AIM

Welcome to
Advanced Integrative Medicine

PERSONAL

Patient Name:

Address:

City/State/Zip:

Social Security #:

Gender: F / M   Marital Status:

Spouse's Name:

Patient's Birthdate: ___/___/___   Age:

Home Phone: Cell:

Email:

Send Statement c/o:

Address:

City/State/Zip:

Phone: Relation:

Emergency Contact:

Phone: Relation:

Employment

Employer:

Address:

Department:

City/State/Zip:

Phone: Ext:

Fax:

Email:

May we ask how you were referred?

My Primary Care Physician referred me for:

Doctor: Specialty:

Phone:

Attorney: *Phone:*

CASE

Were you in an Auto Accident?   Injury Date:

Were you in a Work related Injury?   Injury Date:

Will you be utilizing medical benefits?

NO Insurance	Insurance	______Fund	Auto/Accident Ins
Medicaid/Medical	Medicare	Government	Work Comp Ins

GUARANTOR

Policy Holder:

Address:

City/State/Zip:

Social Security #:

Gender: F / M   Birthdate: _____/_____/_____

Home Phone:

Employer:

Address:

City/State/Zip:

Work Phone:

_______**YES**, I have completed/filed the necessary benefits form.

Insurance Co:

Call Benefits @ (   )   -

Contact: Ext:

Group Name: Group #

ID/Claim #:

Patient is: self   spouse   child   3rd party

other:

Please initial:

____**YES**, I will pay my portion at the time of service.

____**YES**,this office has my permission to copy my driver's license or photo ID for the sole purpose of identification and verification.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I authorize the release of any medical information necessary to process and pay this claim. I authorize payment directly to ***Advanced Integrative Medicine*** of the "Health Benefits," "Medical Reimbursement" from a Third Party Payor and/or "Government Benefits" otherwise payable to me. I understand this office only accepts assignment when insurance pays directly.

I fully understand when the insurance company verifies my benefits, it is not a guarantee or authorization to pay on claims submitted. I agree to pay my portion, plus any balance insurance does not reimburse for, at each visit. I agree to pay/settle any denied/unpaid claims. I understand all claims submitted by this office are my responsibility and require my participation to settle regardless of my insurance company or assignment of benefits.

PRINT

Patient/Guarantor -PRINT name

x   /   /

Patient/Guarantor - signature   Date

Advanced Integrative Medicine

Neck Pain Disability Questionnaire I

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (please print): ______________________ Date: __________

Age: __________ Date of Birth: __________ Occupation: ______________

How long have you had neck pain? ______Years ______Months ______Weeks

Is this your first episode of neck pain? ______Yes ______No

Use the letters below to indicate the type and location of your sensations right now.
Please remember to complete both sides of this form.

KEY:	A= Ache	B= Burning	N= Numbness
	P= Pins & Needles	S= Stabbing	O= Other

Advanced Integrative Medicine

Neck Pain Disability Questionnaire II

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 — Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

Section 2 — Personal Care

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra 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.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned, for example, on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

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 to with slight pain in my neck.
C I can read as much as I want to 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 — Headaches

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.

After Vernon & Mior, 1991
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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 concentrating when I want to.
D I have a lot of difficulty concentrating when I want to.
E I have a great deal of difficulty 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 any 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 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 hr. sleepless).
C My sleep is mildly disturbed (1-2 hrs. sleepless).
D My sleep is moderately disturbed (2-3 hrs. sleepless).
E My sleep is greatly disturbed (3-5 hrs. sleepless).
F My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 — Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities, with some pain in my neck.
C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D I am able to 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.

REVISED January 1, 1995

Comments: ______________________________

____

Patient Signature: ______________________________ Date: ______________

Advanced Integrative Medicine

Patient Health Questionnaire

Patient Name ______________________ Date __________ ID # __________

If you have ever had a symptom in the past listed below, please check that symptom in the past column. If you are presently troubled by a particular symptom check the symptom in the present column. This is a history of various systems of your body and knowledge of these conditions may influence the type of treatment, therapy, or referral you may receive.

Past	Present	Conditions
____	____	Abdominal Pain
____	____	Abnormal Weight Gain/Loss
____	____	Angina
____	____	Anorexia
____	____	Aortic Aneurysm
____	____	Arthritis
____	____	Asthma
____	____	Bladder Infections
____	____	Blood Disorder
____	____	Breast Soreness/Lump
____	____	Cancer, explain
____	____	Chest Pains
____	____	Chronic Cough
____	____	Chronic Sinusitis
____	____	Colitis
____	____	Constipation/Irregular bowel habits
____	____	Convulsions
____	____	Diabetes
____	____	Depression
____	____	Dermatitis/Eczema/Rash
____	____	Difficulty in Swallowing
____	____	Dizziness
____	____	Emphysema (Chronic Lung Disorders)
____	____	Endometriosis
____	____	Epilepsy
____	____	Excessive Thirst
____	____	Fainting
____	____	Frequent Urination
____	____	General Fatigue
____	____	Hand Pain (R___ L___)
____	____	Headache
____	____	Heart Attack (date____________)
____	____	Heartburn/Indigestion
____	____	Hepatitis
____	____	High Blood Pressure
____	____	Irritable Colon

Past	Present	Conditions
____	____	Loss of Bladder Control
____	____	Low Back Pain
____	____	Mid Back Pain
____	____	Muscular Incoordination
____	____	Neck Pain
____	____	Pain in Ankle or Foot
____	____	Pain in Lower Leg or Knee
____	____	Pain in Upper Arm or Elbow
____	____	Pain in Upper Leg or Hip
____	____	Painful Urination
____	____	PMS
____	____	Profuse Menstrual Flow
____	____	Prostate Problems
____	____	Rapid Heart Beat
____	____	Rheumatoid Arthritis
____	____	Scoliosis
____	____	Shoulder Pain
____	____	Stroke (date_______________)
____	____	Swelling, Stiffness of Joint(s)
____	____	Tinnitus (Ear Noises)
____	____	Tumor, Explained ________________)
____	____	Ulcer
____	____	Visual Disturbances
____	____	Jaw Pain
____	____	Wrist Pain

FAMILY HISTORY:

If any of your immediate family members have/had the following, please mark the appropriate line.

	MOTHER	FATHER	BROTHER(S)	SISTER(S)
Cancer	____	____	____	____
Retinal Detachment	____	____	____	____
Chronic Back Problems	____	____	____	____
Kidney Failure	____	____	____	____
Cardiovascular Disease	____	____	____	____
Diabetes	____	____	____	____
High Blood Pressure	____	____	____	____
Rheumatoid Arthritis/Lupus	____	____	____	____

Have you ever had surgery or been hospitalized? ___No ___Yes ______________________

What medications are you currently taking? ______________________

Do you use tobacco? ___No ___Yes

Do you drink alcohol? ___No ___Yes

Do you have or have you had an alcohol, drug, or any other kind of addiction or dependence? ___No ___Yes

In the past 90 days have you had:

Weight gain or loss of 10 or more pounds: No Yes

Any loss of appetite: No Yes

Fevers, Chills, or Night Sweats: No Yes

Doctor's Notes ______________________

____

____

____

x ______________________

Patient Signature Date