NECK DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your 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 MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

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

A I can look after myself normally 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 gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage 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 to with slight pain in my neck.
C I can read as much as I want to 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 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
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 any 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 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)

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my 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 at all.

COMMENTS:____

Name __________________________ Age _____ Date ____________ Score __________

Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your 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 MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 - Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

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.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4 - Walking

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than 1/2 mile.
D Pain prevents me from walking more than 1/4 mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

SECTION 6 - Standing

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than ten minute without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7 - Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one than one quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

SECTION 8 - Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 - Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

COMMENTS: ____

____

NAME: ______________________ DATE: ______ SCORE: _______

Fairbank J, Davies J, et al. The Oswestry Low Back Pain Disability Questionnaire. Physiother 1980; 66(18): 271-273.

How Medicare Works With Chiropractic

Since the 1970s Medicare has covered chiropractic, but it is not covered like the services provided by your medical doctor. This will explain the differences and how they affect you and you doctor.

What Is Covered

Medicare covers the chiropractic adjustment and nothing else. The doctor is required to prove that the adjustment is medically necessary before Medicare will pay for it. This means that the doctor must perform examinations and, if necessary, x-rays. Medicare does not pay for these examinations or x-rays when they are ordered or provided by a chiropractor.

This limitation is not because of a regulation but because of the wording of the Social Security Act. For more services to be covered, a new law would have to be passed by both the House and Senate and signed by the President.

What The Doctor Is Required To Do

As stated above, the doctor is required to prove the adjustments are medically necessary. To do this he has to collect specific information from you that Medicare requires. To do this he must use forms and questionnaires. He does everything within his power to keep the paperwork to a minimum, but he must meet Medicare's requirements or they will not pay for your care like they should.

The doctor is also required to perform examinations and, if necessary, x-rays that Medicare will not pay for. He has to charge you his regular fees for these and other non-covered services or be in violation of Medicare law.

The End Of Care

To prove that your care is medically necessary the doctor must prove that you have what Medicare calls functional improvement. When you no longer have functional improvement Medicare considers your care to be maintenance care, which they consider medically unnecessary and which they will not pay for. Your doctor must report this to Medicare or be in violation of the law. At this point you can choose to discontinue care or continue care and pay for it yourself.

I have read and understand how chiropractic works with Medicare.

Signature: ______________________________ Date: ____________________

Medicare Patient Information Form

Name ______________________________ Date ______________________

Address ____________________________ Date of Birth __________ Age ______

City ______________ State _____ Zip _____ SSN/Medicare Number _______________

Home Phone ____________ Cell Phone ______________ Work Phone ____________

E-Mail _______________ Gender M F Married Y N Spouses Name _____________

Emergency Contact Name ______________________ Relationship _______________

Phone Number ______________ Address ___________________________________

City ____________________ State ____________ Zip _____________________

Medical Doctor Name ______________________ Phone Number ______________

Employers Name ____________________ Occupation ___________________ FT PT

Address ___________________________ Phone Number _____________________

Yes No Are you covered by a Group Health Plan through your current or former employment?

Yes No Are you covered by a Group Health Plan through your spouse or other family member's current or former employment?

Yes No Are you receiving Workers' Compensation (WC) benefits?

Yes No Are you filing a claim with a no-fault insurance or liability insurance?

Yes No Are you being treated for an injury or illness for which another party has been found responsible?

Secondary Insurance

Name of Subscriber ____________________ Member/Subscriber Number/I.D. ___________

Relationship to Subscriber _______________ Subscriber's Date of Birth ______________

Insurance Company Name ____

Claims Mailing Address ____

City ________________________ State __________ Zip ____________________

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, or the above listed secondary insurance company, or its contractors or subcontractors any information needed for this or related Medicare claim. I assign directly to Dr. Long 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 pain by insurance. I authorize the use of my signature on all insurance submissions.

Signature ______________________________ Date ____________________

Medicare History Form

Name____ Date______________________

Main Problem

What pain causes you to come to the office? ____

What caused this pain? ____

When did this pain start? ____________________ How long does this pain last? ____________________

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? ____

What makes this pain better? ____

What makes this pain worse? ____

What else have you done to treat this pain? ____

Other Problem

What other pain do you have? ____

What caused this pain? ____

When did this pain start? ____________________ How long does this pain last? ____________________

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? ____

What makes this pain better? ____

What makes this pain worse? ____

What else have you done to treat this pain? ____

Allergies

Please list any allergies below including allergies to medications.

____

____

____

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Family History

Please tell us about the health of your grandparents, parents, and siblings. Circle or check everything that applies. If someone is deceased, please check or write in the cause.

