# *WELCOME TO RUGEN CHIROPRACTIC*

Date: _____ Name: _____
First Initial Last Jr/Sr

PO Box: _____ & Street Address: _____ City: _____

State: _____ Zip: _____ PATIENT'S Date of Birth: ____-____-____ Male___ Female____
SOCIAL SECURITY#: ____-____-____

If married, spouse's name: _____ E-mail Address: _____

Marital Status: Single:___ Married:___ Divorced:___ Separated:___ Widowed:___ Other: _
home phone: (____)____-_____ Work phone: (____)____-_____ Ext:_____

Cell#: (____)____-_____ Fax#: (____)____-_____

Patient's Information:
Patient's Occupation: _____

Patient's Employer:(spell out complete name-NO INITIALS) _____
Employer's Mailing Address: _____ City: _____
State:_____ Zip:_____ If retired, date of retirement: ____-____-____

Primary Care Physician's Name (Not PA): _____ Phone #:_____
Fax #: _____ Group Name: _____
Address:_____ City:_____ State:_____ Zip:_____

Attorney Information(if applicable) (for accident cases only)
Firm Name:_____
Attorney Name: _____ Address:_____
City: _____ State: _____ Zip:_____ Phone: ____-____-_____

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Guarantor:(person responsible for payment if other than patient)(EX:Parent or Guardian):
Name: _____ Relationship to Patient:_____
Address:_____City:_____ State:____ Zip:_____
Referred by: _____

IS THIS VISIT AS A RESULT OF AN ACCIDENT? YES__ NO___

Work Related: _____ Date of Accident:____-____-____
Auto Accident: _____ Date of Accident:____-____-____
Other: _____ Date of Accident: ____-____-____

ARE YOU RECEIVING PHYSICAL/OCCUPATIONAL THERAPY? Yes ___ No ___
HAVE YOU SEEN ANOTHER CHIROPRACTOR? Yes ___ No ___
If Yes, date of your last treatment:____-____-____ Why are you receiving this treatment? _____
_____

VA PATIENTS ONLY: IS THIS CARE SERVICE CONNECTED? Yes No
(If no, this must be submitted to your personal insurance)

(4/17)

Please Fill Out The Back Of This Page & Sign

## PRIMARY INSURANCE INFORMATION

Medicare _____ Private_____ Worker's Compensation_____ No Fault _____

Insured's Name: _____Address:_____

City:_____ State: _____ Zip:_____ Insured's Phone: _____

INSURANCE CO. NAME: _____

Employer Carrying Ins:_____ Insured's Work#: _____

Insured's Employer Address: _____

Insured's Date of Birth: ___-___-___ Male:__ Female:__ Self___ Spouse____ Child ___ Other ___

## SECONDARY INSURANCE INFORMATION

Medicare _____ Private_____ Worker's Compensation_____ No Fault _____

Insured's Name: _____Address:_____

City:_____ State: _____ Zip:_____ Insured's Phone: _____

INSURANCE CO. NAME: _____

Employer Carrying Ins.:_____ Insured's Wk.# _____

Insured's Employer Address: _____

Insured's Date of Birth: ___-___-___ Male:__ Female:__ Self___ Spouse____ Child ___ Other ___

I understand I will be responsible for payment of all expenses which are not a covered benefit by my insurance or for services denied by my insurance for any reason. This includes all insurance companies including Medicare, worker's compensation and no fault. If I do not notify the receptionist of any insurance changes prior to being treated by the Dr., I will be responsible for full payment. If my insurance company requires a referral from my primary care physician for chiropractic care or preauthorization from my insurance company and I do not have one at the time of service, I am responsible to pay for services provided to me and/or my dependent(s). I understand that an insurance referral/authorization is NOT a guarantee of payment. I am responsible for my insurance deductible at the time of service. I also agree to pay for services, including my insurance co-pay/co-insurance, at the time of service. I am aware that I will owe an administrative fee if I do not pay my insurance co-pay/co-insurance at the time of service. If Rugen Chiropractic does not participate with my insurance company, I will be responsible for full payment. I agree to pay the office charge for any returned checks. I agree to pay the office late fee which will be added to each invoice 30 days past due. I also understand that I will be responsible to pay the office visit fee if I am unable to keep my appointment and do not call before my scheduled appointment time to cancel.

I understand that most insurance companies do not pay for chiropractic visits if I am also receiving physical therapy. I will be responsible for payment of Rugen Chiropractic's customary fees if my insurance denies payment due to concurrent treatment.

I understand any balance not payable by my insurance which is 60 days past due automatically gets turned over to an independent company for collections, and I will be responsible for a collection fee in addition to the amount owed.

