NEW CONDITION DATE _____

SPRINGFIELD CHIROPRACTIC CLINIC - Rodney J. Wachter, D.C. CHART#_____

Patient Name _____ **Email Address**_____

Marital Status: Single Married Widowed Divorced DOB: _____ Sex _____ Home Phone _____

Address: _____ City _____ State _____ Zip_____

Employer: _____ **Work Phone** _____ **Cell Phone**_____

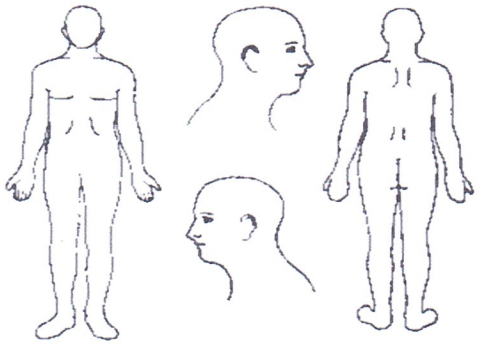
Family Medical Doctor _____ Date of last MD visit _____

Have you seen other chiropractors? NO YES If yes, whom/where did you see? _____

Insurance Carrier_____ Policy Holder Name _____

Policy Holder Date of Birth _____

PRIMARY COMPLAINT Select ONLY One



1. Where is your primary complaint located? **Circle ONE below**

Neck Lt/Rt Upper Back Lt/Rt Mid Back Lt/Rt

Lower Back Lt/Rt Leg Lt/Rt Shoulder Lt/Rt

Arm Lt/Rt Other _____

2. *How and when did this start?* _____

3. My pain is: Constant Comes and Goes

Using a scale from 0 - 10 (10 being the worst), describe your pain intensity

Draw a ❍around your current pain level

Draw a △ arund your pain level at its worst.

0 (1 2 3) (4 5 6) (7 8 9) 10

Mild Moderate Severe

Please mark all areas of pain on the figure above

Describe your pain:

Dull Aching Sharp Stabbing Burning Numb Tingling Pins/Needles

Does your pain radiate? Yes No If yes, to where? _____

4. Is your pain worse in the: Morning Afternoon Night Bedtime No Changes

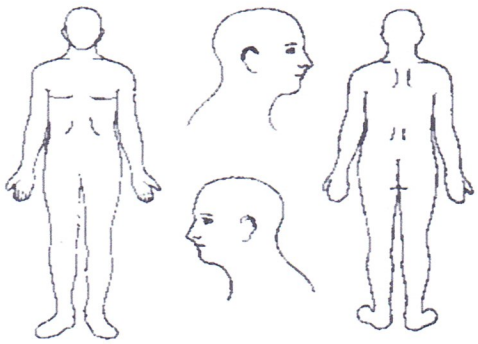
5. What makes your pain worse? Resting Sitting Standing Walking Exercising Bending/Lifting Other _____

6. What makes your pain better? Resting Sitting Standing Walking Medication Other _____

7a. Have you seen another doctor for this condition? YES NO

7b. Have you had any x-rays or other tests for this condition? YES NO

Secondary Complaint



1. Where is your secondary complaint located?

Neck Lt/Rt Upper Back Lt/Rt Mid Back Lt/Rt

Lower Back Lt/Rt Leg Lt/Rt Shoulder Lt/Rt

Arm Lt/Rt Other _____

2. *How and when did this start?* _____

3. My pain is: Constant Comes and Goes

Using the scale below describe your pain intensity.

