Dr. C. Barrett Deubert
2900 Alcoa Hwy
Knoxville TN 37920

THE HEALTH FACTORY

PERSONAL INFORMATION:

Name _____Age _____DOB _____Date _____

Address _____City _____ State_____ Zip_____

Phone (Home) _____Social Security #_____ Sex: M/F Marital Status: S/M/D/W

Occupation Employer _____ Phone (Work)_____

Spouse's Name_____# of Children _____Ages_____

Email address_____

HEALTH HISTORY:

Reason(s) for seeking care?_____

When did this start?_____

How did this happen?_____

Please Circle:

Type of injury: Pain/ Numbness/ Swelling/ Muscle spasms/ Headache/ Tightness/ Stiffness/ Tingling/ Weakness/

Other:_____

Quality: Sharp/ Dull/ Aching/ Throbbing/ Crushing/ Stabbing/ Local/ Radiating/ Burning/ Migraine/ Tension/ Hormonal/ Sinus/

Other:_____

Regions: Head/ Neck/ Upper back/ Lower back/ Pelvis/ R or L arm/ R or L leg/

Other:_____

Radiates or Travels to: Head/ Neck/ Upper back/ Lower back/ Pelvis/ R or L arm/ R or L leg/

Other:_____

Timing: Constant/ Frequent/ Intermittent/ Occasional/ Infrequent/

Other:_____

Severity: 0(none)/ 1/ 2/ 3/ 4/ 5/ 6/ 7/ 8/ 9/ 10(disabling)

Goals: 0(none)/ 1/ 2/ 3/ 4/ 5/ 6/ 7/ 8/ 9/ 10(disabling)

What makes it worse?_____

What makes it better?_____

Any other important information?

_____

_____

Daily Activities: Effects of current conditions on performance

Sleeping/ Running/ Sitting/ Standing/ Other:_____

How long? Extended Periods/ 5 min/ 10 min/ 30min/ 45min/ 1hour/ 2hours/ Other:_____

Result in pain: 0(none)/ 1/ 2/ 3/ 4/ 5/ 6/ 7/ 8/ 9/ 10(disabling)

Current function: 0%/ 10%/ 20%/ 30%/ 40%/ 50%/ 60%/ 70%/ 80%/ 90%/ 100%

Short Term goal function: 0%/ 10%/ 20%/ 30%/ 40%/ 50%/ 60%/ 70%/ 80%/ 90%/ 100% Time frame:_____

Long Term goal function: 0%/ 10%/ 20%/ 30%/ 40%/ 50%/ 60%/ 70%/ 80%/ 90%/ 100% Time frame:_____

List any diagnosis and type of treatment: _____

Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____

Have you or any relative received chiropractic treatment previously? __ Yes __ No If yes, explain:_____

Past traumas or hospitalizations not related to current condition: _____

Have you been treated for any health condition by a physician in the last year? __ Yes __ No

If yes, explain:

_____

Are you currently taking medication? __ Yes __ No List medications:

_____

Have you taken medication in the past? __ Yes __ No List medications

_____

List conditions you are taking medications for:

_____

List the approximate dates of any surgery or previously treated conditions:

_____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain

Pregnant at this Time Y/N

FOR DOCTOR'S USE ONLY

EXAM
__ 99201
__ 99202
__ 99203

X-RAYS
__ 72040
__ 72100
__ 72020

DISEASE OF SPINE
__ M50.03 Cervical Disc Degeneration
__ M47.812 Cervical Spondylosis
__ M50.00 Cervical Disc Deg. w/ Myelopathy
__ R51 Headache
__ M54.12 Cervical Radiculopathy
__ M51.04 Thoracic Dics Deg. w/ Myelopathy
__ M47.814 Thoracic Spondylosis
__ M51.34 Thoracic Disc Deg.
__ M41.20 Idiopathic Scoliosis
__ M51.36 Lumbar Disc Degeneration
__ M51.37 Lumbosacral Disc Degeneration
__ M51.06 Lumb Disc Deg. w/ Myelopathy
__ Q76.2 Spondylolisthesis
__ M47.817 Lumbosacral Spondylolisthesis
__ M54.30 Sciatica, Unspecified
__ M54.31 Sciatica, Right Side
__ M51.32 Sciatica, Left Side
__

SUBLUX
__ M99.01 Cervical
__ M99.02 Thoracic
__ M99.03 Lumbar
__ M99.04 Sacral
__ M99.05 Pelvic
__ M99.06 Lower Extremity
__ M99.07 Upper Extremity

