MEININGER*clinic*
MARK J. MEININGER, BS, DC, CME, CCSP®
Whiplash Case Management, Sports Injury and Spinal Care
National Registry of Certified Medical Examiners

CONFIDENTIAL HEALTH INFORMATION

550 Hampton Road - PO Box 3369
McDonough, GA 30253
Phone (770) 957-7881
Fax (770) 957-6283

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes

When?

Patient Number (office use only)

If so, whom?

Age

Gender ○ Male ○ Female

Race ○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American ○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White ○ Decline to answer

Ethnicity ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over) ○ Never A Smoker ○ Former Smoker ○ Current Every Day Smoker ○ Current Some Day Smoker ○ Heavy Smoker ○ Light Smoker

Your First Name

Your Middle Name

Address

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

City | **State/Province** | **ZIP/Postal Code** | **Preferred Language**

Home Phone | **Cell Phone** | **Cell Phone Carrier** | **Spouse's Name**

Email Address

Emergency Contact | **Emergency Contact's Phone** | **Relationship to Emergency Contact**

Your Occupation

Your Employer | **Work Phone**

Address

May we contact you at work? ○ Yes ○ No

City | **State/Province** | **ZIP/Postal Code**

Preferred method of contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Email

Primary Care Provider's Name

Insurance Carrier | **Policy Number and Claim Number**

Insured's Last Name | **Birth Date (MM/DD/YYYY)**

Who carries this policy? ○ Self ○ Spouse ○ Parent

Insured's First Name | **Insured's Middle Name (or Initial)**

Insured's Employer

Address

City | **State/Province** | **ZIP/Postal Code** | **Employer's Phone**

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____

Rate your pain using a scale of 0 - 10
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Mild----------Moderate---------Severe

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other _____

Secondary Complaint
The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____

Rate your pain using a scale of 0 - 10
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Mild----------Moderate---------Severe

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other _____

Additional Complaint
The additional symptom that prompted me to seek care today is: _____

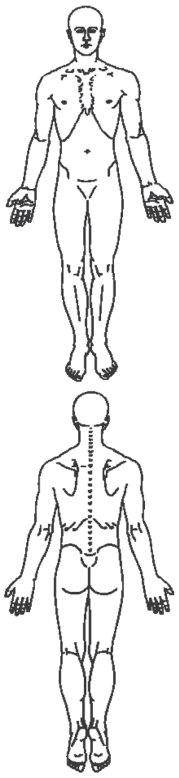
And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____

Rate your pain using a scale of 0 - 10
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Mild----------Moderate---------Severe

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other _____

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



1. What else should Dr. Meininger know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders	
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture	Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness	Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising	Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia	Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea	Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste	Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash	Initials ____

Patient name _____

Patient Number
(office use only) _____

Doctor's Initials _____

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(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	Initials ____

Patient name

Patient Number
(office use only)

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

7. Allergies

Are you allergic to any medications?

Yes	No	
○	○	If Yes please list: _____

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): _____

8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

9. Family History

Some health issues are hereditary. Tell Dr. Meininger about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

10. Are there any other hereditary health issues that you know about? _____

11. Social History

Tell Dr. Meininger about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much? _____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much? _____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much? _____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much? _____			

Hobbies: _____

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12. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. What is the major stressor in your life? _____

14. How much sleep do you average per night? _____ **Hours**

15. What is the type and approximate age of your mattress and pillow? _____

16. What is your preferred sleeping position? _____

17. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

20. What is your Height? _____ **What is your Weight?** _____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, unencrypted emails or personal health information to me or to an authorized recipient as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Patient (or Guardian's) signature

Date (MM/DD/YYYY)

Patient name

Patient Number
(office use only)

Consultation Notes

Doctor's Initials

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VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State _____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed? _____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

License Plate or TAG#

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

(If applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

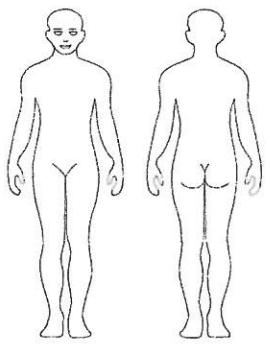
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Neck Index

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.

_____
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Back Index

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.

Doctor's Initials

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MARK J. MEININGER, BS, DC, CME, CCSP®
Whiplash Case Management, Sports Injury and Spinal Care
National Registry of Certified Medical Examiners

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550 Hampton Rd.
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McDonough, Georgia 30253
(770) 957-7881
Fax (770) 957-6283

Informed Consent

Chiropractic, along with other types of healthcare, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment in remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in contesting to treatment

Specific Risk Possibilities Associated with Chiropractic Care:

Stroke: Stroke is the most serious complication of Chiropractic Treatment, and the rarest. According to the journal of CCA, vol. 37, no. 2, June 1993, recent studies estimate the risk of this type of stroke is 1 in every 3 million upper cervical adjustments. Vertebral arteries, which supply the brain with blood, are located within the bones of the upper spine. Therefore, cervical treatment poses a small risk for a stroke, which could result in temporary or permanent brain dysfunction, with some extreme cases resulting in death.