1. Draw a ❍around your current pain level

2. Please draw a △around your pain at its worst.

0 (1 2 3) (4 5 6) (7 8 9) 10

Mild Moderate Severe

Please mark all areas of pain on the figure above

Describe your pain:

Dull Aching Sharp Stabbing Burning Numb Tingling Pins/Needles

Does your pain radiate? YES NO If yes, to where? _____

4. Is your pain worse in the: Morning Afternoon Night Bedtime No Changes

PATIENT NAME _____ DATE_____ CHART#_____

5. What makes your pain worse? Resting Sitting Standing Walking Exercising Bending/Lifting Other _____

6. What makes your pain better? Resting Sitting Standing Walking Medication Other _____

YES NO

8. For Women: Are you pregnant YES NO DLMP _____

9. Since your last visit to this office:

a. Have you had any surgeries? If yes, explain _____

b. Are you taking any medications? YES NO

c. Has their been a change of medication since your last visit? YES NO

d. Any major falls or accident? YES NO

Explain _____

e. Any automobile accidents? YES NO

10. At present are you being treated for any other medical conditons? Explain:_____

11. Do you smoke/drink? YES NO How much? _____ Smoking: How long?_____

FAMILY HISTORY

☐ Father living good health ☐ Mother living good health ☐ Siblings living good health

Circle all that apply. Leged: M=Mother F=Father S=Sibling O=Other

M F S O	Heart Disease	M F S O	Lung Disease
M F S O	Cancer	M F S O	Diabetes
M F S O	Hypertension	M F S O	Low Back Problems
M F S O	Stroke	M F S O	Rheumatoid Arthritis
M F S O	Chronic Headaches	M F S O	Neck Problems
M F S O	Scoliosis	M F S O	Auto Immune (Lupus)

Deceased Father/Age _____ Cause of death _____

Deceased Mother/Age_____ Cause of death _____

Deceased Sibling/Age_____ Cause of death _____

Are you covered by a Group Health Plan through your current employer? _____Yes _____No

Are you covered by a Group Health Plan through your spouse or other family member's current or former employer? _____Yes _____No

Are you receiving Workmen's Compensation Benefits? _____Yes _____No

Are you filing a claim with no fault or liability insurance? _____Yes _____No

Are you being treated for an injury or illness for which another party has been found responsible? _____Yes _____No

I the undersigned, hereby authorize the Springfield Chiropractic Clinic, Rodney J. Wachter, (and whomever may be designated as assistants) to administer such examinations and treatments as they deem necessary. I the undersigned give Springifeld Chiropractic Clinic permission to contact me at the following phone numbers. This will also serve as an update to my HIPAA information. The complete HIPAA form is available upon request.

Home _____ ( ) Leave Message ( ) Do not leave message

Work _____ ( ) Leave Message ( ) Do not leave message

Cell Phone _____ ( ) Leave Message ( ) Do not leave message

Our policy requires payment in full for all services at the time of visit unless insurance is filed on your behalf (co-payments deductibles will then be collected at time of service). If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for all legal fees and any other expenses incurred in collecting your account. All accounts over 90 days may be subject to an interest fee of 1.5% per month - 18% annually.

PATIENT SIGNATURE _____ DATE _____

PATIENT NAME PRINTED _____

WITTNESS: _____

Reviewed By:_____

SPRINGFIELD CHIROPRACTIC CLINIC
2208 Memorial Blvd., Springfield, TN 37172

NECK INDEX

RODNEY J. WACHTER, D.C.

PATIENT NAME: _____ DATE: _____ CHART# _____

This questionnaire will give the doctor information about how your neck condition affects your everyday life. Please answer every section by circling ONE statement that best applies to you.

Mark your answer according to this scale:

1. It's there and I can do it no matter what
2. I know it's there – it bugs me, and I can still do it
3. I'm hurting – I can do it, but I would rather not
4. Hurts pretty bad, but I can still try to do it
5. I don't want to do it – it hurts too bad

PAIN INTENSITY

0 The pain/discomfort comes and goes and is very mild
1 The pain/discomfort is mild and does not vary much
2 The pain/discomfort comes and goes and is moderate
3 The pain/discomfort is moderate and does not vary much
4 The pain comes and goes and is severe
5 The pain is very severe and does not vary much

PERSONAL CARE

0 I can look after myself normally without causing extra pain
1 I can look after myself but it causes extra pain/discomfort
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 Because of the pain I am unable to do any washing & dressing without help and I stay in bed

LIFTING, i.e. GROCERIES,CHILDREN,ETC

0 I can lift heavy weights without causing extra pain/discomfort
1 I can lift heavy weights but it causes extra pain/discomfort
2 Pain prevents me from lifting heavy weights off the floor
3 Pain prevents me from lifting heavy weights off floor, but I Can manage if they are conveniently positioned on table
4 I can only lift very light weights at most
5 I cannot lift or carry anything at all

