AGAPE APPLICATION & AUTHORIZATION FOR TREATMENT

Name_____Date:_____

Address:_____City_____State_____Zip_____

Home #_____Cell #_____Work #_____

EMAIL ADDRESS_____

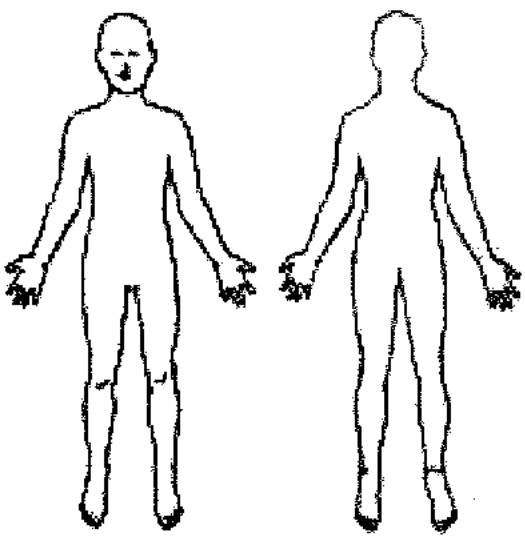
(will not share email addresses, for Agape Chiropractic promotional purposes only)

Date of Birth: _____ **Referred to our office by:** _____

Who is responsible for your bill? Self _____Spouse _____Employer _____Insurance_____

Please print name and address of responsible party_____

Employer: _____



If you are in pain, please mark the exact location of your pain on the diagran
Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standin when sitting, etc.

MAJOR COMPLAINT

(Please describe only your major problem)

_____

_____

_____

_____

_____

_____

Below please mark on a scale from zero to ten, I rate my pain as follows:

0 = No pain 10 =Severe pain

Neck-shoulder-arm pain	**Mid Back Pain**	**low back and leg pain**
0 _____ 10	0 _____ 10	0 _____ 10

How did this condition develop? (What caused it? How did it start? _____

_____

Any accidents, falls, etc., that might have caused your problem? _____

_____

Have you ever received any treatment for this condition? If yes, where, when, and what were your results?

_____

_____

_____

Has this problem been getting better, worse, or staying the same? _____

Is there anything that you do that makes your condition worse? _____

_____

Patient' Signature _____Social Security._____

Patient'Signature_____Social Security._____

AGAPE HEALTH HISTORY RECORD

Name: _____

Date of last physical examination_____
Please list all symptoms.

1._____
2._____

PLEASE CHECK ONLY THE ITEMS THAT APPLY TO YOU.

HAVE YOU EVER HAD….

Measles_____ Mumps_____ Chicken pox_____
Hay fever_____ Scarlet fever_____ Ringing in ears_____ Pneumonia_____
Influenza_____ Pleurisy_____
rheumatic fever_____ Bone/joint disease_____ Neuritis or neuralgias_____
Bursitis, Sciatica or lumbago_ Polio _____ Meningitis_____
Nephritis_____ Gallbladder disease _____ Anemia_____
Jaundice_____ Bladder disease_____ Epilepsy_____
Concussion/head injury_____ Enlarged glands____ recurrent sore throats___
Incontinence_____ broken/cracked/sprained bones__ Dislocations_____ Fainting
spells_____ colitis/other bowel disease_____ Earaches_____
Blurred/Double vision_____ Pain behind eyes____ Recurrent nose bleeds_____
Do you wear glasses_____ glasses last checked_____ Recurrent head colds_____
Sinus trouble_____ Night sweats/hot flashes_____ Chronic cough_____
Muscle spasms_____ Easy bruising_____ Inability to stand heat/cold_____ Chronic
cough laying down___ Heartburn_____ Recurrent stomach pains____

Weight now_____1 year ago_____ How many bed pillows to you use___ purple lips or fingers_____
Do you have shortness of breath when you: Walk several blocks_____One flight of stairs_____laying down____
Palpitations or fluttering of heart____Swelling of hands, feet or ankles_____What time of day?_____
Leg cramps-Walking/sleeping_____enlarged veins in legs_____ Recurring stomach pains_____

Signature of Patient_____Date_____

NECK DISABILITY INDEX
AGAPE CHIROPRACTIC CENTER

Name:_____ **Date:**_____ **File #:**_____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

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 extra 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 off the floor, but I can manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ 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 with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all due to pain.

SECTION 5 - Headaches

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

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 when I want to.
- ☐ 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 not do any work at all.