	Living Deceased	Heart Disease	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Multiple Sclerosis	Lung Disease
Paternal Grandfather	L or D Cause							
Paternal Grandmother	L or D Cause							
Maternal Grandfather	L or D Cause							
Maternal Grandmother	L or D Cause							
Father	L or D Cause							
Mother	L or D Cause							
Sibling M F	L or D Cause							
Sibling M F	L or D Cause							
Sibling M F	L or D Cause							

Habits

☐ Smoking — Packs/Day ______________________

☐ Alcohol — Drinks/Week______________________

☐ Recreational Drugs — Type/Frequency ______________________

☐ High Stress Level — Reason ______________________

Past History

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No
Pinched Nerve☐ Yes ☐No
Psychiatric Care ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No
Fractures ☐ Yes ☐ No
Gout ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Prostate Problem ☐ Yes ☐ No
STD's ☐ Yes ☐ No
Tumor/Growth☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No
Herniated Disk☐ Yes ☐ No
Herpes ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
Multiple Sclerosis ☐ Yes ☐ No
Parkinson's Disease ☐ Yes ☐ No
Rheumatoid ☐ Yes ☐ No
Stroke ☐ Yes ☐ No

Have you had any other illnesses in the past ______________________________________

____

Have you had any injuries ____

____

Have you been hospitalized ____.

Have you had any surgeries ____.

Medications	Vitamins/Herbs/Supplements

I certify that the information that I have given here is true and accurate to the best of my knowledge.

Print Name ____

Signed ______________________________________ Date ____________________

Long Chiropractic Office
4978 Northcutt Place, Dayton, OH 45414
7244 Far Hills Ave. Centerville, OH 45459
(937) 278-7246 (p) ~ (937) 278-5640 (f)

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. Please read the following and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

The chiropractic adjustment, clinical procedures, physical therapy procedures, and rehabilitation exercises are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury, such as fractures, muscular strain, ligamentous sprain, intervertebral disc injury, nerve injury, or stroke. The doctor, of course, will not give any treatment or care if he determines such care may be contra-indicated. It is the responsibility of the patient to disclose any known latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized health care service and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by Long Chiropractic Office, I am granting authorization to proceed with treatment that Dr. Long deems necessary. Furthermore, any additional questions I may have regarding chiropractic treatment will be answered upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Consent to Evaluate and Treat a Minor:

I, ______________________________ being the parent or legal guardian of ______________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

To whom may we communicate your healthcare information?

Spouse: ______________________________________

Children: ______________________________________

Others: ______________________________________

No one: [ ]

May we leave messages regarding your personal healthcare information on any answering device?
(i.e. home answering machines or voicemails) Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have read the Notice of Privacy Practices Form (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: ______________________________________

Signature: ______________________________ Date: ______________________

RED FLAG QUESTIONNAIRE

NAME ______________________________ DATE ________________ AGE ____

Please check the appropriate response. If "yes", please explain. If you are not sure, check the "?" box.

NO	YES	?	
☐	☐	☐	Do you have a past history of cancer?
☐	☐	☐	Have you had any unexplained weight loss?
☐	☐	☐	Does your pain improve with rest?
☐	☐	☐	Are you over 50 years old?
☐	☐	☐	Failure to respond to a course of conservative care (4-6 weeks)?
☐	☐	☐	Have you had spinal pain greater than 4 weeks?

NO	YES	?	
☐	☐	☐	Prolonged use of corticosteroids (such as organ transplant Rx)?
☐	☐	☐	Intravenous drug use?
☐	☐	☐	Current or recent urinary tract, respiratory tract or other infection?
☐	☐	☐	Immunosuppression medication &/or condition?

NO	YES	?	
☐	☐	☐	History of significant trauma?
☐	☐	☐	Minor trauma in person >50 years old?
☐	☐	☐	Do you have osteoporosis (weak bones)?
☐	☐	☐	Are you over 70 years old?
☐	☐	☐	Any history of prolonged use of corticosteroids?

NO	YES	?	
☐	☐	☐	Acute onset urinary retention or overflow incontinence (wet underwear)
☐	☐	☐	Loss of anal sphincter tone or fecal incontinence (bowel accidents)
☐	☐	☐	Saddle anesthesia (numbness in the groin region)
☐	☐	☐	Global or progressive muscle weakness in the legs (legs give out)

COMMENTS: ____

LONG CHIROPRACTIC OFFICE

4978 NORTHCUTT PLACE, DAYTON, OHIO 45414 (937) 278-7246

Patient Name:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. Medicare doesn't pay for the services below; if you receive any of these services, you will be financially responsible for them.

Services		Reason Medicare May Not Pay:	Estimated Cost
Exam	99202-99204		\$40 - \$138
X-Rays	72040-73100	Non-Covered Services	\$35 - \$150
Modalities	97010-97039		\$15 - \$50
Therapeutic Procedures	97110-97530		\$30 (per unit)

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.

Additional Information: This ABN form is only for non-covered Medicare services. Medicare never pays for such services.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have read and understand this notice.

Signature:	Date:

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