STEPHENSON CHIROPRACTIC

Dr. Jason D. Stephenson & Dr. Kimberly Stephenson

807 Rhodes Street Hartselle, AL 35640

256.773.1113

scwc@att.net

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy	palpation	vital signs
range of motion testing	orthopedic testing	basic neurological testing
muscle strength testing	postural analysis testing	
ultrasound	hot/cold therapy	EMS
radiographic studies		

The material risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

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The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with ***DR. Jason Stephenson*** and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated: _____**

_____ _____

Patient's Name Doctor's Name

_____ _____

Signature **Signature**

_____

Signature of Parent or Guardian (if a minor)

Trust Us To Get You Back In Action

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ESTIMATE OF INSURANCE BENEFITS

You are expected to know what your plan covers before you come in. There are so many plans and they are ever changing, so we cannot keep up with everyone. By signing below you are stating you understand and agree to the above statements.

Date_____

Patient Name_____ DOB_____

Based on information provided by your insurance company_____
we **estimate** your insurance benefits as follows:

Policy Effective date_____ Applicable Waiting Period_____

Deductible_____; Remaining_____

Co-Insurance / Co-pay: _____

X-Rays: * If deductible was already met, insurance pays 80% and patient pays 20%.
Otherwise patient pays 100%.
* Medicare will **not** cover x-rays or examination or therapy.
Limitations: * Number of Visits _____ or * $ Limit per benefit period _____

DME (Durable Medical Equipment) amount _____

Insurance Benefits Quoted by_____ Phone_____
(Insurance company personnel)

Verification Completed by_____
(Stephenson Chiropractic Center personnel)

THIS IS NOT A GUARANTEE OF PAYMENT

I,_____ ,understand that I will be billed and will have to pay any amount not paid by my insurance company.
Patient Signature_____Date_____

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CASE HISTORY

PLEASE FILL IN ALL THE BLANKS OR USE n/a

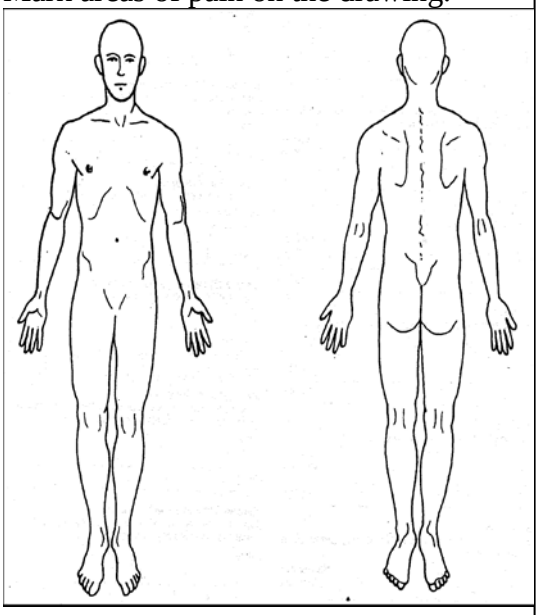
*Name: _____ Today's Date: _____
*Sex: Male ___ Female___ Date of Birth: _____ Age: _____
*Marital Status: Married ____ Single ____ Divorced ____ Widowed_____
Number of children _____
*Patient social security number: _____
Address: _____ City: _____
State: _____ Zip: _____Phone (Home): _____
Phone (Work): _____ Phone (cell) _____
E-mail address: _____

If responsible party is different from above: Name_____
Address: _____ City: _____
State: _____ Zip: _____Phone : _____
DOB: _____ SS#_____
Insurance info: _____
As the responsible party you will be liable for payment as stated below.

Patient Occupation: _____Employer:_____
Spouse Name: _____Spouse's Employer: _____
Spouse SS#:_____
Name of emergency contact _____Phone #_____
Have you seen a chiropractor before? Yes ___ No___
Chiropractor's name: _____
Who is your primary care physician? _____
How did you hear about our office? _____

Date of accident or beginning of symptoms: _____
Reason for your visit today? _____
Have you had this condition before ? Yes ___No___ When_____
When did it start? _____
What makes it worse_____ What makes it better_____
Does it interfere with Work___ Sleep___ Recreation___ Daily routine___ Other_____

Office use only
O_____
P_____
Q_____
R_____
S_____
T_____

AREAS AND SEVERITY OF PAIN **List the area of pain and circle the number below** to describe the amount of pain with "1" indicating minor discomfort and "10" representing severe pain. 1. _____ 1 2 3 4 5 6 7 8 9 10 2. _____ 1 2 3 4 5 6 7 8 9 10 3. _____ 1 2 3 4 5 6 7 8 9 10 4. _____ 1 2 3 4 5 6 7 8 9 10 5. _____ 1 2 3 4 5 6 7 8 9 10	Mark areas of pain on the drawing. 

