PLEASE FILL OUT AND BRING TO YOUR APPOINTMENT. THIS WILL SAVE YOU SOME VALUABLE TIME.

WE VERY MUCH APPRECIATE IT.

THE DOCTORS AND TEAM AT MIDWEST MULTICARE

Midwest Multicare | 4238 N. Knoxville Ave, Peoria, IL 61614
ph: 309-282-6419 Fax: 309-282-6003
www.midwestmulticare.com

Midwest Multicare and Associates
4238 N Knoxville Ave
Peoria, IL 61614
Ph: (309) 282-6419

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ___/___/___

Email: _____ Birth Date: ___/___/___ Age: ____ Gender: F M

Would you prefer a text or email appointment reminder (PLEASE CIRCLE): TEXT EMAIL

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (____) _____

Guardian: _____ Date of Birth: ___/___/___ Phone: (____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

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

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (____) _____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

Phone (____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (____) _____

Spouse is a student at _____ ☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency? _____ 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 Please check ALL that apply.

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

_____

Approximately, when did your injury or condition occur? ___/___/____

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: _____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

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

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

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

Date of last physical examination? _____

What surgery 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 ☐ Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/____ Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO If yes, who is the employer? _____

****

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

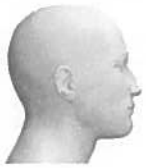
I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/____

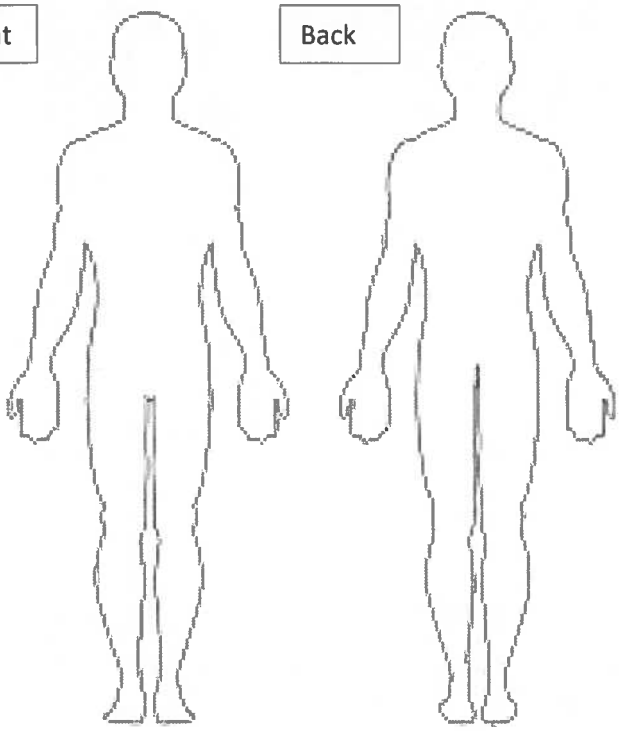
Name: _____ Date: _____

SUBJECTIVE PAIN ASSESSMENT

Left Right



Front Back



RATE YOUR PAIN

PLACE AN "X" ON THE DRAWINGS TO THE LEFT WHEREVER YOU HAVE PAIN. BESIDE THE "X", INDICATE THE TYPE OF PAIN YOU ARE EXPERIENCING

A= Ache

B= Burning

ST = Stabbing

SP = Spasm

N = Numbness

P = Pins and Needles

T = Throbbing

(Exampe: XST between your shoulders means you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PRESENT AS PERCENT OF DAY: 25% 50% 75% 100%

Patient or authorized rep signature: _____ Date: _____

The Primary Care Low Back Disability Questionnaire (PCLBDQ)

FAX (800) 599-8350

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) ___/___/___
Provider Last Name	Provider First Name	Provider Phone (area code first)	

Instructions: This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please **circle the choice which most closely describes your problem**.

SECTION 1 – Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is very severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting
A. I can lift heavy weight without pain.
B. I can lift heavy weight, but it gives me pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned- e.g., on a table.
E. Pain prevents me from lifting heavy weights, but can manage light-medium weights if they are conveniently positioned.
F. I can only lift very light weights at the most.

SECTION 4 – Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than 1hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

SECTION 6 – Standing
A. I can stand as long as I want without pain.
B. I have some pain on standing but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7 – Sleeping
A. I get no pain in bed.
B. I get pain in bed but it doesn't prevent me from sleeping well.
C. Because of my pain my normal night's sleep is reduced by <¼.
D. Because of my pain my normal night's sleep is reduced by <½.
E. Because of my pain my normal night's sleep is reduced by <¾.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted by social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 – Traveling
A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain restricts all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening

Office Use Only PCLBDQ SCORE: _____

I understand that the information I have provided above is current and correct to the best of my knowledge.