Soreness: Chiropractic adjustments are sometimes accompanied with post treatment soreness. This is normal, but be sure to inform your doctor of Chiropractic of the soreness.

Soft Tissue Injury: Occasionally Chiropractic treatment may aggravate a disc injury, or cause a minor joint, ligament, tendon or other soft tissue injury.

Rib Injury: Manual adjustments to the thoracic spine could cause a rib injury or fracture. Keep in mind that this is very uncommon, and treatment is performed very carefully to minimize such risk. Precautions such as pre-adjustment X-rays are taken and thoroughly analyzed in cases that are considered at risk of such injury.

Physical Therapy Burns: Heat generated by physical therapy modalities can cause minor burns to the skin. Burns that are serious are very unlikely, but should be reported, as well, as other side effects you may be experiencing.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptoms, condition or disease. An attempt to provide the best Chiropractic care is our goal, and if the results are not successful, we will kindly refer you to another health care provider. If you have any questions, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have Chiropractic treatment administered.

_____ _____
Patient's Printed Name **Today's Date**

_____ _____
Patient's Signature **Parent or Guardian**
Signature if Minor

_____
Doctor's Initials

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ASSIGNMENT, LIEN, RELEASE & POWER OF ATTORNEY

THIS ASSIGNMENT, LIEN, RELEASE, AND POWER OF ATTORNEY (hereinafter the "Agreement"), is entered into this _____ Day of _____, 20____between _____hereinafter "Patient" and Dr. Mark J. Meininger PC.

WHEREAS Patient desires to receive chiropractic services from Dr. Mark J. Meininger PC and desires to assign certain rights and benefits to Dr. Mark J. Meininger PC for such benefits.

Accordingly, Patient hereby enters into this contract and consents to and agrees to the following provisions:

A. Patient hereby authorizes Dr. Mark J. Meininger PC to furnish a full report and records regarding Patient's case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all tests of any type or character to Patient's attorney and insurer(s).
B. Patient hereby assigns to Dr. Mark J. Meininger PC any and all benefits payable by Patient's insurance plan(s), Patient's health care plan(s), and any and all benefits payable by an insurer or any other person or entity as a result of charges incurred by Patient for services rendered by Dr. Mark J. Meininger PC. Patient also assigns to Dr. Mark J. Meininger PC any and all contractual rights Patient has against insurers, health care benefit plan(s), or any other person or entity potentially liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Dr. Mark J. Meininger PC.
C. Patient fully understands that Patient is directly and fully responsible to Dr. Mark J. Meininger PC for all bills for services rendered and that this agreement is made solely for additional protection and consideration for Dr. Mark J. Meininger PC to await payment. Patient further understands that such payment to Dr. Mark J. Meininger PC is not contingent on any settlement, claim, judgment, or verdict that Patient may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other person or entity possibly liable to Patient for payment of heath care costs incurred by Patient as a result of services rendered by Dr. Mark J. Meininger PC, Patient agrees to be responsible for any such outstanding balance, including interest at a rate of 1% per month, plus attorney's fees, court costs and postage costs incurred by Dr. Mark J. Meininger PC.
D. Patient fully understands that this lien and assignment given to Dr. Mark J. Meininger PC herein is irrevocable.
E. By executing this Agreement, Patient hereby instructs and directs any attorney representing Patient to honor this Agreement and issue payment directly to **Dr. Mark J. Meininger PC, PO BOX 3369, 550 Hampton Road, McDonough, Georgia 30253, telephone number (770)957-7881.** Patient directs that his/her attorney be bound by this lien and treat it, irrevocably, as an assignment due to Dr. Mark J. Meininger PC. Dr. Mark J. Meininger PC is relying upon this Agreement, and as a result of such reliance, Dr. Mark J. Meininger PC is providing care and treatment for which this Agreement provides security for payment. Moreover, Patient agrees that Dr. Mark J. Meininger PC is to be viewed as a third-party beneficiary of this direction to Patient's attorney, and it is Patient's intent to impose upon Patient's attorney(s) an obligation to comply with the terms of this directive.
F. Patient hereby instructs and directs all insurers and all other persons possibly liable or responsible for Patient's healthcare costs to issue payment for healthcare services rendered by Dr. Mark J. Meininger PC directly to Dr. Mark J. Meininger PC, PO BOX 3369, 550 Hampton Road, McDonough, Georgia 30253, telephone number (770)957-7881.
G. Patient agrees that he or she has an obligation to provide a copy of this Agreement to Patient's attorney(s), insurer(s), and all other persons possibly liable or responsible for Patient's healthcare costs. Patient further agrees

Initials _____

that Dr. Mark J. Meininger PC has Patient's consent and authority to provide copies of this Agreement to any other person or entity it deems necessary.