WORK – INCLUDE HOUSEWORK AND YARDWORK

0 I can do as much work as I want
1 I can do my usual work, but no more
2 I can do most of my usual work but with difficulty
3 I can't do my usual work
4 I can't hardly do any work at all
5 I can't do any work at all

HEADACHES

0 I have not 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

CONCENTRATION

0 I can concentrate fully without difficulty
1 I can concentrate fully with slight difficulty
2 I have a fair degree of difficulty concentrating
3 I have a lot of difficulty concentrating
4 I have a great deal of difficulty concentrating
5 I can't concentrate at all

SLEEPING

0 I have no trouble sleeping
1 My sleep is slightly disturbed for less than 1 hour
2 My sleep is mildly disturbed for up to 1-2 hours
3 My sleep is moderately disturbed for up to 2-3 hours
4 My sleep is greatly disturbed for up to 3-5 hours
5 My sleep is completely disturbed for up to 5-7 hours

DRIVING OR RIDING AS A PASSENGER

0 I can drive my car without neck pain or discomfort
1 I can drive as long as I want with slight pain/discomfort
2 I can drive as long as I want with moderate pain/discomfort
3 I can't drive as long as I want because of moderate neck pain
4 I can hardly drive at all because of sever neck pain
5 I can't drive my car at all because of neck pain

READING/COMPUTER WORK

0 I can read as much as I want with little/no pain/discomfort
1 I can read as much as I want with slight neck pain
2 I can read as much as I want with moderate pain
3 I can't read as much as I want because of moderate pain
4 I can't read as much as I want because of severe pain
5 I can't read/computer work at all

RECREATION/HOBBIES

0 I have no neck pain during all recreational activities
1 I have some neck pain with all recreational activities
2 I have some neck pain with a few recreational activities
3 I have neck pain with most recreational activities
4 I can hardly do any recreational activities due to neck pain
5 I can't do any recreational activities due to neck pain.

INDEX SCORE _____

SPRINGFIELD CHIROPRACTIC CLINIC
2208 Memorial Blvd., Springfield, TN 37172

BACK INDEX

RODNEY J. WACHTER, D.C.

PATIENT NAME: _____ DATE: _____ CHART# _____

This questionnaire will give the doctor information about how your back condition affects your everyday life. Please answer every section by circling ONE statement that best applies to you.

Mark your answer according to this scale: 1. It's there and I can do it no matter what
2. I know It's there – it bugs me, and I can still do it
3. I'm hurting – I can do it, but I would rather not
4. Hurts pretty bad, but I can still try to do it
5. I don't want to do it – it hurts too bad

PAIN INTENSITY

0 The pain/discomfort comes and goes and is very mild
1 The pain/discomfort is mild and does not vary much

2 The pain/discomfort comes and goes and is moderate
3 The pain/discomfort is moderate and does not vary much
4 The pain comes and goes and is severe

5 The pain is sever and does not vary much

PERSONAL CARE

0 I can look after myself without causing extra pain/discomfort
1 I can look after myself but it gives me extra pain/discomfort

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 Because of the pain, I am unable to do any washing and Dressing without help, and I stay in bed

LIFTING

0 I can lift heavy weights without extra pain/discomfort
1 I can lift heavy weights but it causes extra pain/discomfort
2 Pain prevents me from lifting heavy weights off floor
3 Pain prevents me from lifting heavy weights of floor , but I can manage if they are conveniently positioned on table
4 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if conveniently positioned
5 I can only lift light weights at the most

WALKING

0 I have no pain/discomfort on walking
1 I have some pain 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

SITTING

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

INDEX SCORE _____

STANDING

0 I can stand as long as I want without pain/discomfort
1 I have some pain while standing but it does not increase with time
2 I can't stand for more than 1 hour without increasing pain
3 I can't stand for longer than ½ hour without increasing pain
4 I can't stand for longer than 10 minutes without increasing Pain
5 I avoid standing because it increases pain immediately

