REMINDERS

We remind our patients about upcoming appointments by either contacting you by telephone or text messages. Please check your preferred method of appointment reminders.

☐ Telephone
Phone number 1.______________________ Phone Number 2.________________________

☐ Text message
Mobile Number__________________ Mobile Carrier (example Verizon)_______________

I understand that my appointment times are reserved exclusively for me and if I do not give 24 hours notice for a cancellation, I will be charged for a missed appointment.

Name: ____
(Please print)

Signature: ____ Date: _______________

PUTTY CHIROPRACTIC CENTER
REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Patient Name: ____________________________MI:_______
Date: ____________________ SSN: ______________________
Address: ____
City: __________________ State: _____ Zip: ______________
Email: ____
DOB: _____/_____/__________ Sex: □ M □ F Age: ________
□ Married □Widowed □Single □Minor
□Divorced □Partnered for _____ years
Employer/school: _____________________________________
Employer/school address: _____________________________
____
Employer/school ph: (______) __________________________

Spouse/parent/guardian name: __________________________
Spouse/parent/guardian's employer: _____________________
Spouse/parent/guardian DOB: ___/___/_________________
Spouse/parent/guardian SSN: ___________________________
Referred by: ____

PHONE NUMBERS

Cell: (____) ______________ Home: (____) _____________
Best time to reach you _________________ by □ cell □ home

EMERGENCY CONTACT: Name: ___________________________
Cell: (____) ______________ Home: (____) _____________

ACCIDENT INFORMATION

Is this condition due to a motor vehicle accident? □ yes □ no
Is this condition due to work related injury? □ yes □ no
If you answered yes to either question please fill out the personal injury form or the work related form.

INSURANCE INFORMATION

Who is responsible for this account?

____

Relationship to Pt: _______________________
Insurance company: _______________________
ID#:_____________________________________
Is Pt covered by additional insurance? □Y □N
Subscriber's Name: _______________________
DOB: ___/___/____ SSN: _______________
Relationship to Pt: _______________________
Ins Company: ____________________________
ID#: ____________________________________

ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent(s) have insurance coverage with ___________________
And assign directly to Dr. Putty all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all chargers whether or not paid by insurance, I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance companies 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 OR GUARDIAN:

____

Date:___/___/____

PATIENT CONDITION

Reason for visit: ____
When did your symptoms appear? _________________ Give a brief description of what caused your symptoms: ______
____
Have you seen any other doctors for this condition? □ yes □ no: If yes, who and when: ___________________________
Please rate the severity of pain from 1(no pain) to 10 (worst pain I have ever had): __________
Is your pain: □ constant sever pain, □ constant but the intensity changes, □ comes and goes (at times I have no pain)
Have you ever had this problem in the past?________ How long did it last? __________ If you have seen another doctor for the same pain please describe the treatment (medication, physical therapy, x-rays, MRI, chiropractic care etc...)_____

PLEASE TURN OVER AND FILL OUT THE BACK PAGE

PUTTY CHIROPRACTIC CENTER
REGISTRATION AND HEALTH HISTORY

What treatment have you had for this condition? ☐ Medication ☐Physical therapy ☐Chiropractic ☐None ☐Other________
Name of doctors or providers that have treated you for this condition ____
Date of last: ☐x-rays ______________ ☐MRI/CT/bone scan/advanced imaging ______________ ☐blood test__________
☐physical exam______________ ☐urine test ______________ ☐spinal exam______________

Please mark with an X to indicate if you have/had any of the following.

