

Dr. R. A. Foxworth
Practice of Chiropractic

PATIENT INFORMATION

Date _____
 Patient _____

 Street _____

 City _____ State _____ Zip _____
 Sex: M F Age _____ Birthdate _____
 Single Married Separated Divorced Widowed
 Patient SS# _____
 Occupation _____
 Employer _____
 Employer Address _____
 Employer Phone _____
 Spouse's Name _____
 Birthdate _____ SS# _____
 Occupation _____
 Spouse's Employer _____
 Whom may we thank for referring you?

INSURANCE

Who is responsible for this account? _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____
 Is patient covered by additional insurance? Yes No
 Subscriber's Name _____
 Birthdate _____ SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent(s)) have insurance coverage with _____ and assign directly to Dr. R. A. Foxworth 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 hereby authorize the doctor to release all information necessary, to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

 Responsible Party Signature

 Relationship

 Date

PHONE NUMBERS

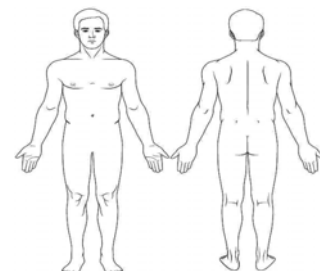
Home _____ Work _____ Ext _____
 Email Address _____
 *will not be shared with any other entity under penalty of Federal Law
IN CASE OF EMERGENCY, CONTACT
 Name _____
 Relationship _____
 Home phone _____ Work phone _____
 Name of Nearest Relative _____
 Phone or Nearest Relative _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____
 Type of accident Auto Work Home Other
 To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other
 Supervisor/Adjuster _____
 Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for visit? _____
 When did your symptoms appear? _____
 If long-standing, when did THIS episode begin: _____
 Is this condition getting progressively worse? Yes No Unknown
 Mark an X on the picture where you continue to have pain, numbness, or tingling.
 Rate the severity of your pain on a scale from 0 (least pain) to 10 (severe pain) _____
 Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other
 How often do you have this pain? _____
 Is it constant or does it come and go? _____
 Does it interfere with your Work Sleep Daily Routine Recreation
 Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

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

Have you been told you may need surgery? Yes No

By Whom?: _____

What made you finally decide to seek treatment for this condition? (just won't go away, pain, interference with work, family duties, recreation etc.): _____

What made you decide to see a Doctor of Chiropractic? (Referred by your physician, want to avoid side-effects of medicine, want to avoid surgery, want to treat naturally if possible, etc.): _____

Family Doctor: _____

A report will be sent to your treating or referring physician(s) to keep them informed of your treatment and progress with your authorization.

Please initial: _____ Please provide a report to my physicians _____ Please do NOT provide a report to my physicians

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Please circle any conditions below if you now have, or have had them in the past

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

EXERCISE	WORK ACTIVITY	HABITS/OTHER	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/Day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/Week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffine	Cups/Day _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level	Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls _____	_____	_____
Head Injuries _____	_____	_____
Broken Bones/Dislocations _____	_____	_____
Surgeries _____	_____	_____
Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____

Date: ____/____/____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely 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.

SECTION 2 - PERSONAL CARE

- 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 some pain.
- Washing and dressing increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - LIFTING

- I can lift heavy objects without any extra pain.
- I can lift heavy objects, but it gives extra pain.
- Pain prevents me from lifting heavy objects off the floor.
- Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned on a table.
- Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- I can only lift very light objects at the most.

SECTION 4 - WALKING

- I have no pain with walking.
- I have some pain but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.

- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 - SITTING

- I can sit in any chair as long as I like.
- 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 half an hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain.

SECTION 6 - STANDING

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain.

SECTION 7 - SLEEPING

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Pain reduces my normal sleep by 1/4 each night.
- Pain reduces my normal sleep by 1/2 each night.
- Pain reduces my normal sleep by 3/4 each night.
- Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.

0-20% Minimal Disability 20-40% Moderate Disability 40-60% Severe Disability

TOTAL

SCORE _____ %

60-80% Crippled

80-100% Bed Bound or Exaggerating

(OFFICE USE ONLY)

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

- | | |
|--|--|
| <input type="checkbox"/> My social life is unaffected by pain apart from limiting more energetic interests.
<input type="checkbox"/> Pain has restricted my social life and I do not go out very often.
<input type="checkbox"/> Pain has restricted my social life to my home.
<input type="checkbox"/> I have hardly any social life because of the pain. | <input type="checkbox"/> I get extra pain while traveling which compels me to seek alternate forms of travel.
<input type="checkbox"/> Pain restricts all forms of travel.
<input type="checkbox"/> Pain prevents all forms of travel except that done lying down. |
|--|--|

SECTION 9 - DRIVING / RIDING IN A CAR, ETC.

- I get no pain while 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 alternate forms of travel.

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 at presents.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Please rate the severity of your low back pain by indicating on the following scale.

No Pain 0—1—2—3—4—5—6—7—8—9—10 Severe Pain

Please rate the percent improved since beginning treatment for this condition/episode.

(0% - 100%) _____%

Patient Signature: _____ Date: _____

0-20%	Minimal Disability	20-40%	Moderate Disability	40-60%	Severe Disability	TOTAL
SCORE _____%						
	60-80%	Crippled		80-100%	Bed Bound or Exaggerating	

(OFFICE USE ONLY)

NECK PAIN AND DISABILITY INDEX

Patient Name: _____

Date: ____/____/____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely 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 worse than imaginable at the moment.