TRACTION
__ M24.20 Ligament Disorder, Undpecified

GROUP THERAPY
__ R29.3 Abnormal Posture

ADD OTHER DIAGNOSIS CODE
_____

QUADRUPLE VISUAL ANALOGUE SCALE

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____

What speed was the collision? _____

Type of impact: Front Impact / Side Impact / Rear Impact

Does your job require you remain in long term stressful postures? _____

(*i.e. all day seating, repeated lifting, long term computer use)*

Past Spinal Traumas? _____

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field

_____

Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident, birth trauma

_____

INITIAL NUTRITIONAL PROFILE

Have you tested with high triglycerides or high cholesterol? (Y / N) Values? _____

Have you tested with high blood pressure? (Y / N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

Do you eat breakfast daily from Monday to Friday? (Y / N)

How many days per week do you skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

Diet Soda Coffee Juice Milk Soda Alcohol

Please list any supplements you take regularly:

_____

INITIAL FITNESS PROFILE

How many times per week do you exercise? Cardiovascular ___Hours ___Days/Wk

Weight Training ___Hours ___Days/Wk Low Impact (Yoga, etc.) ___Hours ___Days/Wk

What are your fitness goals? _____ Are you happy where your at currently? _____

How willing are you to change any of these things to reach your health goals? ***(Scale of 1-10)*** _____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation. I have read the Privacy Policy of The Health Factory, and/or I am aware this document is available for my viewing.

_____

Patient Signature Date

Females only regarding X-ray/Imaging studies

Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on _____/_____/_____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____

Patient Signature Date

INSURANCE INFORMATION:

Insurance Company_____ Phone_____

Insured's Name _____ Insured's Date of Birth _____

Insured's Social Security # _____

Subscriber's Name_____ Subscriber's Date of Birth_____

Subscriber's Social Security **#**_____

Relationship to Insured_____

Secondary Insurance Company_____Phone_____

ACCIDENT INFORMATION:

Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __ Other _____

Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __ Other _____

Date of accident_____ Fault_____

Do you have medical pay benefits on your auto insurance?__Yes__No__Don't know

Auto Insurance Company_____Claim Number_____

Agent Name_____Phone Number_____

Medicare Advanced Beneficiary Notice:

All Medicare patients are responsible for their $155 deductible for chiropractic care. Medicare does not cover exams, but requires them before any adjustments of the spine can be performed. Medicare does not cover x-rays, but they may be necessary for treatment to occur. Medicare provides coverage for chiropractic adjustments when Medicare rules are met. The patient is responsible for any services that are not covered by Medicare or supplemental insurance.

Assignment and Release:

I agree to treatment by my doctor and such person's of the doctor's choosing, which may include interns, preceptors, Chiropractic Assistants, etc. and hereby provide my consent for treatment. I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Charles Barrett Deubert (Doctor of Chiropractic) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

When you sign the consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You have the right to ask us to restrict the users or disclosers made for the purposes of treatment, payment, or health care operations. Please refer to our Notice of Privacy Practices for further information.

Patient Name

X_____

Patient Signature | Date | Witness Initials

X_____ **X_____** **X_____**

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DR. CHARLES BARRETT DEUBERT TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATED THIS ____ DAY OF _____, 20___

_____ _____

Patient Signature Witness Signature

Parental Consent for Minor Patient:

Patient Name: _____

Patient age: _____ DOB: _____

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to The Health Factory to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- ☐ I give permission to The Health Factory to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- ☐ If The Health Factory contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- ☐ I give permission to The Health Factory to use my name on a welcome board, referral board, and birthday board.
- ☐ I give permission to The Health Factory to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- ☐ I give permission to The Health Factory to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- ☐ I give The Health Factory permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- ☐ By signing this form you are giving The Health Factory permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at The Health Factory plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of The Health Factory. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by The Health Factory for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, The Health Factory will not refuse to provide treatment however, it will not be possible for The Health Factory to file third party billing on my behalf and I will be responsible for 1)payment in full at the time services are provided to me 2) scheduling my own appointments since The Health Factory will be unable to contact me 3) all contact with The Health Factory regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN:_____ DOB:_____Today's Date: _____

Patient's name (please print): _____

Patient's Signature: _____

_____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print):_____

Signature:_____

Description of Representative's Authority to Act on Patient's Behalf:_____