AIDS/HIV	( )	Diabetes	( )	Liver Disease	( )	Rheumatic Fever	( )
Alcoholism	( )	Emphysema	( )	Measles	( )	Scarlet Fever	( )
Allergy shots	( )	Epilepsy	( )	Migraines	( )	Sexually Transmitted Ds	( )
Anemia	( )	Fractures	( )	Miscarriage	( )	Stroke	( )
Anorexia	( )	Glaucoma	( )	Mononucleosis	( )	Suicide Attempt	( )
Appendicitis	( )	Goiter	( )	Multiple Sclerosis	( )	Thyroid Problems	( )
Arthritis	( )	Gonorrhea	( )	Mumps	( )	Tonsillitis	( )
Asthma	( )	Gout	( )	Osteoporosis	( )	Tuberculosis	( )
Bleeding disorders	( )	Heart Disease	( )	Pacemaker	( )	Tumors, Growths	( )
Breast lump	( )	Hepatitis	( )	Parkinson's Ds	( )	Typhoid fever	( )
Bronchitis	( )	Hernia	( )	Pinched Nerve	( )	Ulcers	( )
Bulimia	( )	Herniated disk	( )	Pneumonia	( )	Vaginal Infections	( )
Cancer	( )	Herpes	( )	Polio	( )	Whooping Cough	( )
Cataracts	( )	High Blood Pressure	( )	Prostate Problems	( )	Other : ______________	
Chemical Dependency	( )	High Cholesterol	( )	Prosthesis	( )	______________	
Chicken pox	( )	Kidney Ds	( )	Psychiatric Care	( )	______________	
				Rheumatoid Arthritis	( )	______________	

Headaches (HA) ( ) How often do you have HA? ______________ How long do they last? ______________________

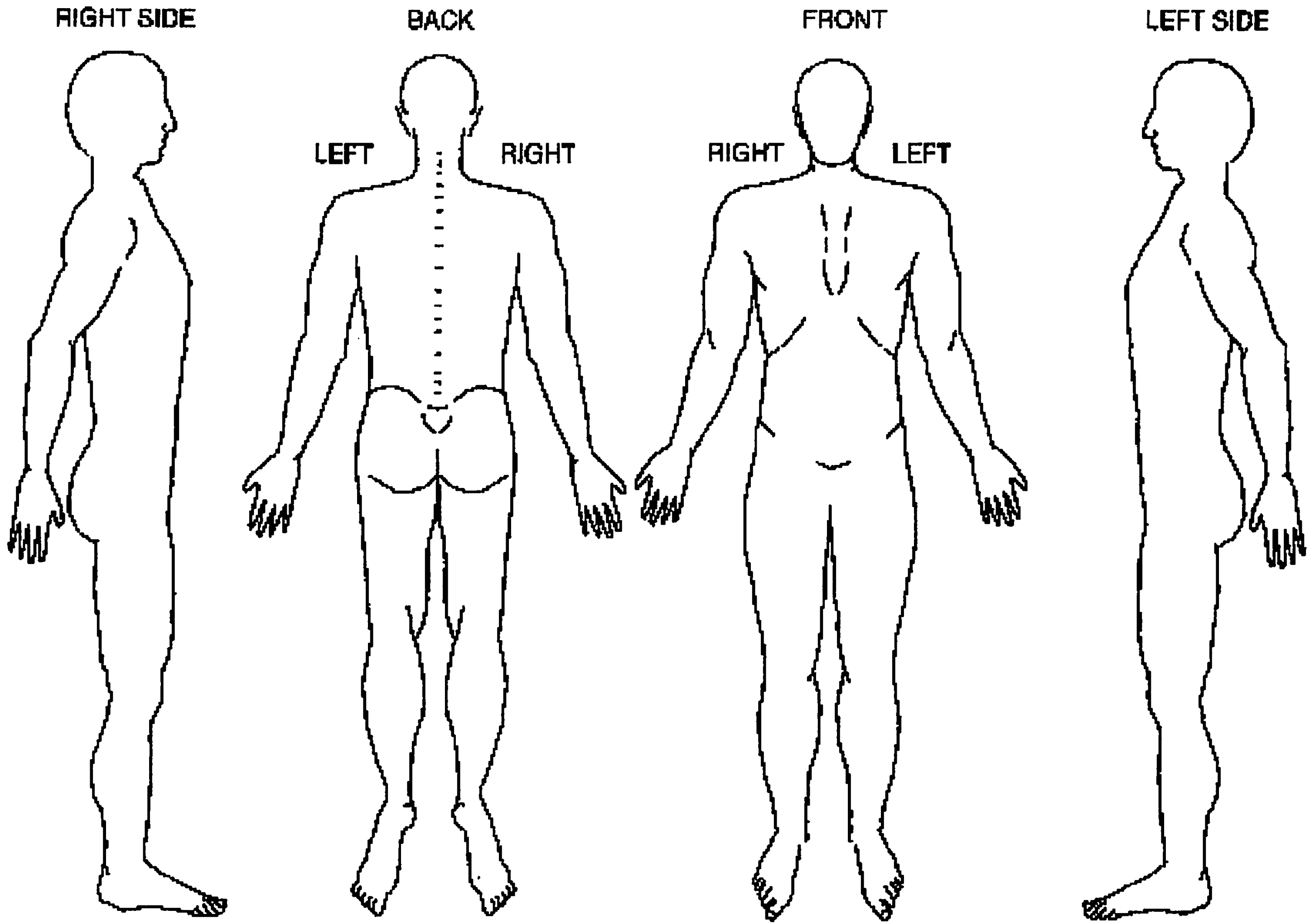
Pregnancy history: # of pregnancies ______ # of live births ______ # of c-sections______ # of vaginal deliveries______
Are you currently pregnant? ☐ yes ☐ no If yes when is due date? ______________
Any complications with this pregnancy or any past pregnancy? ______________________________

