West Mesa Wellness

Dr. David B. Greif, D.C.

PATIENT INFORMATION FORM

Name: _____ Today's Date: ____/____/____

Social Security Number ____-____-____ Date of Birth: ____/____/____ Age: ____

Gender: F / M Height: _____ Weight: _____

If you are **UNDER 18** years of age, who are your legal parents or guardian? **(Parent must sign a Consent to Treat A Minor Form)**

Father: _____ DOB: ____/____/____ Phone: (____) ____-____
Mother: _____ DOB: ____/____/____ Phone: (____) ____-____
Guardian/Foster Parent _____ DOB: ____/____/____ Phone: (____) ____-____

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many Children? _____

CURRENT ADDRESS

Street _____
City _____ State _____ Zip _____
Phone (____)____-____ Cell (____) ____-____ Work (____) ____-____

Occupation _____ Employer _____
Student at _____ ☐ Full-Time ☐ Part-Time

Name of Spouse _____ Spouse DOB ____/____/____
Spouse Occupation _____ Spouse Employer _____
Spouse Work Phone (____) ____-____

EMERGENCY CONTACT _____ Phone (____) ____-____
Address of contact person _____

How did you learn about us?

_____

Is your condition or injury due to an accident or work-related cause? ☐ Yes ☐No
Did the condition or injury result from an automobile accident? ☐ Yes ☐ No
Did the condition or injury result from a work related accident or cause? ☐Yes ☐ No
If yes briefly describe: _____

If this condition did not result from an automobile accident or work related accident, where did the injury occur? _____

Approximate date of injury ____/____/____

8625 Golf Course Rd NW, Ste A2, ABQ NM 87114 (505)899-6600 fax (505) 899-3262

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Please indicate any other healthcare providers who you've seen for this injury/condition and dates seen

Name: _____ Type of Practice: _____ Last Visit ___/___/___
Name: _____ Type of Practice: _____ Last Visit ___/___/___
Name: _____ Type of Practice: _____ Last Visit ___/___/___

Date of last physical examination: _____/_____/_____
What operations have you had? _____ When? _____
Serious illnesses or conditions: _____ When? _____

Have you been treated for any health condition by a physician in the last year: ☐ Yes ☐ No
Describe: _____
What medications or drugs are you taking? _____

Have you ever suffered from:

☐ Dizziness	☐ Arthritis	☐ Digestive Disorders
☐ Backaches	☐ Headaches	☐ Nervousness
☐ Heart Trouble	☐ Numbness	☐ Sinus Trouble
☐ Diabetes	☐ Asthma	☐ Anemia
☐ Hernia	☐ Neuritis	☐ Cancer

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ Yes ☐No ☐ Uncertain

Do you have health insurance? ☐ Yes ☐ No Company: _____
Full Name of Policy Holder: _____ DOB: _____/_____/_____
Does the policy holder have insurance through his/her employer? ☐ Yes ☐ No
If yes, who is the employer? _____

****

I have read, understood and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patients Signature: _____ Date: _____/_____/_____

GENERAL HEALTH HISTORY --- WEST MESA WELLNESS

Check only the conditions that apply to you and indicate when you experienced them

GENERAL HISTORY	PAST	PRESENT
☐ I bruise easily	☐	☐
☐ I heal slowly	☐	☐
☐ Smoke cigarettes or use tobacco products	☐	☐
☐ Diabetes, hypoglycemia, thyroid disorder kidney or liver disease or tuberculosis	☐	☐
☐ Heart attack or have a heart pacemaker or neck/chest shunt	☐	☐
☐ Infectious diseases such as AIDS, tuberculosis etc.	☐	☐
☐ Difficulties or intolerance to ice or heat packs on your skin	☐	☐
☐ Dizziness, blacking out, balance, fainting or tripping	☐	☐
☐ Epilepsy , seizures, convulsion history or neurological disorders	☐	☐
☐ Multiple sclerosis, lupus, paralysis, or meningitis	☐	☐
☐ Cancer/ cancer treatment of any kind	☐	☐
☐ History of strokes	☐	☐
☐ Blood clots, anemia, vascular disorders, or aneurysm	☐	☐
☐ High blood pressure	☐	☐
☐ Scoliosis, spondylothesis, spina bifida or fused vertebrae	☐	☐
☐ Bulging or herniated disks	☐	☐
☐ Osteoporosis, osteopenia, ankylosing spondylitis	☐	☐
☐ Osteoarthritis, rheumatoid arthritis or gout	☐	☐
☐ High blood pressure	☐	☐
☐ Chest or breast implants (male or female)	☐	☐
☐ Current or chance of pregnancy (x-rays may be taken)	☐	☐

