

## Oswestry Disability Index

This questionnaire is designed to help us better understand how your back pain affects your ability to manage everyday life activities. Please check the box of the one statement in each section that best applies to you. Although you may consider that two of the statements in any section relate to you, please mark the box that most closely describes your present-day situation. Thank you

# BACK

### Section 1-Pain Intensity

- ☐ 0 My pain is mild to moderate, I do not need pain killers
- ☐ 1 The pain is bad, but I manage without taking pain killers
- ☐ 2 Pain killers give complete relief from pain.
- ☐ 3 Pain killers give moderate relief from pain.
- ☐ 4 Pain killers give very little relief from pain.
- ☐ 5 Pain killers have no effect on the pain.

### Section 2- Personal Care (washing, dressing, etc.)

- ☐ 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; I am slow and careful.
- ☐ 3 I need some help but 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 was with difficulty and stay in bed

### Section 3- Lifting

- ☐ 0 I can lift heavy weights without extra pain.
- ☐ 1 I can lift heavy weights, but it gives me extra pain.
- ☐ 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned for example on a table.
- ☐ 3 Pain prevents me from lifting heavy weights. But I can manage light to medium weights if they are conveniently positioned.
- ☐ 4 I can lift only very light weights.
- ☐ 5 I cannot lift or carry anything at all.

### Section 4- Reading

- ☐ 0 I can read as much as I want to with no pain in my back.
- ☐ 1 I can read as much as I want to with slight pain in my back.
- ☐ 2 I can read as much as I want with moderate back pain.
- ☐ 3 I can't read as much as I want because of moderate back pain.
- ☐ 4 I can hardly read at all because of severe pain in my back.
- ☐ 5 I cannot read at all.

### Section 5- Sitting

- ☐ 0 I can sit as long as I want with no pain.
- ☐ 1 I have slight discomfort when sitting for a long time.
- ☐ 2 I have moderate discomfort when sitting for a long time.
- ☐ 3 I have severe discomfort when sitting for a long time.
- ☐ 4 I can only sit for a short time without severe discomfort.
- ☐ 5 I can't sit for more than a few minutes.

### Section 6- Concentration

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

### Section 7- Work

- ☐ 0 I can do as much work as I want to.
- ☐ 1 I can only do my usual work, but no more.
- ☐ 2 I can do most of usual work, but no more.
- ☐ 3 I cannot do my usual work.
- ☐ 4 I can hardly do any work at all.
- ☐ 5 I can't do any work at all.

### Section 8- Driving

- ☐ 0 I can drive my car without any back pain.
- ☐ 1 I can drive my car as long as I want with slight pain in my back.
- ☐ 2 I can drive my car as long as I want with moderate pain in my back.
- ☐ 3 I can't drive my car as long as I want because of moderate pain in my back.
- ☐ 4 I can hardly drive at all because of severe pain in my back.
- ☐ 5 I can't drive my car at all.

### Section 9- Sleeping

- ☐ 0 I have no trouble sleeping.
- ☐ 1 My sleep is slightly disturbed (less than 1 hr. sleepless.)
- ☐ 2 My sleep is moderately disturbed (1-2 hr. sleepless.)
- ☐ 3 My sleep is moderately disturbed (2-3 hr. sleepless.)
- ☐ 4 My sleep is greatly disturbed (3-4 hr. sleepless.)
- ☐ 5 My sleep is completely disturbed (5-7 hr. sleepless.)

### Section 10- Changing Degree of Pain

- ☐ 0 My pain is rapidly getting better.
- ☐ 1 My pain fluctuates, but overall is definitely getting better.
- ☐ 2 My pain is getting better but slowly.
- ☐ 3 My pain has stayed about the same.
- ☐ 4 My pain is gradually getting worse.
- ☐ 5 My pain is rapidly getting worse.

Office use ONLY: Score \_\_\_\_ (.50) = \_\_\_\_

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# NECK

### Section 1-Pain Intensity

- ☐ 0 My pain is mild to moderate, I do not need pain killers
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- ☐ 3 Pain killers give moderate relief from pain.
- ☐ 4 Pain killers give very little relief from pain.
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- ☐ 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; I am slow and careful.
- ☐ 3 I need some help but 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 was with difficulty and stay in bed

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- ☐ 0 I can lift heavy weights without extra pain.
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- ☐ 3 Pain prevents me from lifting heavy weights. But I can manage light to medium weights if they are conveniently positioned.
- ☐ 4 I can lift only very light weights.
- ☐ 5 I cannot lift or carry anything at all.

### Section 4- Reading

- ☐ 0 I can read as much as I want to with no pain in my neck.
- ☐ 1 I can read as much as I want to with slight pain in my neck.
- ☐ 2 I can read as much as I want with moderate neck pain.
- ☐ 3 I can't read as much as I want because of moderate neck pain.
- ☐ 4 I can hardly read at all because of severe pain in my neck.
- ☐ 5 I cannot read at all.

### Section 5- Headaches

- ☐ 0 I have no headaches at all..
- ☐ 1 I have slight headaches that come infrequently.
- ☐ 2 I have moderate headaches that come infrequently.
- ☐ 3 I have moderate headaches that come frequently.
- ☐ 4 I have severe headaches that come frequently.
- ☐ 5 I have headaches almost all the time.