Exercise:		**Work Activity:**		**Habits:**		
None	( )	Sitting	( )	Smoking	( )	Packs/Day: ______________
Mild	( )	Standing	( )	Smokeless tobacco	( )	Cans/Day: ______________
Moderate	( )	Light Labor	( )	Alcohol	( )	Drinks/Week: ______________
Heavy	( )	Heavy Labor	( )	High Stress Level	( )	Reason for stress: ______________

Injuries/falls/accidents: Please include date if possible
Surgeries:______________________________
Head injuries: ______________________________
Broken bones: ______________________________
Trauma: ______________________________
Motor Vehicle Crash: ______________________________

Medications: ______________________________ **Allergies:** ______________________________

PUTTY CHIROPRACTIC CENTER
260 Burley Ave
Hopkinsville KY 42240
270-886-0068



Please label the areas where you have pain. Use the following key:
A – ache B – burning N – numbness P – pins/needles S – sharp/stabbing O – other ________________

PUTTY CHIROPRACTIC CENTER

ERIC PUTTY, DC

Consent to treatment

I hereby request and consent to the performance of chiropractic exam, adjustments and/or adjunctive therapies on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future render treatment to me which by working for or associated with or serving as back-up for the doctor named above.

I understand that results are not guaranteed and are informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time, based upon the fact then known, are in my best interest. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this office and/or employed staff.

Patient initial______

Missed appointment policy

As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Cancellations must be received 24 hours in advance of appointment time. Patients who do not contact us prior to their appointment will receive a no-show charge of $35. Patients with frequently missed appointments will only be seen on a walk-in basis.

Patient initial______

Financial obligation

You agree to reimburse us the collection fees of any collection agency, which shall be based on a percentage at a maximum rat of 33 1/3 % of the amount due at the time you account is placed with a collection agency, and all cost and expenses incurred for any collection efforts on your account, including reasonable attorney's feed incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing.

Patient initial______

Privacy Practices

I acknowledge that I have been given the opportunity to read a copy of Putty Chiropractic Privacy Practices and also receive a copy if I so choose. I understand that if I have questions or complaints that I should contact the Privacy Official.

Patient initial_____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____

Print Patient Name

____ ________________________

Patient Signature (or responsible party) **Date**

____ ________________________

Witness **Date**

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | 0 1 2 3 4 5 6 7 8 9 10 | *Unbearable pain*

Name ______________________________ **Date** ______________

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – 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 severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would 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 increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase 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.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only 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 ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on 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 ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – 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 nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect 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.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but 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.