PRIOR INJURY OR MUSCULOSKELTAL PAIN

☐ Work Injury	☐ Other Injury	☐ Arm Pain/Numbness
☐ Motorcycle Injury	☐ Head Injury	☐ Leg Pain/ Numbness
☐ Sports Injury	☐ Neck Pain	☐ Headaches/Migraines
☐ Pedestrian Injury	☐ Mid Back Pain	☐ Car Accident
☐ Lifting Injury	☐ Low Back Pain	☐ Fall
☐ Military Injury	☐ Shoulder Pain	

FRACTURES/BROKEN BONES

☐ Spinal Vertebrae	Date_____	☐ Skull	Date_____
☐ Collar Bone	Date_____	☐ Rib	Date_____
☐ Arm/Hand	Date_____	☐ Leg/Foot	Date_____
☐ Pelvis/Hip	Date_____		

PREVIOUS SURGERY

☐ Spinal Surgery	Date_____	☐ Gallbladder/Kidney	Date_____
☐ Heart	Date_____	☐ Cancer	Date_____
☐ Head/Brain	Date_____	☐ Pelvis	Date_____
☐ Shoulder/Arm/Hip/Leg	Date_____	☐ Hernia	Date_____
☐ Appendix/Stomach	Date_____	☐ Other	Date_____

DO YOU EXERCISE?

☐ 1-2 times a week	☐ I do cardiovascular workouts	☐ I do not exercise
☐ 3-5 times a week	☐ I play sports regularly	☐ I am willing to exercise
☐ I do yoga.	☐ I do weight training	☐ I am not willing to exercise

Check all symptom areas

- ☐ Headaches/Migraines
- ☐ Neck Pain, Soreness, Stiffness
- ☐ Low back Pain, soreness, Stiffness
- ☐ Arm/Hand pain, Numbness, or Tingling
- ☐ Upper Back Pin, Soreness, stiffness
- ☐ Hip Pain
- ☐ Leg or Foot Pain, Numbness, or Tingling
- ☐ Other

How did your symptoms come on?

- ☐ Suddenly
- ☐ Gradually

Symptom/Pain Description

Please circle the word/words that best describe how your symptoms currently feel to you

Pain	Irritating	Numbness	Throbbing	Gnawing
Ache	Dull	Sickening	Tender	Weakness
Pinching	Shooting	Miserable	Unbearable	Soreness
Pulling	Spreading	Pressing	Radiating	Exhausting
Stiff/Tight	Nagging	Deep Pain	Tearing	Pins and Needles
Heavy	Crushing	Superficial Pain	Needles	Bony

Have you ever been to a chiropractor before for any condition? **Yes** **No**

If yes, chiropractor's name:_____ Year _____

Problem seen for:_____

Do you have any problems laying face down on an examination table? Yes No

If yes, why?_____

Are you taking any medications? **Yes** **No**

- ☐ Muscle Relaxants
- ☐ Blood Pressure/Stroke Prevention meds
- ☐ Osteoporosis (bone strengthening) meds
- ☐ Cortisone injections
- ☐ Pain/Anti-Inflammatory meds
- ☐ Other:_____

When is pain worse/What activities increase your pain levels?

- ☐ In the morning
- ☐ In the afternoon/evening
- ☐ During sleep hours
- ☐ Standing up from sitting position
- ☐ Bending over
- ☐ Lying down flat
- ☐ Sitting down
- ☐ Poor posture
- ☐ Walking
- ☐ Standing
- ☐ Exercise/Stretching
- ☐ Other

Has your pain been associated with any of the following?

