320 Ichord Ave
Ste J 1 and 2
Waynesville, MO 65583

Ph: 573-774-4177
Fax: 573-774-3921

Adult Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION:1

First Name: ____ Last Name: ____ DOB: ____ Gender: ○ M ○ F

SSN: ____ Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

# of Children: ____ Occupation: ____

Street Address: ____ Apt./Unit #: ____ City: ____ State: ____ Zip Code: ____

Height: ____ Weight: ____ Email: ____

Cell Phone: ____ Other Phone: ____

2. Emergency Contact: ____ Emergency Relation: ____ Emergency Phone: ____

3. How did you hear about us? (please select all that apply & list who in the box that appears)

☐ Current Patient (list who) ____

☐ Professional Referral/Doctor (list who) ____

☐ Google Search ____

☐ Facebook ____

☐ Community Partner (list who) ____

☐ Other (specify) ____

4. Who is your primary care physician? ____ Date of your last visit: ____

Reason for your last doctor visit: ____

5. Are you also receiving care from any other health professionals?

○ Yes

○ No

6. If yes, please name them and their specialty:

	Name	Specialty
1		
2		
3		

7. Please note any significant family medical history:

____

____

____

____

CURRENT HEALTH CONDITIONS

8. What health condition(s) bring you into our office?

____

____

____

____

9. Have you received care for this problem before?

- ○ Yes
- ○ No

If yes, which types of care? Please list

____

10. When did the conditions first begin? ______________________

How did the problem start?
○ Suddenly ○ Gradually ○ Post-Injury

Is this condition:
○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better?

____

What makes the problem worse?

____

YOUR HEALTH GOALS

11. Your top three health goals:

1.

2.

3.

CHIROPRACTIC HISTORY

12. What would you like to gain from chiropractic care?

- Resolve existing challenge
- Overall wellness
- Both

13. Have you ever visited a chiropractor?

- Yes
- No

If yes, which practice(s)?

14. What is their specialty?

- Pain Relief
- Physical Therapy & Rehab
- Nutritional
- Subluxation-based
- Other

If other, specify:

15. Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

16. Have you ever had any significant falls, surgeries or other injuries as an adult?

- Yes
- No

17. If yes, please explain:

____

18. Notable childhood injuries?

- Yes
- No

19. If yes, please explain:

____
____
____
____

20. Youth or college sports?

- Yes
- No

If yes, list major injuries:

____

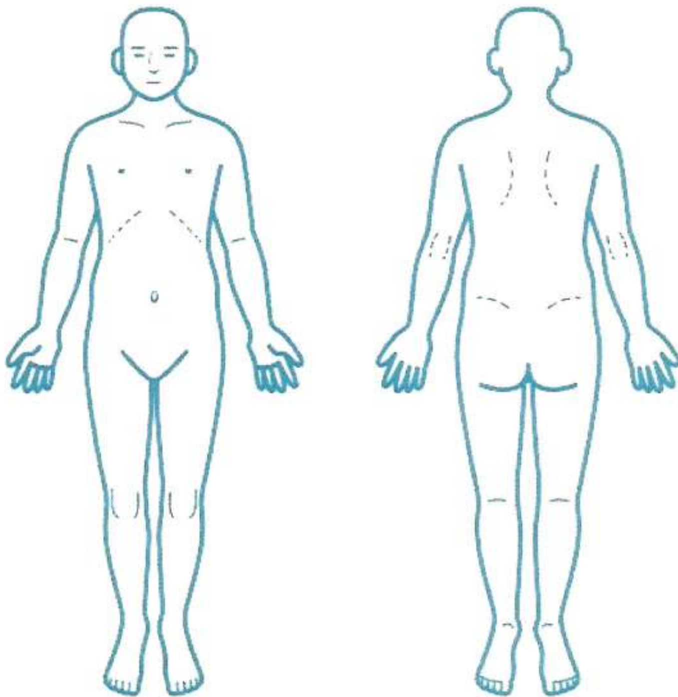
21. Any auto accidents?

- Yes
- No

22. If yes, please explain:

____
____
____
____

23. *Please indicate where you are experiencing pain or discomfort.*



24. Exercise Frequency?
○ None ○ 1-2x per week ○ 3-5x per week ○ Daily

What types of exercise?

___

25. How do you normally sleep?
○ Back ○ Side ○ Stomach

Do you wake up:
○ Refreshed and ready ○ Stiff and tired

26. Do you commute to work?

○ Yes

○ No

If yes, how many minutes per day?

___

27. List any problems with flexibility (ex. Putting on shoes/socks, etc.):

___

___

___

___

28. How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

___

TOXINS: Chemical & Environmental Exposure

29. Please rate your CONSUMPTION for each:

	1 - None	2	3 - Moderate	4	5 - High
Alcohol					
Water					
Sugar					
Dairy					
Gluten					
Processed Foods					
Artificial Sweeteners					
Sugary Drinks					
Cigarettes					
Recreational Drugs					

30. Are you taking any medications?

- Yes
- No

31. If yes, please list which and why:

____

____

____

____

32. Are you taking any vitamins or supplements?

- Yes
- No

33. If yes, please list which and why:

____

____

____

____

THOUGHTS: Emotional Stresses & Challenges

34. Please rate your STRESS for each:

	1 - None	2	3 - Moderate	4	5 - High
Home					
Work					
Life					
Money					
Health					
Family					

35. Are there other emotional stresses or challenges you'd like to tell us about?

____

____

____

____

Patient Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.