### Section 6- Concentration

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

### Section 7- Work

- ☐ 0 I can do as much work as I want to.
- ☐ 1 I can only do my usual work, but no more.
- ☐ 2 I can do most of usual work, but no more.
- ☐ 3 I cannot do my usual work.
- ☐ 4 I can hardly do any work at all.
- ☐ 5 I can't do any work at all.

### Section 8- Driving

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

### Section 9- 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).

### Section 10- Changing Degree of Pain

- ☐ 0 My pain is rapidly getting better.
- ☐ 1 My pain fluctuates, but overall is definitely getting better.
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- ☐ 3 My pain has stayed about the same.
- ☐ 4 My pain is gradually getting worse.
- ☐ 5 My pain is rapidly getting worse

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# Electronic Health Records Intake Form

*In compliance with Medicare 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 \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_



# Doctor Patient Agreement

*Mills Chiropractic*

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The purpose of this agreement is not only to make you aware of our office standards but more importantly it is to allow us to better serve you and get you the best results in the shortest amount of time. We have found that patients who adhere to this agreement have had better results.

## What We Want To Do For You

We want to be your partner in health and make sure that you are getting the right type of care. If we don't feel that we can help you we will direct you to someone who can help. We want to give you state of the art care through the ProAdjuster and other services, and we want to do so in a timely manner.

## About Your Visit

- Every visit you will check into the front computer when you first arrive. This lets us know that you are here and it also lets Dr. Mills know how you are doing that day. If you have questions or need assistance please let us know; we will be glad to help you.
- If you are adjusted on the ProAdjuster please remove necklaces, belts, and hooded sweatshirts. If you are adjusted manually please remove dangling jewelry, belts, hooded sweatshirts and items from your pocket.
- When you have completed your visit, please see the CA (Chiropractic Assistant) at the checkout desk to schedule your next appointment and pay your co-pay.

## Payment

Payment is required for every visit; you may pay the day of care or in advance for multiple appointments. We know that healthcare is expensive. That is why our Office Manager will walk you through several different payment plans for your specific treatment plan. They will also go over insurance benefits, co-pays, and deductibles. We accept credit cards (Visa, MasterCard, American Express, and Discover), CareCredit, cash, and checks\*.

I will keep my balance under \$200.00. If I default on any balance I am responsible for the 33.3% attorney's fee and 0.5% annual interest.

\*There is a \$25 processing fee for any returned checks.

## A Few Notes on Insurance

- If you receive a check from your insurance company you need to bring it and the statement to the office within three business days of receiving it. This will be the only way that we can apply the credit to your account.
- If the insurance company is not responding in a timely manner (60 days) to your claims you may be required to call and/or write them to help with the collection process.
- If the insurance company deems services are not medically necessary or not covered under your plan you will be responsible for the unpaid balance. We will work our hardest to inform you of any problems we foresee and work with you on a payment plan if any of these issues arise.
- Your insurance will only cover acute care. Acute care is defined as regular visits to resolve a specific problem that should be resolved in 8 – 12 weeks. Any visits after acute care are considered wellness, maintenance, or supportive care. Those are not covered by your insurance and are solely your responsibility.

## Special Consultation Workshop

We want you to understand how chiropractic care is an essential part of a healthy lifestyle. That is why we require all new patients to come to the class within two weeks of their initial visit. Dr. Mills will be

discussing how chiropractic care works and things that you can do at home to achieve a healthier lifestyle. The class is included in your initial visit and is held at our office every week at 6:10 pm on alternating Mondays and Tuesdays. If these times do not work for you let us know and we will try to work something out. We strongly recommend that you bring your partner in health with you.

### **Appointments**

Dr. Mills has specified a specific treatment plan for you to help get you to your optimum health as quickly as possible, which is why it is so important to keep your appointments. If you cannot make an appointment we understand, however, please call us immediately and reschedule for as soon as possible within the next week. Please call at least two hours ahead of your appointment time if you need to reschedule or cancel your appointment or it will result in a missed appointment. Upon your 4<sup>th</sup> missed appointment\* you will be charged \$20 service charge for that appointment and every missed appointment thereafter.

\*A missed appointment occurs only when you do not call within 2 hours of your appointment to reschedule or cancel.

### **Cell Phones**

Out of respect for all patients in the office we ask that you silence your cell phones upon entering the office. Please do not take or make phone calls while in the office, this is a HIPPA violation and impedes upon the privacy of others in our office. We will not begin or continue your treatment if you are on a phone call. If it is an emergency please step outside on the porch.

### **Emergency Numbers**

In case of a medical emergency please call 911. If it is a Chiropractic emergency such as a severe flare up, fall, or minor injury during non-business hours please call our office's emergency line at 502-863-3520.

### **Results**

Your results are positively influenced by adhering to our recommendations. If you are unhappy with your results, we respectfully request that you share your feelings so that we may resolve any of your concerns. If you have any questions about our office standards please ask and we will be happy to explain.

**I have read and understand all of the office standards and I agree to adhere to them:**

Patient name (please print) \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient cell phone number \_\_\_\_\_

Patient email address \_\_\_\_\_

### ***Official Use Only***

Chiropractic Assistant Signature \_\_\_\_\_