I authorize the release of any medical or other information necessary to process my claims. I also authorize reports to be sent to my primary care physician. I authorize payment of medical benefits to Rugen Chiropractic.

I give Rugen Chiropractic permission to leave messages on my answering machine or with the person answering my phone.

Patient Signature _____ Date ____-____-____

Parent/Guardian signature if patient is under the age of 18: _____

Date: _____ Relationship to Patient: _____

(3/12)

# PATIENT QUESTIONNAIRE

Patient Name: _____ Date: ___-___-___

**Is this visit the result of an accident? Yes No Date of injury or date symptoms began: ___-___-___**
**( ) Workers' Comp. ( ) No Fault ( ) Other _____**
**Are you working? Yes No** If No, date last worked: ___-___-___
If Yes, light duty: ___-___-___ Regular duty: ___-___-___ Totally Disabled: ___-___-___
**What recent events may have caused your symptoms?** _____

1. Have you had any imaging? Yes No If Yes, where & when?: _____
2. **Have you seen another Doctor/Chiropractor/Physical/Occupational Therapist for this injury?**
   **Yes___ No___**
   **Are you still receiving treatment? Yes No Date of last treatment: ___-___-___**

3. How do you feel today?

**Current Complaint:**

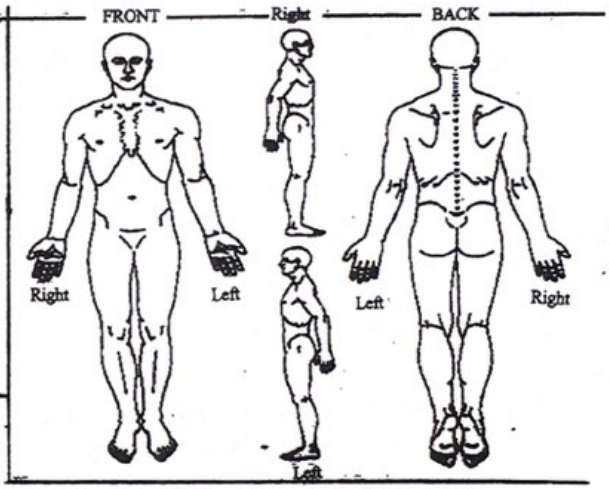
0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable

**Average Pain level over the past week:**

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

Use code and mark diagram where you are experiencing pain today:

**A = ACHE**
**B = BURNING**
**C = CRAMPS**
**D = DULL**
**N = NUMBNESS**
**P = PINS & NEEDLES**
**S = STABBING**
**SW = SWELLING**
**T = TIGHTNESS**
**TH = THROBBING**
**O = OTHER**




4. How often do you experience your symptoms per day?
(Circle one) Constantly (76-100%) Frequently (51-75%) Occasionally (26-50%) Intermittently (0-25%)

**SINCE BEGINNING TREATMENT:**

1. Are you getting better? Please rate your improvement since starting care for this episode: ____%
   (Circle one) no improvement slight moderate greatly improved
2. Have your abilities to perform your activities of daily living or work activities improved? Yes No
3. Have you had any new complaints/conditions since starting care? Yes No
   Have you had any re-injuries or events that have prolonged your recovery? Yes No
   Explain: _____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify the receptionist and the Doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ Date: ___-___-___

(1/17)