36.

	Past	Present
Anxiety & Constant Stress		
Focus & ADHD Challenges		
Difficulty Sleeping		
Low Energy and Fatigue		
Depression and Mood Regulation Challenges		
Lightheadedness & Dizziness		
Vertigo		
Tension Headaches		
Migraines		
Stiff Neck & Shoulders		
Pain, Numbness, & Tingling in Arms and Hands		
TMJ and Jaw Pain		
Vision & Hearing Issues		
Ear & Sinus Infections		
Sore Throat and Strep		

Strep & Upper Respiratory Infections		
Allergies and Autoimmune Challenges		
Chronic Inflammation		
Acid Reflux, GERD, & Indigestion		
Poor Metabolism & Weight Control		
High Blood Pressure		
Asthma		
Chronic Chest Colds & Cough		
Bronchitis & Pneumonia		
Functional Heart Conditions		
Gallbladder Pain & Issues		
Stomach Ulcers and Pain		
Blood Sugar Problems		
Skin Conditions / Rash		
Ulcerative Colitis		
Crohn's Disease		
IBS		
Kidney Challenges		
Gas Pain & Bloating		
Gluten & Casein Intolerance		
Constipation		
Bladder & Urination Issues		
Cysts & Endometriosis		
Fertility Challenges		
Erectile Dysfunction		
Hemorrhoids		
Low Back Pain & Stiffness		
Sciatica & Radiating Pain		
Lumbopelvic / SI Joint Pain		
Disc Degeneration		
Leg Weakness & Cramps		
Restless Legs		
Poor Circulation & Cold Feet		
Weak Ankles & Arches		

ACKNOWLEDGEMENT & CONSENT

37. Patient Name:

____

______________________________ ______________

Signature Date

OGLE CHIROPRACTIC & REHAB CENTER, LLC
320 Ichord Ave. Ste J Waynesville, MO 65583
573-774-4177

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Ogle Chiropractic & Rehab Center, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Please list those whom we may give your information to:

Name: ______________________________ Phone#: __________________

Name: ______________________________ Phone#: __________________

Name: ______________________________ Phone#: __________________

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have **received** a copy of the Notice of Patient Privacy Policy. _______Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Note that some of your treatment may be performed in an "open area". Private areas are available upon request to discuss your health information upon request. _______Patient Initials

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

____ ______________
Patient or Legally Authorized Individual Signature Date

____ ______________
Print Patient's Full Name Time

____ ______________
Witness Signature Date

Office Fee Schedule and Financial Policy

Service	Charges
Consultation	N/C
Initial Exam (Required)	$80
Progress Report	$40
X-Rays (per set) 2 views min.	$75
Adjustment	$40
Acupuncture	$45
Spinal Decompression	$50 per session
X-Ray Consult	$30
E-Stim	$15
Cupping	$20
Intersegmental Traction (Roller) Table	$15
Ultrasound	$25
B12 Injection	$25 each
IMR Mat	$25
Diathermy	$15
No Call/No Show to Appt	$25
ART (Active Release Technique)	$30.00

Financial Policy and Chiropractic Treatment Plans

Our responsibilities: We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. We will provide you the best service possible to meet your needs. We will correct any errors we have made if there is a dispute. We are available to answer any questions and will do our best to serve you in a polite and courteous manner. We will provide you a superbill at your request. We accept cash, credit/debit, and checks for payment of services rendered on each day. NOTE: There will be a returned check fee assessed if one is received.

Your responsibilities: Payment is expected at time of service unless you arrange a payment plan set up between you and the doctor. Know your insurance carriers' requirements for filing insurance claims. Every insurance carrier is different. We will verify your insurance coverage for you, however, remember your agreement with your insurance company is between you and them. Please contact the member services telephone number on the back of your card for more information. Information given by your insurance company is not a guarantee of coverage.

Cancellations: Please make any cancellations with at least 24 hours' notice or you will be billed a $25 no call/no show fee.

Collections: I fully understand that I am financially responsible for and agree to pay all charges. In consideration of the chiropractic services furnished to me, I hereby agree to pay Ogle Chiropractic and Rehab Center, LLC any balance due within sixty days from presentation of my bill. In the event of default, I promise to pay legal interest on Indebtedness together with 50% collection costs and attorney fees as may be required to effect collections.

Prices are subject to change at any time
I have read and I understand the above policy.

Patient Signature ______________________________ Date______________________

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize **Ogle Chiropractic and Rehab Center, LLC** and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also with to rely on the practice doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

By signing below I acknowledge my consent to be examined:

The specifics of the doctor's recommendation will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment/treatment plan.