Please list any concerns about your symptoms and anything else you would like the doctor to know:
_____
_____
_____

- **Habits:**
  - ☐ Smoking: Packs per day _____
  - ☐ Alcohol: Drinks per day / week _____
  - ☐ Coffee/Tea: Cups per day _____
  - ☐ Vitamins/herbs (list all being taken):_____
    _____
- **Exercise:** ___None; ___Moderate; ___Daily
- **Family History:**
  Has any member of your family had any of the following diseases?
  ___Diabetes; ___Kidney; ___Arthritis; ___Heart; ___Cancer; ___Lung
  Do you have any family members who suffer from the same condition you do? Yes___No___
  Who_____
- Have you had any of the following? (Please check or place an "x" in the box)
  - ☐ Appendicitis
  - ☐ Pneumonia
  - ☐ Diabetes
  - ☐ Anemia
  - ☐ Epilepsy
  - ☐ Hypertension
  - ☐ Cancer
  - ☐ Heart Disease
  - ☐ Polio
  - ☐ Rheumatic Fever
  - ☐ Arthritis
  - ☐ Tuberculosis
  - ☐ AIDS
  - ☐ Alcoholism

❖ Have you had any of the following **surgeries**? If yes, please list date.

- Tonsillectomy_____
- Hernia_____
- Stomach_____
- Sinus_____
- Vision correction_____
- Female organs_____
- TMJ_____
- Mastectomy_____
- Back_____
- Heart_____
- Gall bladder_____
- Tubes in ears_____
- Cataract_____
- Appendectomy_____
- Thyroid_____
- Breast Surgery_____
- Hemorrhoids_____
- Neck_____
- Prostate_____
- Joints_____

List ALL other surgeries please:_____

❖ List **any accidents, injuries, falls** and their dates:

- Car: _____
- Sports: _____
- School: _____
- Other: _____

❖ List any **broken bones or dislocations**:

_____
_____

Have you ever had a spinal tap or spinal injection? Yes __ No___
Have you even been knocked unconscious? Yes __ No___
Have you ever had a lapse in memory? Yes __ No___
Have you ever had, MRI or CAT scan of your spine? Yes __ No___ **When?** _____

❖ Do you suffer from any condition other than that for which you are consulting us?

_____

❖ Are you presently taking any prescription medication? __ Yes __ No
If yes, please list:

_____
_____
_____

❖ **WOMEN ONLY**
IS THERE ANY CHANCE YOU MAY BE PREGNANT? Yes____ No____

- cramps
- painful menstruation
- hot flashes
- irregular cycle
- breast lumps
- miscarriage

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that the doctor's office will as a courtesy bill my insurance for me one time and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for any balance due for services rendered. In our day and time insurance companies are hiring other companies to make demands of paperwork and information under impossible time restraints in order to not be responsible for the bill. You as the patient may not even be aware your insurance company has contracted you out to a 4th party. You as the patient are financially liable for the total amount whether they deny, ignore, or simply do not pay. This agreement supersedes any agreement whether blind or separate with third, fourth or fifth parties that have been contracted by your insurance companies which is not in accordance with the above information on this page and any other party will be considered null and void. You are fully responsible. In case of non-payment or default, I am responsible for all costs of collections including but not limited to court costs and reasonable attorney fees. Additionally in the event of non-payment or default, I will be responsible for any collection agency fees. I understand and agree that all debts not paid by the due date will accrue a TEN dollar ($10.00) monthly charge until balance is paid in full. When using a credit card there is a 5% charge for balances over $400.00. There will be a $35.00 fee for returned checks and credit/debit card charge backs or disputes. There will be a $25 charge for missed appointments unless cancelled within 24 hours. We have a $250.00 maximum balance policy, after your balance reaches $250.00 we have the right to not schedule you until the balance is paid down.

I hereby authorize the doctor to examine me and treat my condition as he or she deems appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. The doctor will not be held accountable for any pre-medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: _____ Date: _____

Review of Systems

Please fill out all of the sections. If none of the conditions apply, select “None”

Constitutional:
- **None**
- Chills
- Daytime Drowsiness
- Fatigue Fever
- Night Sweats
- Weight Gain
- Weight Loss

Eyes/Vision:
- **None**
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching (around the eye)
- Photophobia
- Tearing
- Wears Galsses/Contacts

Ears, Nose and Throat:
- **None**
- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infection(s)
- Ear Pain
- Fainting
- Headaches
- Head Injury (history of)
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Rhinorrhea (runny nose)
- Sinus Infections
- Snoring
- Sore Throats
- Tinnitus (ringing in the ears)
- TMJ Disorder