SECTION 2 - PERSONAL CARE (washing, dressing, etc.)

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

SECTION 3 - LIFTING

- I can lift heavy objects without any extra pain.
- I can lift heavy objects, but it gives extra pain.
- Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned on a table.
- Pain prevents me from lifting heavy objects, but I can manage light to medium objects.
- I can lift very light objects.
- I cannot lift or carry anything at all.

SECTION 4 - READING

- I can read as much as I want with no pain in my neck.
- I can read as much as I want to with light pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I can't read as much as I want to because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.

- I cannot read at all.

SECTION 5 - HEADACHES

- I have no headache 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 headaches almost all the time.

SECTION 6 - CONCENTRATION

- I can concentrate fully with no difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty in concentrating.
- I have a lot of difficulty in concentrating.
- I have a great deal of difficulty in concentrating.
- I cannot concentrate at all.

SECTION 7 - WORK

- I can do as much work as I want.
- I can do only my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly work at all.
- I cannot do any work at all.

SECTION 8 - DRIVING

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

0-20% Minimal Disability

20-40% Moderate Disability

40-60% Severe Disability

TOTAL

SCORE _____ %

60-80% Crippled

80-100% Bed Bound or Exaggerating

(OFFICE USE ONLY)

NECK PAIN AND DISABILITY INDEX

I can't drive at all.

SECTION 9 - SLEEPING

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

SECTION 10 - 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 am able to engage in a few of my usual recreational activities because of neck pain.
- I can hardly do any recreational activities because of neck pain.
- I can't do any recreational activities at all.

Please rate the severity of your neck pain by indicating on the following scale.

No Pain 0—1—2—3—4—5—6—7—8—9—10 Severe Pain

Please rate the percent improved since beginning treatment for this condition/episode.

(0% - 100%) _____%

Patient Signature: _____ Date: _____

0-20%	Minimal Disability	20-40%	Moderate Disability	40-60%	Severe Disability		TOTAL
SCORE _____%							
	60-80%	Crippled		80-100%	Bed Bound or Exaggerating		
(OFFICE USE ONLY)							

**Foxworth Chiropractic
NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Our practice is dedicated, and applicable federal and state laws require us, to maintain the privacy of your health information. These laws require us to provide you with Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is in effect as of April 2003, and will remain in effect until we replace it.

CHANGES TO NOTICE

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our policy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of the Notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information, you may forward your complaint to us using the contact information listed below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any questions or complaints to:

Dr. R.A. Foxworth
1 Layfair Dr., Ste. 210
Flowood, MS 39232
Phone: 601-932-9201
Fax: 601-932-4962
E-mail: CCCms@aol.com

ACKNOWLEDGEMENT OF AVAILABILITY OF FULL PRIVACY PRACTICES

I, _____, (Name of Patient) acknowledge that I have been advised that Foxworth Chiropractic will provide me, upon request, a full Notice of Privacy Practices, which describes the Practice's policies and procedures regarding the use and disclosure of any Protected Health Information created, received, or maintained by the Practice.

Date: _____

Print Name: _____

Signature: _____

Foxworth Chiropractic
NOTICE OF PRIVACY PRACTICES
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ (Name of Patient), consent to Foxworth Chiropractic's (the Practice's) use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but are not limited to quality assessment activities, credentialing, business management, and other general operations activities. *These operational activities include providing an initial report or progress reports regarding my treatment/diagnosis and progress notes to my former, current, or any future physicians that I may be referred to by this practice.* I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, and future physical and mental health or condition; the provision of health care to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Physician or Practice has acted in reliance on this consent.

CONSENT FOR OTHER COMMUNICATIONS AND PRACTICE POLICIES UNRELATED TO TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Our office will from time to time mail a practice newsletter, post-cards, thank-you letters to whomever may have referred you to our practice, and other written and electronic communications to keep you informed about our practice, your condition, the conditions we treat, and general health information. We may also, with your permission, recognize you on our Thank You for Referring Bulletin Board, or other in office Bulletin Boards, if you have referred a patient to us for care, have a birthday or anniversary, or we feel recognition is in order, due to your goodwill toward the practice or others. You have the right to "opt-out" of these communications and recognitions by checking the appropriate line below.

I would like to "opt-out" of the items noted below.

___ Practice newsletter, post-cards, thank you letters, thank you for referring letters, and other written and electronic communications to keep you informed about our practice, your condition, the conditions we treat, and general health information.

___ Please do not recognize me in the practice newsletter or in office bulletin if I have referred a patient to you for care, or have a birthday or anniversary, or you feel recognition is in order due to my goodwill toward the practice or others.

Date: _____
Signature of Patient or Representative _____
Printed Name of Patient or Representative _____
Description of Representative's Authority _____

REVOCAION OF CONSENT

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that the Physician or Practice has acted in reliance on this consent. By my signature below, I hereby REVOKE this consent, effective (date)

_____.
Print Name: _____ Signature: _____
Witnessed by:
Print Name: _____ Signature: _____

Signature of Personal Representative: _____ Date: _____
Printed Name of Patient or Representative: _____
Description of Personal Representative's Authority: _____