Based on current findings, practice doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, the practice has provided me with the specific pamphlets and other literature and practice doctors have answered my questions regarding the planned treatments and course of care that I will receive. Practice doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

   I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and purposed course of care and treatments by the Practice.

_______________________ _______________________/__________

Patient's Printed Name Patient's Signature Date

Patient counseled by:_______________________________________

Signature of doctor

Ogle Chiropractic and Rehab Center, LLC Roland-Morris Questionnaire

Patient name:______________________________ Signature:______________________________ Date: __________

Previous Date & Score________ ____%increase/decrease Score___________

Please read instructions: when your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe your pain during every day activities.

1[ ] I stay at home most of the time because of my pain.

2[ ] I change position frequently to try to get my comfortable.

3[ ] I walk more slowly than usual because of my pain.

4[ ] Because of my pain, I am not doing any jobs that I usually do around the house.

5[ ] Because of my pain, I use a handrail to get upstairs.

6[ ] Because of my pain, I lie down to rest more often.

7[ ] Because of my pain, I have to hold on to something to get out of an easy chair.

8[ ] Because of my pain, I try to get other people to do things for me.

9[ ] I get dressed more slowly than usual because of my pain.

10[ ] I only stand up for short periods of time because of my pain.

11[ ] Because of my pain, I try not to bend or kneel down.

12[ ] I find it difficult to get out of a chair because of my pain.

13[ ] I have pain almost all the time.

14[ ] I find it difficult to turn over in bed because of my pain.

15[ ] My appetite is not very good because of my pain.

16[ ] I have trouble putting on my sock (or stockings) because of the pain.

17[ ] I can only walk short distances because of my pain.

18[ ] I sleep less well because of my pain.

19[ ] Because of my pain, I get dressed with the help of someone else.

20[ ] I sit down for most of the day because of my pain.

21[ ] I avoid heavy jobs around the house because of my pain.

22[ ] Because of pain, I am more irritable and bad tempered with people than usual.

23[ ] Because of my pain, I go upstairs more slowly than usual.

24[ ] I stay in bed most of the time because of my pain.

Consent to X-Ray

Patients Name: ______________________________

I hereby authorize Dr. ______________________ and whomever he/she designates as his/her assistant's to take x-rays of myself (or said minor).

Dated this _________ day of _________________ 20_____

Witness ____
Printed Name

____
Signature

Patient ____
Printed Name

____
Signature

____
Signature of Parent or Guardian (if patient is a minor)

Pregnancy Warning

Patient Name____ Date______________

- ◊ I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.
- ◊ I have been advised that the 10 days following the onset of a menstrual period are generally considered to be safe for x-ray examination.

With those factors in mind, I am advising my doctor that:

I am pregnant:	Yes	No	Don't Know
I could be pregnant:	Yes	No	Don't Know
I have an IUD:	Yes	No	Don't Know
I have had a tubal ligation:	Yes	No	Don't Know
I am late with my menstrual period:	Yes	No	Don't Know
I am taking oral contraceptives:	Yes	No	Don't Know
I have had a hysterectomy:	Yes	No	Don't Know
I have irregular menstrual periods:	Yes	No	Don't Know

My last menstrual period began on: ________________________

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed now.

I hereby authorize the Doctor to examine and treat any condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-rays negatives will remain the property of this office.

____
Patient Signature Date

____
Guardian or Parent Signature Authorizing Care Date

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Waynesville, MO 65583
W: 573-774-4177
Fax: 573-774-3921
www.oglechiropractic.com

OGLE CHIROPRACTIC PHOTO RELEASE

I, on behalf of myself and/or my minor children, hereby grant Ogle Chiropractic, LLC, (OC) and its officers, chiropractors, owners and employees the right to take photographs of myself and my minor child(ren), while on the premises of OC or while attending any offsite event hosted or otherwise sponsored by OC or any of OC's affiliate businesses. I further give permission for the use of such photographs in the advertising, business, web-hosted, social media account, or educational materials promulgated, created, designed, purchased or otherwise used by OC for purposes of promoting OC. I hereby waive any applicable right of privacy that I may assert on behalf of myself or my minor child(ren), and further agree that such photos may be used for any additional lawful purposes related to promoting OC and it's affiliates as well as chiropractic treatment in general. To the extent that such disclosures show a doctor/patient relationship, I hereby waive such privilege on behalf of myself and my minor child(ren) for the limit purposes enumerated herein specifically related to photographic material.

I have fully read and understand the implications of this wavier and release and hereby affix my signature in acknowledgment of my agreement with such terms. By affixing my signature below, I am also confirming that I am at least 18 years of age, or, if signing on behalf of a minor child, that I am at least 18 years of age.

I am at least 18 years of age and have read and understand the above:

Patient Name: ____

If under 18 years of age the legal guardian or parent has read and understands the above:

Parent/Guardian Name: ______________________________________

Parent/Guardian

____ ____________________

Patient Signature Date