SLEEPING

0 I get no pain/discomfort in bed
1 I get pain/discomfort in bed, but it doesn't prevent me from sleeping well
2 Because of pain, my normal night's sleep is reduced ¼ and can wake me up.
3 Because of pain, my normal night's sleep is reduced by ½
4 Because of pain, my normal night's sleep is reduced by ¾
5 Pain prevents me from sleeping at all

SOCIAL LIFE/HOBBIES/RECREATION

0 My social life is normal and gives me no pain/discomfort
1 My social life is normal but 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
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

TRAVEL/DRIVING

0 I get no pain/discomfort while traveling/driving
1 I get some pain while traveling/driving, but none of my usual forms of travel/driving make it any worse
2 I get pain/discomfort while traveling/driving but it does not compel me to seek alternative forms of travel
3 I get extra pain while traveling, which compels me to seek alternative forms of travel
4 Pain restricts all forms of travel
5 Pain prevents all forms of travel except that done lying down

CHANGING DEGREE OF PAIN

0 My pain/discomfort is rapidly getting better
1 My pain/discomfort fluctuates, but overall is getting better
2 May pain seems to be getter better, but is slow
3 My pain is neither getting better nor worse
4 My pain is gradually worsening
5 My pain is rapidly worsening

Springfield Chiropractic Clinic
2208 Memorial Blvd., Springfield, TN 37172

Rodney J. Wachter, D.C.
Phone: 615-384-4000

Consent to Chiropractic Examination and Treatment

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. The primary treatment provided by Doctors of Chiropractic is spinal manipulative therapy, also referred to as an adjustment. A Doctor of Chiropractic uses his/her hands and/or a mechanical instrument on the patient's body in such a way as to move the patient's joints. This may cause an audible "pop" or "click" such as when a person "cracks" his knuckles. The patient may feel a sense of movement as well.

Other procedures commonly used by Doctors of Chiropractic include the following:

Physical Examination	Postural Analysis	Vital Signs	Traction/Decompression	Palpation
Bracing and Support Applications	Ultrasound Therapy	Hot/Cold Therapy	Electrical Muscle Stimulation	
Diagnostic Studies	Manual Therapy	Laser Therapy	Rehabilitation	

The material risks associated with chiropractic treatment

Initials _____Chiropractic treatment utilizes very safe, non-invasive procedures performed in chiropractic offices to reduce pain, restore range of motion, and promote overall body wellness, among other various benefits. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Possible complications include but are not limited to the following: muscle strain, dizziness, nausea, flushing, fractures, disc injuries, dislocations, cervical myelopathy, burns, costovertebral strains and separations. It is not uncommon for patients to experience temporary soreness after the first few treatments. In rare cases, manipulation of the neck has been associated with injuries to the arteries of the neck, leading to or contributing to serious complications, including stroke. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Initials _____Fractures are rare occurrences and generally result from underlying weakness of the bone for which the Doctor of Chiropractic checks during the taking of the patient's history, and during examination and x-ray. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options may include the following

Initials _____ Self administered, over-the-counter analgesics and rest
Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers
Hospitalization/Surgery

There are risks and benefits associated with all the above treatment options, which the patient may wish to discuss with his/her medical doctor.

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Failure to seek care could result in serious medical conditions going unrecognized. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that **Rodney J. Wachter, D.C.** will advise me of any material risks in this regard.
2. Neither the practice of chiropractic nor the practice of medicine is an exact science, and my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. It is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, and an undesirable result does not necessarily indicate an error in judgment or treatment.
4. Dr. Wachter does not guarantee any results with respect to any course of care or treatment.

DO NOT SIGN UNTIL YOU HAVE READ ABOVE AND UNDERSTAND THE ABOVE. ONCE READ AND UNDERSTOOD, PLEASE CHECK THE APPROPRIATE BLOCK IN THE PARAGRAPH AND BELOW AND SIGN.