SECTION 8 - Driving

- ☐ I can 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 pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ 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 mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 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 at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

SIGNATURE_____

REVISED OSWESTRY INDEX(LOW BACK)
AGAPE CHIROPRACTIC CENTER

Name:_____ **Date:**_____

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 - Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderately increasing
- ☐ 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 (Washing, Dressing, etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

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 off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 - Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ 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 without pain.
- ☐ I can sit only 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 ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain standing, but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7 - Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

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 has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing . . .
- ☐ Pain has restricted my social life and I do not go much.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

SECTION 9 - Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain prevents all forms of travel except done lying down.
- ☐ Pain restricts all forms of travel.

SECTION 10 - Changing Degrees 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 slowly improves.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

SIGNATURE_____

AGAPE CHIROPRACTIC FINANCIAL POLICY

PAYMENT RESPONSIBILITY: SINCE YOU ARE THE INDIVIDUAL SEEKING MEDICAL SERVICES, YOU ARE RESPONSIBLE FOR PAYMENT OF ALL CHARGES ASSOCIATED WITH YOUR VISIT INCLUDING DEDUCTIBLE AND COPAY. IN CASE OF A MINOR, THE PARENT OR GUARDIAN THAT ACCOMPANIES THE PATIENT IS RESPONSIBLE FOR PAYMENT. UNACCOMPANIED MINORS MUST BRING PAYMENT WITH THEM.

REBILLING FEE: A REBILLING FEE OF $25.00 PER MONTH WILL BE CHARGED ON ALL OPEN ACCOUNTS OVER 30 DAYS OLD*, INCLUDING ACCOUNTS ON A PAYMENT PLAN.*

MISSED APPOINTMENTS: WE RESERVE THE RIGHT TO CHARGE A MISSED APPOINTMENT FEE FOR APPOINTMENTS MISSED, OR CANCELLED WITHOUT 24 HOURS NOTICE. A CHARGE OF $40.00 WILL BE CHARGED ON APPOINTMENTS WITH DR. HUFNAGLE AND $75.00 WILL BE CHARGED FOR APPOINTMENTS WITH THE MASSAGE THERAPIST.

RETURNED CHECKS: A FEE OF $30.00 WILL BE CHARGED FOR ANY RETURNED CHECK.

INSURANCE CLAIMS: OUR OFFICE WILL BILL YOUR INSURANCE, HOWEVER WE WOULD LIKE TO RESTATE THAT SINCE MEDICAL SERVICES ARE BEING PROVIDED TO YOU AND NOT YOU INSURANCE COMPANY, *YOU ARE RESPONSIBLE FOR YOUR BILL, NOT YOUR INSURANCE COMPANY.*

IF WE ARE A PARTICIPATING PROVIDER UNDER YOUR INSURANCE PLAN, PLEASE READ THE FOLLOWING CAREFULLY.

PROOF OF INSURANCE: THE INSURANCE CARD WILL BE CHECKED AT THE TIME YOU SIGN IN AND PAY FOR YOUR CO-PAY. PLEASE PRESENT THE CARD TO THE RECEPTIONIST. WE WILL ALSO MAKE A COPY OF THE CARD FOR OUR RECORDS.

USUAL AND CUSTOMARY RATES, AND SERVICES NOT COVERED: ALL SERVICES THAT ARE PROVIDED TO YOU ARE DUE AND PAYABLE AT THE TIME OF YOUR VISIT WHETHER OR NOT THE CHARGES ARE DEEMED USUAL AND CUSTOMARY BY YOUR INSURANCE COMPANY AND WHETHER OR NOT THE SERVICES ARE COVERED BY YOUR INSURANCE.

INSURANCE BENEFITS VERIFICATION: -WRITTEN OR VERBAL VERIFICATION FROM YOUR INSURANCE CARRIER IS REQUIRED IN ADVANCE AS A CONDITION FOR TREATMENT AS IS COMPLETION OF THE PATIENT AUTHORIZATION FOR TREATMENT FORM.

WE WOULD LIKE TO THANK YOU FOR THE TRUST YOU HAVE PLACED IN US FOR YOUR CHIROPRACTIC CARE. IF YOU HAVE ANY QUESTIONS ABOUT PAYMENT OR FINANCIAL RESPONSIBILITIES, PLEASE SPEAK WITH OUR OFFICE STAFF.