**Patient Name** _____ **Date** _____

**What type of regular exercise do you perform?** ① None ② Light ③ Moderate ④ Strenuous

**What is your height and weight?** Height [ ][ ][ ] (Feet, Inches) Weight [ ][ ][ ] lbs.

**For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.**

| Past | Present | | Past | Present | | Past | Present | |
|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Headaches | ○ | ○ | High Blood Pressure | ○ | ○ | Diabetes |
| ○ | ○ | Neck Pain | ○ | ○ | Heart Attack | ○ | ○ | Excessive Thirst |
| ○ | ○ | Upper Back Pain | ○ | ○ | Chest Pains | ○ | ○ | Frequent Urination |
| ○ | ○ | Mid Back Pain | ○ | ○ | Stroke | | | |
| ○ | ○ | Low Back Pain | ○ | ○ | Angina | ○ | ○ | Smoking/Use Tobacco Products |
| | | | | | | ○ | ○ | Drug/Alcohol Dependence |
| ○ | ○ | Shoulder Pain | ○ | ○ | Kidney Stones | | | |
| ○ | ○ | Elbow/Upper Arm Pain | ○ | ○ | Kidney Disorders | ○ | ○ | Allergies |
| ○ | ○ | Wrist Pain | ○ | ○ | Bladder Infection | ○ | ○ | Depression |
| ○ | ○ | Hand Pain | ○ | ○ | Painful Urination | ○ | ○ | Systemic Lupus |
| | | | ○ | ○ | Loss of Bladder Control | ○ | ○ | Epilepsy |
| ○ | ○ | Hip/Upper Leg Pain | ○ | ○ | Prostate Problems | ○ | ○ | Dermatitis/Eczema/Rash |
| ○ | ○ | Knee/Lower Leg Pain | | | | ○ | ○ | HIV/AIDS |
| ○ | ○ | Ankle/Foot Pain | ○ | ○ | Abnormal Weight Gain/Loss | | | |
| | | | ○ | ○ | Loss of Appetite | **Females Only** | | |
| ○ | ○ | Jaw Pain | ○ | ○ | Abdominal Pain | ○ | ○ | Birth Control Pills |
| | | | ○ | ○ | Ulcer | ○ | ○ | Hormonal Replacement |
| ○ | ○ | Joint Swelling/Stiffness | ○ | ○ | Hepatitis | ○ | ○ | Pregnancy |
| ○ | ○ | Arthritis | ○ | ○ | Liver/Gall Bladder Disorder | ○ | ○ | |
| ○ | ○ | Rheumatoid Arthritis | | | | | | |
| | | | ○ | ○ | Cancer | **Other Health Problems/Issues** | | |
| ○ | ○ | General Fatigue | ○ | ○ | Tumor | ○ | ○ | |
| ○ | ○ | Muscular Incoordination | | | | ○ | ○ | |
| ○ | ○ | Visual Disturbances | ○ | ○ | Asthma | ○ | ○ | |
| ○ | ○ | Dizziness | ○ | ○ | Chronic Sinusitis | | | |

**Indicate if an Immediate family member has had any of the following:**

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

**List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:**

_____ _____ _____

_____ _____ _____

**List all the surgical procedures you have had and times you have been hospitalized:**

_____ _____ _____

_____ _____ _____

# Rugen Chiropractic

1002 Kinderhook St., Valatie, NY 12184
518/758-1400 Fax: 518/758-1438
Robert K. Rugen, DC NPI#1588634042
Glenn E. Rugen, DC DABCN NPI#1033189725
Tax #:141785070

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**PATIENT GIVING CONSENT:**

Name: _____ Date of Birth:____-____-____
Address:_____

**PURPOSE OF CONSENT:**

By signing this consent form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the above address. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation.

I _____ have had full opportunity to read and consider the contents of this consent form. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations to the following:

| | |
|---|---|
| _____ Name | _____ Relationship |
| _____ Name | _____ Relationship |
| _____ Name | _____ Relationship |
| _____ Name | _____ Relationship |

Signature: _____ Date: ____-____-____

**RUGEN CHIROPRACTIC**
1002 Kinderhook St., Valatie, NY 12184
Robert K. Rugen, DC Glenn E. Rugen, DC DABCN

# Rugen Chiropractic Privacy Policy

We realize your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of your personal information. This notice explains why we collect information about you, what we do with the information and how we protect your privacy.

## Collecting Information

Our office offers chiropractic services to our patients. To provide these services, we must collect non-public personal information about our patients. This information may include telephone numbers, address, date of birth, and social security number. We also receive confidential health information about our patients.

## Sharing Information

We treat your personal information as confidential. We may share your health information to a physician or other healthcare provider providing treatment to you and/or with your insurance company in order to process claims. PLEASE BE ASSURED THAT WE DO NOT SHARE YOUR PERSONAL INFORMATION TO MARKET ANY PRODUCT OR SERVICE.

## Health Care Operations

We use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when the doctor is ready to see you. If necessary to contact you by telephone and you are unavailable, we will not leave a message on your answering machine or with the person answering the phone without your prior consent to do so.

## Abuse or Neglect

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

By signing this form, you are saying that you have read our privacy policy and give your consent to use and disclose your protected health information to carry out treatment, payment activities and health care operations.

Print Name: _____ Sign:_____ Date:_____

If this consent is signed by a personal representative on behalf of the patient named:_____, complete the following:

Representative's Name: Print: _____ Sign: _____
Relationship to Patient: _____ Date: _____

# Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** _____ **Date** _____

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

### Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

### 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).

### Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

### Concentration

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

### Work

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

### Personal Care

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 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 I do not get dressed, I wash with difficulty and stay in bed.

### Lifting

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

### Driving

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

### Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

### Headaches

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

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

*Neck Index Score* _____

# Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** _____ **Date** _____

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

### Pain Intensity

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

### Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

### Sitting

⓪ I can sit in any chair as long as I like.
① I can only 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 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

### Standing

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

### Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

### Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

### Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

### Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

### Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
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.

### Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

*Back Index Score* _____