Signature_____ Date_____

With permission Hudson-Cook N, Tomes-Nicholson K, Breen AC. A Revised Oswestry Back Disability Questionnaire. Manchester Univ Press, 1989.

Mailing address:
Landmark Healthcare, Inc., 1750 Howe Avenue, Suite 300, Sacramento, CA 95825

Neck Disability Index Questionnaire

FAX (800) 599-8350

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) / /
Provider Last Name	Provider First Name	Provider Phone (area code first)	

Instructions: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity
A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)
A. I can look after myself without causing pain.
B. I can look after myself normally but it causes pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

DISABILITY INDEX SCORE: %_____

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all

I understand that the information I have provided above is current and correct to the best of my knowledge.

Signature_____ Date_____

Mailing address:
Landmark Healthcare, Inc., 1750 Howe Avenue, Suite 300, Sacramento, CA 95825

Midwest Multicare & Associates
4238 N. Knoxville Ave.
Peoria, IL 61614

I acknowledge that I have discussed my payment options with Midwest Multicare or Associates, PC and that I have decided the following course of payment for my care.

☐ Please bill my insurance company. I know that co pays, deductibles, and pay schedules are a contract between my insurance company and me, not Midwest Multicare or an Associate.

☐ I wish to utilize the cash payment option. First appointment charge is $87.00 then every visit after is $45.00 due at time of visit. This method of payment is an agreement between Midwest Multicare or an Associate and me.

☐ Workers Compensation/Motor Vehicle Accident/ Personal Injury - Patient is responsible for remainder due after financial party has paid.

If I decide to change payment options, I will fill out and date a new form.

_____ _____

Name Date

I acknowledge that I am receiving, or about to receive, health care services from a doctor at Midwest Multicare, and that I have been advised that the doctors requests that payment be made for services when the service is rendered. ***Also, I understand that any contracts I have with any third-party payer is a contract strictly between the payer and me and that I am totally responsible for all debts incurred. ALSO, I UNDERSTAND THAT IF PAST-DUE COLLECTION IS REQUIRED ON MY ACCOUNT, I WILL BE HELD RESPONSIBLE FOR ALL SERVICE CHARGES INCURRED IN THE PAST-DUE COLLECTION AND FOR ANY LEGAL FEES REQUIRED TO COLLECT THE DEBT.***

DISCLOSURE & CONSENT for CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT

You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it's simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic X-Rays, on me (or the patient named below, for whom I am legally responsible for) by the Doctor of Chiropractic named below and/other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working are associated with, or serving as a backup for the Doctor of Chiropractic named below.

Pregnancy Release
This is to certify that to the best of my knowledge I am not pregnant and that Midwest Multicare has my permission to perform an x-ray evaluation. I have been advised that X-ray can be hazardous to an unborn child.

Date of last menstrual period:_____
Patients Signature:_____Date:_____

I have had the opportunity to discuss with the Doctor of Chiropractic named below my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, and increased symptoms and pain or no movement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the fact that then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

Please see other side

I have read or have had read to me, the above contract. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the Patient:

Relationship to patient: _____

_____
Print name

_____
Signature of patient

_____
Date signed

To be completed by Doctor or Staff:

_____ _____
Witness to patient's signature Date

Midwest Multicare
4238 N Knoxville Ave
Peoria, IL 61614

In consideration of your agreement to treat me, I agree to the following:

AUTHORIZATION TO RELEASE INFORMATION

I authorize you to release all information necessary concerning my physical condition to any insurance company, attorney, or adjustor in order to process all claims for reimbursement of charges incurred as the result of professional services rendered. Also, I release you of any consequence thereof.

ASSIGNMENT OF CAUSE OF ACTION

In the event that any insurance company is obligated by contractual agreement to make payment to me or you, for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor and I authorize you to process the claim in either my name or your name. Also, I understand that all insurance companies contractually obligated will keep me informed of all transactions and of any amounts of overpayment by any contractually obligated insurance company.

AUTHORIZATION TO PAY DIRECTLY TO THE DOCTOR

In consideration of the chiropractic services rendered, and to be rendered by Dr. Hunt, I authorize and direct the payments to Dr. Hunt, any amount I now or hereafter owe you out of the proceeds of any settlement of my case, and/or by any insurance companies obligated to reimburse me for the charges for services, or otherwise obligated to reimburse me or make payment to me based in whole or in part upon the charges made for services rendered.

ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge that I am receiving, or about to receive, health care services from Midwest Multicare, and that I have been advised that Dr. Hunt requests that payment be made for services when the service is rendered. Also, I understand that any contracts I have with any third-party payer is a contract strictly between the payor and myself, and that I am totally responsible for all debts incurred. ALSO, I UNDERSTAND THAT IF ANY PAST-DUE COLLECTION IS REQUIRED ON MY ACCOUNT, I WILL BE HELD RESPONSIBLE FOR ALL SERVICE CHARGES INCURRED IN THE PAST-DUE COLLECTION AND FOR ANY LEGAL FEES REQUIRED TO COLLECT THE DEBT.

_____ _____

Patient Signature Date

Midwest Multicare, PC
4238 N Knoxville Ave
Peoria, IL 61614
Phone # (309) 282-6419 Fax # (309) 282-6003

PATIENT CONSENT AND DOCTOR'S LIEN

RE: Patient: _____

Date of Accident/Injury: _____

Case Name: _____

Case Number: _____

Court: _____

County of _____, State of Illinois

Consent and Authorization

The undersigned patient _____, ("Patient") hereby consents to the examination, treatment, procedures and services to be performed by the doctors at Midwest Multicare, PC ("Provider"), including emergency treatment.

Patient authorizes Provider to release any information needed to process the claims with respect to the examination, treatment, procedures and services rendered by Provider. Patient further directs that a photocopy of this Claim Agreement and Lien be considered as valid as the original.

Patient further authorizes _____ ,("Attorney") to keep Provider advised of the progress of Patient's court case at reasonable intervals.

Irrevocable Lien

Patient hereby authorizes and directs Attorney to pay Provider directly any sums due for medical services rendered to Patient. Patient directs Attorney to withhold such funds from any settlement, verdict or judgment that is rendered in the said court case. Patient hereby notifies Attorney that Patient is giving Provider a lien on these benefits or settlement proceeds. In consideration for Provider waiting for payment, this lien is irrevocable and can only be satisfied by full payment of all sums due for medical services rendered. Patient authorizes Provider to notify Attorney of this lien at Provider's discretion. Patient understands that any settlement, verdict or judgment proceeds cannot be disbursed to Patient without first satisfying this lien.

Should a dispute arise regarding payment of Provider's charges, Patient authorizes and directs Attorney to hold in escrow all monies sufficient to satisfy this lien until the dispute can be resolved. Patient acknowledges that it would be a violation of Attorney's ethical duties to disburse the disputed funds prior to resolution of the lien dispute.

Patient understands and agrees that even though this lien has been given, Patient remains personally responsible for payment in full of Provider's fees for all services rendered. Patient is solely responsible to make appropriate arrangements for payment of such fees, including but not limited to insurance benefits. Patient acknowledges that this obligation to pay Provider's fees is not dependent on the outcome of Patient's court case.

Payment Deferred Until Resolution

Provider hereby agrees to await Patient's payment of Provider's fees until the said court case is resolved by settlement, judgment or verdict, except to the extent that payment is available from Patient's medical insurance.

Collection Costs and Interest

Should Patient's account fall into arrears, Patient agrees to pay Provider's reasonable costs of collection, including interest, attorney fees, court costs and/or third party collection costs, and interest of 2% per month (24% per year).

Change of Legal Counsel

If Patient should retain new legal counsel, Attorney and Patient agree to notify Provider immediately upon such change. Patient shall direct such new legal counsel to execute another copy of this Agreement and deliver same to Provider.

Amendments; Revocation

This Agreement cannot be modified, amended or revoked by any party without the express written consent of all parties.

Acknowledgement by Patient

I acknowledge that this Agreement must be signed by myself and by my attorney before any medical services will be provided to me by Provider.

_____ _____

Patient's Signature Date

_____ _____

Provider's Signature Date

_____

Print Name & Title (if any)

TO PATIENT'S ATTORNEY:

Name of Attorney: _____

Address: _____

_____

Please sign, date and return one copy of this Patient Consent and Doctor's Lien to [Name of Medical Facility]. Keep one copy for your records.

Accepted and approved:

_____ _____

Attorney's Signature Date

_____

Print Name

Information	Patient	Attorney
Name		
Firm		
Street Address		
Apartment / Suite #		
City, State, Zip		
Telephone		
Fax		
Email		