PATIENT:

I ( ) have read, or ( ) have had read to me, the above explanation of chiropractic adjustment and related treatment. I hereby authorize **Dr. Rodney J. Wachter** and his assistants, associates and other appropriate persons to render care, to perform an examination and to provide an appropriate evaluation and treatment plan to address the complaints, problems, and medical history I have provided. I have discussed any questions, comments, or concerns with Dr. Wachter and have had my inquiries answered to my satisfaction. By signing below, I state that I have weighed the risks and/or benefits in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ Patient Name

_____ Patient Signature (Parent or Guardian if a minor)

_____ Date

_____ Witness

Patient Name _____ Chart#_____ Date_____

ATTENTION PATIENT!

DO NOT SIGN THIS FORM UNTIL YOU HAVE SPOKEN WITH THE DOCTOR.

PATIENT STATUS AT TIME OF INFORMED CONSENT PROCESS

Based on my personal observations, medical history, and direct conversation with the patient, I conclude that throughout the consent process the patient was:

- ☐ Of legal age
- ☐ Oriented x3
- ☐ Disoriented as to _____
- ☐ Coherent and lucid
- ☐ On prescription/OTC medications but unimpaired
- ☐ Proficient in understanding English language
- ☐ Assisted in understanding by an interpreter
  Interpreter's Name: _____
- ☐ Resolute in denying the use of alcohol and/or recreational drugs prior to consent
- ☐ Unable to give legal consent _____
  Patient Representative
- ☐ Consent given through legal guardian _____
  Relationship to Patient

Patient's questions (if any) and information supplied are as follows:

_____

_____

_____

Comments: _____

I certify that the above accurately describes the above named patient's status during the informed consent, and that he/she understands the explanation of chiropractic adjustment and related treatment.

I _____ have been given an opportunity to ask questions regarding my care.

_____ _____

Patient Signature Date

_____ _____

Rodney J. Wachter, D.C. Date

Springfield Chiropractic Clinic
Rodney J. Wachter, D.C.

Patient Name: _____ Date of Birth: _____ Chart#_____

Are you currently taking any prescribed medications? _____Yes _____No

Prescribed Medications

Medication	# of Refills	Quantity of Pills	Strength	Dose Form	What is this for?

Are you allergic to any medications? _____Yes _____No
Please list each drug to which you have an allergic reaction to on a separate line.

Name of Drug	Allergic Reaction

_____ _____

Patient Signature Date

Springfield Chiropractic Clinic
Rodney J. Wachter, D.C.

U.S. Government Certification Data

Dear Patient:

The U.S. Government is now requiring that we supply them with the following information. We appreciate your help as we update patient records.

Please print all information

Name_____ Today's Date _____

Date of Birth_____

Ethnicity: (Please circle)

Hispanic or Latino Non-Hispanic or Latino

Race: (Please circle)

White American Indian/Native Asian Black/African American
Native Hawaiian/Pacific Islander Two or More

Preferred Language: (Please circle)

English Spanish French German Italian
Mandarin Cantonese Tagalong Japanese Other _____

If we need to contact you, how would you like the confidential information to be received?

Home phone: _____ Work Phone: _____
Cell phone: _____
E-Mail: _____
Mailing address: _____

Smoking Status: (Please circle)

Smokes every day Smokes some days Former Smoker Never Smoked

Have you been diagnosed with: (Circle all applicable)

Asthma Diabetes Hypertension/Blood Pressure Problems

Are you taking medication for: _____High Blood Pressure _____Diabetes _____Asthma

Have you had any change of medications since your last update/visit to this office? _____Yes _____No

Are you taking the flu shot for the current season? ____Yes ____No ____I am not planning on taking the flu shot.

Springfield
Chiropractic Clinic
The power that made the body, heals the body.

Dr. Rodney J. Wachter
Chiropractic Physician

Ph: 615.384.4000 • Fx: 615.384.4487 **www.spfdchiropractic.com** **2208 Memorial Blvd. • Springfield, TN 37172**

ATTENTION PATIENTS:

A complete copy of the HIPAA Privacy Law is available under the "Privacy Policy Statement" tab.
Or, if you prefer, you may request a copy at your appointment.

Thank you!

Springfield Chiropractic Clinic