- ☐ Excessive Fatigue/Malaise
- ☐ Weight Loss
- ☐ Low Grade Fever
- ☐ Bowel/Bladder Disorders
- ☐ Ovarian Pain
- ☐ Kidney Pain/Painful Urination
- ☐ Night Pain/Night Sweats
- ☐ Abdominal pain
- ☐ Balance Problems

A. Contract for Care: I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my practitioner. I agree to participate in the self care program selected. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my practitioner to provide safe and effective treatment.

B. Consent for Care: it is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

PATIENT'S SIGNATURE_____ **DATE**_____

FINANCIAL POLICY AND AGREEMENT
West Mesa Wellness

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions, In this Agreement, "Office" and "Clinic" shall refer to Taylor Ranch Chiropractic d/b/a West Mesa Wellness located at 8625 Golf Course Rd, NW, Ste A-2, Albuquerque, NM 87114. "Financial Policy" or "Agreement" shall refer to this document.

Personal Responsibility for My Charges, I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that (1) any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments resolved by the Office towards my Charges, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full promptly upon demand, and shall not constitute an 'accord and satisfaction' of my Charges, regardless of any such terms or restrictions indicated on, or included on , or included with any payments, and (2) any delay in paying the full amount of my Charges beyond fourteen (14) calendar days of demand shall be construed as a 'default' of my obligation.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges, I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). I understand that there may be many situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the Office. I agree that if I have any questions about the Terms of Non-Coverage, I can ask to see copies of the Office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I further agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may, in my opinion, not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall i hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved, Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers. Notwithstanding the foregoing, in the event that the Office determines in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, 'Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing'. I hereby waive the application of such laws. In the event that no mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Authorization to Sign My Name on Payments; Transfer of Credit Balances, I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase "by West Mesa Wellness", shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions, I have reviewed the Office's "Assignment & Lien" and Health Insurance Election forms and further agree to the terms and definitions set forth in these documents. Said documents are incorporated herein by reference. In the event that my condition is related to an accident , including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filing and terminating liens, and submitting notices of same to Payers.

I have read, understand and agree to the terms of this Agreement.

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: ____/____/____

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information (HIPAA "Consent Form")

For the purposes of this Consent Form, "Office" shall refer to : Taylor Ranch Family Chiropractic d/b/a WEST MESA WELLNESS.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment or health care operations and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment or health care operations and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patients Name (please print): _____

Signature: _____ Date: ____/____/____

West Mesa Wellness

8625 Golf Course Rd. NW Ste. A-2 Albuquerque, NM 87114

505 899-6600 Fax 505-899-3262

Patient's Name_____ Date_____

NECK PAIN/DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark one 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 the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing 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 weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently placed.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Reading

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

Section 5 - Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Score_____

Section 6 - Concentration

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

Section 7 – Work

- ☐ I can do as much work as I want to.
- ☐ I can only do 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 do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving

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

Section 9 – Sleeping

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

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain.
- ☐ I am able to engage in all my recreation activities with some neck pain.
- ☐ I am able to engage in most, but not all my usual recreation activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I can't do any recreational activities

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Patient's Name_____ Date_____

LOW BACK PAIN/DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark one box which MOST CLOSELY describes your problem.**

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain comes and goes and is mild.
- ☐ 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 can look after myself normally without causing 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 weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently place.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ I have no pain walking.
- ☐ I have some pain in walking but it does not increase with distance.
- ☐ I cannot walk more than 1 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 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases my pain right away.

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 can't stand for longer than 1 hour without increasing pain.
- ☐ I can't stand for longer than 1/2 hour without increasing pain.
- ☐ I can't stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

Section 7 – Sleeping

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

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.
- ☐ Pain limits my interest in energetic social activities (dancing).
- ☐ Pain has restricted my social life and I do not get out as often.
- ☐ Pain has restricted my social life to my house.
- ☐ I hardly have any social life because of the pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys less than 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

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.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Score_____