TOTAL ______________

NECK PAIN 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: ____________________ **DATE:** __________ **SCORE:** __________

PUTTY CHIROPRACTIC CENTER

260 BURLEY AVE
HOPKINSVILLE KY42240
270-886-0068

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:___________________________ **Last Name:**___________________________

Email address: __________________@__________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ___________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (*These summaries are often blank as a result of the nature and frequency of chiropractic care.*)

Patient Signature: ____ Date:________________

For office use only

Height: _________ Weight:___________ Blood Pressure:______/______

PUTTY CHIROPRACTIC CENTER

260 BURLEY AVE ❊ HOPKINSVILLE ❊ KY ❊ 42240 ❊

PHONE NUMBER: 270-886-0068 FAX NUMBER: 270-890-6068

PATIENT PORTAL- PATIENT PROVIDER E-MAIL
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION VIA ELECTRONIC MEDIA

PATIENT NAME: ________________________________DOB:__________________

EMAIL ADDRESS:____

BY SIGNING THIS FORM, I AUTHORIZE PUTTY CHIROPRACTIC CENTER TO COMMUNICATE VIA PERSONAL, SECURED ACCESS PATIENT PORTAL WITH ME FOR MY MEDICAL CARE AND TREATMENT. PUTTY CHIROPRACTIC WILL PROVIDE NOTICES VIA MY PERSONAL E-MAIL THAT INFORMATION CAN BE FOUND IN MY PATIENT PORTAL. NO PERSONAL HEALTH INFORMATION IS TRANSMITTED VIA OR INTO MY PERSONAL E-MAIL. I UNDERSTAND THAT THE FOLLOWING TYPES OF PROTECTED INFORMATION MAY BE USED OR DISCLOSED AND RETAINED BY DR. PUTTY AS A RESULT OF THE COMMUNICATIONS:

1. MY PERSON HEALTH INFORMATION
2. IMAGING REPORTS
3. LABORATORY TEST RESULTS
4. OTHER TEST RESULTS

PATIENT OR LEGAL REPRESENTATIVES WHO WOULD LIKE TO COMMUNICATE WITH THEIR PROVIDER BY ELECTRONIC MEDIA PATIENT PORTAL SHOULD CONSIDER THE FOLLOWING ISSUES BEFORE SIGNING THIS AUTHORIZATION. YOU CAN ACCESS THE PATIENT PORTAL BY GOING TO OUR WEBSITE AT WWW.PUTTYCHIROPRACTIC.COM

- Not allow anyone else to have access to your username and password
- Not store messages on your employer-provided computer
- Never use the portal for emergency needs or time sensitive issues
- Putty Chiropractic Center will not be liable for any information lost or misdirect due to technical errors or failures.

I acknowledge that I have read and fully understand the above terms and understand that there are confidentiality risks associated with any type of online communication, I understand that I may refuse to sign this authorization.
I have read and understand the information in this authorization form.

Patient Signature /Date____

Patient Authorization for Disclosure to Designated Provider
Authorization to Release Medical Record Information

Putty Chiropractic Center❋260 Burley Ave❋Hopkinsville, KY 42240

Phone Number: 270-886-0068 Fax Number: 270-890-6068

Type of Authorization: Designated Provider

Patient Name____

Patient SS#____

DOB:____

Purpose of Request- I request and authorize the disclosure or release of my protected health information as identified below. To/From (circle one) the following provider:

Name of Practice____

Name of Provider____

Address____

City, State, Zip Code____

Phone Number ____________________________**Fax Number**___________________

Description of information to be disclosed- I authorize the disclosure of the following protected health information about me to the person(s) identified above:

____Complete medical record (to include any or all information regarding HIV(aids) and testing, sexual abuse, spouse or child abuse, mental illness and substance abuse including controlled substance or alcohol abuse or

___Only the following: ____

____

Purpose of disclosure- This protected health information is being used or disclosed to carry out treatment, payment and/or healthcare operations.

Expiration or termination of authorization- This authorization will expire within ___ days from the date of my signature below.

Patient Signature: ____________________________________ **Date**____/____/_____

Signature of authorized person: _______________________**Relationship to Patient:** __________________