H. **Patient agrees that in the event Patient receives any check, draft, deposit, transfer, title, property, or other payment subject to this Agreement, Patient agrees to act as fiduciary agent for Dr. Mark J. Meininger PC and will immediately deliver said check, draft, deposit, transfer, title, property, or other payment to Dr. Mark J. Meininger PC to be applied towards Patient's debt for services rendered.**

I. **In the event Patient's attorney or agent receives any type of check, draft, deposit, transfer, title, property, or other payment subject to this Agreement, Patient hereby instructs and directs his/her attorney to pay Dr. Mark J. Meininger PC in full for Patient's debt for services rendered.**

J. Patient hereby appoints Dr. Mark J. Meininger PC as Patient's true and lawful attorney, irrevocable, and with full power of substitution, for Patient and in Patient's name, to ask, demand, sue for, collect, endorse, sign and receive proceeds from insurance, other health benefits, and third-party claims relating to services rendered to Patient by Dr. Mark J. Meininger PC. Dr. Mark J. Meininger PC is not obligated or compelled to exercise such powers but may do so in its sole discretion. Patient agrees to fully cooperate with Dr. Mark J. Meininger PC in collecting said amounts.

K. Patient hereby authorizes Dr. Mark J. Meininger PC to receive a complete copy of Patient's insurance policy/policies, including any declarations, endorsements, conditions, limitations, or exclusions.

L. Being that this Agreement is contractual in nature and irrevocable, it will supersede any future bankruptcy filings and proceedings, and payment will still be due.

M. Patient agrees and understands that interest of 1% per month on any unpaid balance will begin to accrue 60 days after settlement of Patient's claim, judgment on Patient's claim, verdict on Patient's claim, or Patient's or Patient's attorney's receipt of any type of payment on Patient's claim, whichever occurs first.

N. Patient further agrees to provide to Dr. Mark J. Meininger PC the name of the alleged tortfeasor(s) and the alleged tortfeasor's/tortfeasors' insurer(s) once known by Patient or Patient's attorney.

O. A copy of these documents shall be as binding as the document bearing the original signatures.

_____ _____

Date Patient's Signature (and Guardian if Minor)

_____

Patient's Printed Name (and Guardian if Minor)

_____ _____

Date Dr. Mark J. Meininger PC

_____ _____

Date Patient's Attorney Signature

_____

Attorney's Printed Name

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PATIENT RESPONSIBILITY FOR PAYMENT

As a service to our patients, Dr. Mark J. Meininger PC will submit charges for chiropractic treatment to the patient's insurance company. I, hereby, authorize Dr. Mark J. Meininger, PC and/or Meininger Clinic to furnish information to my insurance carriers concerning my illness and/or treatment. I, hereby, assign to Dr. Mark J. Meininger, PC and/or Meininger Clinic all payments for chiropractic/medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Dr. Mark J. Meininger, PC and/or Meininger Clinic and the staff may attempt to verify in advance that the patient's insurance company will pay for specific chiropractic procedures. Occasionally, even though coverage was verified and an authorization may have been obtained before the chiropractic services were provided, the insurance company denies the claim. If the insurance company denies payment or will only pay a portion of the chiropractic bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible in addition to whatever amounts the insurance company does not pay.

I understand that if I obtain services from the chiropractor without a referral (HMO or POS) from my primary care physicians that I will be responsible for the amount that the insurance states is the responsibility of the patient. I agree to pay all chiropractic/ medical expenses within 30 days of the date that I am billed for those expenses, unless other arrangements have been made with Dr. Mark J. Meininger PC.

I understand that if my insurance company forwards the check to me that I will be responsible to endorse the check to Dr. Mark J. Meininger, PC and/or Meininger Clinic immediately for services rendered at the office of Dr. Mark J. Meininger, PC and/or Meininger Clinic.

CONTRACTUAL AGREEMENT TO PAY CHIROPRACTIC EXPENSES

I agree to pay all **COPAYS, COINSURANCE AND DEDUCTIBLES** at the time of service, unless other arrangements have been made with Dr. Mark J. Meininger PC. I understand that if my account is not paid and is turned over to Dr. Mark J. Meininger, PC's collection agency that I will be responsible for the full amount owed, plus any legal fees, collection fees and attorney fees to Dr. Mark J. Meininger, PC.

_____ _____
Date **Patient or Patient's Guardian Signature**

_____
Patient's Printed Name

_____ _____
Date **Dr. Mark J. Meininger PC**

Current Employer: _____
Address: _____
_____
Employer Phone: _____

Current Insurer: _____
Address: _____
_____
Current Insurer Phone:_____

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PAYMENT INFORMATION

Who should we bill for your treatment cost? Please check one below.

[ ] Your Medical Insurance [ ] Attorney [ ] Your Auto insurance

[ ] The Person responsible for the Accident or [ ] Self Pay

The Patient is ultimately responsible for any and all treatment cost

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PLEASE PROVIDE THE FOLLOWING INFORMATION

_____
Name of Company Responsible for Payment

_____
Name of Insurance Adjuster of Attorney

_____
Phone Number and extension

_____
Claim# or Policy #

_____ _____
Print Name Date

_____
Signature