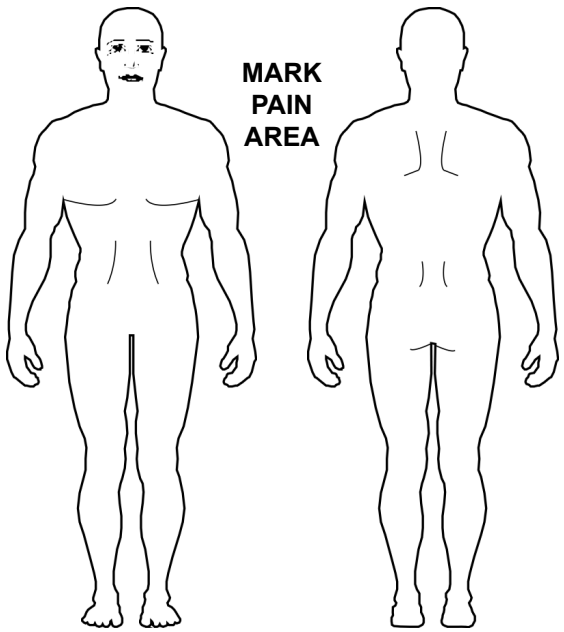
_____

_____

_____

_____

_____



+++ Burning **000 Stabbing**
--- Sharp **III Consistent**

Date: _____Patient Signature: _____

Date: _____Doctor Reviewed Signature:_____

HOFFMANN CHIROPRACTIC LLC

AUTO ACCIDENT QUESTIONNAIRE

Name_____ Date_____

Date of Accident_____

Brief description of Accident (i.e. rear-ended, head on, side impact, etc.) _____

_____

_____

Describe any secondary collisions (i.e. pushed into vehicle in front of you) _____

_____

Do you recall striking anything inside the vehicle? (ice. knees on dashboard, head on windshield)

□ NO □ YES explain:_____

What type of vehicle were you in? _____ Estimated Speed_____

What type of vehicle was the other driver in ?_____ Estimated Speed_____

Describe damage to your vehicle □ Light □ Moderate □ Heavy Damage Estimate _____

After the accident was your vehicle □ Drivable □ Not drivable

Were you □ Driver □ Passenger - Sitting:_____

At the time of the accident: Visibility was □Good □ Poor

Time of Day □ Daylight □ Night

Road conditions □Dry □ Wet □ Snow/Ice

At the time of impact:

Were you looking □ Toward Left □ Straight ahead □ Toward Right □ Up □ Down

Was your foot on the brake? □Yes □ No

Were you □ Braced for Impact □ Unaware of Impending collision

Were you wearing a seatbelt? □ Yes □ No Did your airbag deploy? □ Yes □ No

Was your headrest □Adjusted properly □ Not Adjusted □ Don't Recall

Stop Here. Lower section for doctor's evaluation

□MIC1	Subjective symptoms	10pts.
□MIC2	Symptoms, Loss of ROM	50pts.
□MIC3	Symptoms, ROM & Neuro	90pts.

Modifiers

□	Canal Size	10-12 mm	20
□	Canal Size	13-15 mm	15
□	Kyphotic Cervical Curve		15
□	Straightened Cervical Curve		10
□	Blocked/ Fused Segments		15
□	Loss of Consciousness		15
□	Pre-existing DJD		10

□ Hyper/Hypo Mobility on Flex./Ext.

10-30	Excellent
35-70	Good
75-100	Poor
105-125	Guarded
130-165	Unstable

Complicating Health/Lifestyle Factors:

_____

_____

_____

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

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.

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).

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.

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.

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.

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.

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.

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.

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.

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

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

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 _____

HOFFMANN CHIROPRACTIC LLC

DOCTOR-PATIENT RELATIONSHIP
AND
INFORMED CONSENT

CHIROPRACTIC
It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy, and Medicine, and for the patient to understand what to expect from chiropractic care. It is the chiropractic premise that proper spinal alignment allows normal nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. In this way, chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic procedures often depends on environment, underlying causes, and the physical and spinal conditions of each individual patient. It is important that the patient understands what to expect from your chiropractic care. Due to the complexities of nature, and the many variables (both known and unknown) that can affect a patient's response, no doctor can promise specific results. The Doctor of Chiropractic provides a specialized, unique, non-duplicating health service. The Doctor of Chiropractic is licensed in a special area of practice and is available to work with other types of providers in your health care regime.

ANALYSIS
Your doctor will conduct a clinical analysis for the express purpose of determining whether there is evidence that your situation may be the result of a vertebral subluxation and that you might respond satisfactorily to chiropractic care. If such is found, chiropractic care will be recommended in an attempt to restore spinal integrity.

RESULTS
The purpose of chiropractic care is to promote natural health through the reduction of the vertebral subluxation. Since there are so many variables, it is difficult to predict the time schedule or the efficacy of the chiropractic adjustment on any given patient. Sometimes the response is phenomenal, however, in most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same type of care and actual response is not predictable. Many medical failures have found significant benefit through chiropractic care. In turn, many conditions, which do not respond to chiropractic care, may be helped through medical treatment. Chiropractic and medicine may never be so exact as to provide definite answers to all problems; however, both have made great strides in patient care.

DIAGNOSIS
Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the human spine, and its effects on the nervous system, they are not internal medical specialists. Every patient should be mindful of his/her own symptoms and should secure other opinions should he/she have any concerns as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
By signing below, the patient gives the doctor permission and authority to care for him/her in accordance with recognized and acceptable chiropractic analytical and corrective procedures. The chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give an adjustment if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through other health care procedures whether he/she is suffering from pathological conditions (latent or otherwise), illnesses, injuries, or deformities which would otherwise not come to the attention of the doctor.

TO THE PATIENT
Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care.

I have read and understand the foregoing explanation of chiropractic care given to me. I hereby give my consent for the doctor to render chiropractic care to me.

Patient's Signature: _____ Date: _____

HOFFMANN CHIROPRACTIC LLC
3933 Highway 59, Suite A
Mandeville, LA 70471
Ph. 985-629-1332 Fax. 985-327-5449

Authorization for Release of Records

Date_____

I hereby authorize the release of my medical records and request that they be transferred from:

To:_____

Phone#:_____ Fax #:_____

Address: _____

City: _____State _____Zip _____

and sent to,

Melissa Hoffmann, DC

3933 Highway 59, Suite A
Mandeville, LA 70471
Ph. 985-629-1332 Fax. 985-327-5449

Records to be disclosed: _____

_____

Patient's Name: _____

DOB: _____ Date of Records_____

Patient's Signature_____ Date _____

Patient Health Information Consent Form

(Notice of HIPAA Privacy Practices)

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

(Print Name) (Signature) (Date)

Hoffmann Chiropractic LLC
1660 Highway 59, Suite 500
Mandeville, LA 70448
Phone: 985-629-1332 Fax: 985-327-5449
E-mail: hoffmannchiropracticllc@yahoo.com