****** I HAVE READ, UNDERSTAND AND AGREE TO THE PROVISIONS OF THIS FINANCIAL POLICY.***

REVISED:11-1-06

SIGNATURE:_____DATE_____

AGAPE CHIROPRACTIC CENTER
118 S. MILWAUKEE AVE
LAKE VILLA, IL. 60046
(847) 356-9498

ELECTRONIC HEALTH RECORDS QUESTIONAIRE

Last Name, First Name_____
Ethnicity (ie: Japaneze, Chinese, Korean, Vietnamese)_____
Race (ie: Asian, White, African American, Latino) _____
Preferred Language_____
How do you want us to inform you of confidential information? (ie: cell, House phone, Work phone)_____
How do you want us to do reminders calls?_____

Address:_____
City, state, zip_____
Home Phone _____Cell _____Work_____

SSN_____
Date of Birth_____

Employer's Name:_____
Employer's Address:_____
Employer's City, Sate, Zip_____
Employer's Phone_____

Insured's Name_____
Relationship to the patient_____
Insured's Address_____
Insured's City, State, zip_____

Insurance Company_____
Insurance Company's Address_____
Insurance Company's City, State Zip_____
Insurance Company's ID_____Group # _____

Medications:_____Dosage(ie: 50 Mg)_____How Often_____

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Height_____ Weight_____

----------TO BE FILLED IN BY OFFICE STAFF----------

Blood Pressure_____BMI_____

NOTES_____
_____
_____

Over →

SMOKING

Are you a current smoker? Y N
If yes, how many packs per day_____

If not a current smoker, have you ever smoked? Y N
How long ago did you quit?_____
How many packs per day when you quit?_____

ALLERGIES

Do you have allergies to medications?
If yes, which ones_____
_____
_____
_____

Do you have any seasonal allergies?
If yes, which ones_____
_____
_____

Do you have any other allergies?
If yes, which ones_____
_____
_____

PATIENT INTAKE FORM

Patient Name_____ **Date**_____

Is today's problem caused by: __Auto Accident ___Workman's Compensation __Major medical

What is your: Height_____ Weight _____ Date of Birth_____
Occupation_____

How would you rate your overall health?
___Excellent __Very Good ___Good ___Fair ___Poor

What type of exercise do you do?
___Strenuous __Moderate ___ Light ___None

Please indicate if you or your immediate family members have any of the following:
___Rheumatoid Arthritis ___Diabetes ___Lupus ___Heart problems __Cancer __ALS Multiple Sclerosis____

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	
__	__	**Headaches**
__	__	**Neck Pain**
__	__	**Upper Back Pain**
__	__	**Mid Back Pain**
__	__	**Low Back Pain**
__	__	**Shoulder Pain**
__	__	**Elbow/Upper Arm Pain**
__	__	**Wrist Pain**
__	__	**Hand Pain**
__	__	**Hip Pain**
__	__	**Upper Leg Pain**
__	__	**Knee Pain**
__	__	**Ankle/Foot Pain**
__	__	**Jaw Pain**
__	__	**Joint Pain/Stiffness**
__	__	**Arthritis/Rheumatoid**
__	__	**Tumor**
__	__	**Muscular in coordination**

Past	Present	
__	__	**High Blood Pressure**
__	__	**Heart Attack**
__	__	**Chest Pains**
__	__	**Stroke**
__	__	**Angina**
__	__	**Kidney Stones**
__	__	**Bladder Infection**
__	__	**Painful Urination**
__	__	**Loss of Bladder Control**
__	__	**Prostate Problems**
__	__	**Abnormal Weight Gain/Loss**
__	__	**Loss of Appetite**
__	__	**Abdominal Pain**
__	__	**Ulcer**
__	__	**Hepatitis**
__	__	**Liver/Gall Bladder Disorder**
__	__	**General Fatigue**

Past	Present	
__	__	**Diabetes**
__	__	**Excessive Thirst**
__	__	**Frequent Urination**
__	__	**Smoking/tobacco use**
__	__	**Drug/Alcohol Dependence**
__	__	**Allergies/What**_____
__	__	**Depression**
__	__	**Systemic Lupus**
__	__	**Epilepsy**
__	__	**Dermatitis/Eczema/Rash**
__	__	**HIV/AIDS**
__	__	**Dizziness**
__	__	**Chronic Sinusitis**
__	__	**Visual Disturbances**
__	__	**Asthma**

For Females Only

__	__	**Birth Control Pills**
__	__	**Pregnancy**
__	__	**Hormonal Replacement**

List all prescription medications/dosage and times per day you are currently taking:_____

_____

List all of the over the counter medications or vitamins you are currently taking:_____

_____

Have you ever been hospitalized? Yes__ No__ Surgical Procedures? Yes___ No___ If yes, why_____

_____

PLEASE TURN OVER

What activities do you do at work?

__Sit	__Most of the day	__Half the day	__A little of the day
__Stand	__Most of the day	__Half the day	__A little of the day
__Computer work	__Most of the day	__Half the day	__A little of the day
__On the phone	__Most of the day	__Half the day	__A little of the day
__Frequently Travels	__Car	__Plane	__Other

What activities do you do outside of work?_____

_____

Have you seen any other chiropractor before? If yes, when?_____

_____

Have you had significant past trauma? If yes, please describe_____

_____

Anything else pertinent to your visit today?_____

_____

_____

Signature of Patient_____Date_____