Respiration:
- **None**
- Asthma
- Coughing up Blood
- Shortness of Breath
- Sputum Production
- Wheezing

Cardiovascular:
- **None**
- Angina (chest pain or discomfort)
- Chest pain
- Claudication (leg pain or achiness)
- Heart Murmur
- Heart Problems
- Orthopnea (difficulty breathing while lying)
- Palpitations (irregular or forceful heart beat)
- Paroxysmal Nocturnal Dyspnea (shortness of breath at night)
- Shortness of Breath
- Swelling of Leg(s)
- Ulcers
- Varicose Veins

Gastrointestinal:
- **None**
- Abdominal Pain
- Belching
- Black, tarry stools
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice (yellowing of skin)
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber (quality)
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

Female:
- **None**
- Birth Control Therapy
- Birth Complications
- Burning Urination
- Hormone Therapy
- Irregular Menstruation
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

Male:
- **None**
- Burning Urination
- Erectile Dysfunction
- Frequent Urination
- Hesitancy or Dribbling
- Prostate Problems
- Urine Retention

Endocrine:
- **None**
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

Skin:
- **None**
- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia (numbness, prickling, or tingling)
- Rash
- History of Skin Disorders
- Skin Lesions or Ulcers
- Varicosities

Nervous System:
- **None**
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

Allergy:
- **None**
- Anaphylaxis (history of)
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

Hematology :
- **None**
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion(s)
- Bruises easily
- Fatigue
- Lymph Node Swelling

Psychological:
- **None**
- Anhedonia (inability to experience joy or enjoy life)
- Anxiety
- Appetite Changes
- Behavioral Change(s)
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Change(s)

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of the STEPHENSON CHIROPRACTIC & WELLNESS CENTER, PC'S *Notice of Privacy Practices for Protected Health Information.*

Date_____

_____ _____

Patient Signature Authorized Provider Rep.

_____ _____

Personal Representative Printed Personal Rep. Signature

Description of personal representative's authority to act for the patient

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I,_____ give permission to the people listed below to view, discuss or pick up my medical or billing information. The people listed below must present driver's license or a photo ID.

_____

_____

_____

As per Board of Chiropractic Examiners 190-X-5-.09 Request for medical records must be **stated in writing and signed by the patient.** The reasonable cost of reproducing copies of written or typed documents or reports shall not be more than one dollar ($1) for each page of the first 25 pages, not more than 50 cents ($.50) for each page in excess of 25 pages, and a search fee of five dollars($5). If the records are mailed to the person making the request, reasonable costs shall include the actual costs of mailing. A person may also charge the actual cost of reproducing X-rays and other special chiropractic records. A minimum of 24 hours is required for X-ray records, reports, or copies.

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Date _____Patient Signature _____

Authorized Provider Rep._____

Personal Representative Printed_____

Personal Rep. Signature_____

Description of personal representative's authority to act for the patient

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X-Rays and Records of Stephenson Chiropractic & Wellness Center, PC

In accordance with Alabama Chiropractic Law the x-rays that you are about to receive are permanent records of this office. This is in accordance with Alabama State Board of Chiropractic Examiners RULE 190-X-5-.09

The fee you are paying is for the information off the x-rays. In an effort to keep cost down you are not being charged in advance for copies of the x-rays. Hospitals add this to their initial fees.
You are able to obtain a free copy of the x-ray report with a signed request. The original x-rays will stay on this premise for five (5) years. If a copy is needed for another doctor's office or hospital you can obtain one for a nominal fee but the original films will not leave this premise.

This is in accordance with Alabama State Board of Chiropractic Examiners RULE 190-X-5-.09. Page 26 (2a) Upon request of a patient or authorized agent of a patient, licensees and clinics permit holder are required to, at a minimum, turn over to a patient or his or her authorized and accurate copies of any pertinent chiropractic records of the patient when requested to do so by the patient or his or her authorized agent for a legitimate purpose which is stated in writing and signed by the patient. The reasonable costs of reproducing copies of written or typed documents, or reports shall not be more than one dollar ($1) for each page of the first 25 pages, not more than 50 cents ($.50) for each page in excess of 25, making the request, reasonable costs shall include the actual cost of mailing. A reasonable timeframe of less than 2 weeks to pick up records will be honored but not guaranteed.

_____ _____

Patient Witness

_____ _____

Date Date

Trust Us To Get You Back In Action

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Liability Agreement

Stephenson Chiropractic & Wellness Center, PC has advised me that any examination and/or therapies I receive today may not be considered medically necessary. Although Insurance may reduce or deny reimbursement for the procedure(s), I have advised the doctor to proceed with the service(s) and I will assume full responsibility for payment on all procedures. Your insurance agreement is between you and your insurance provider. As a courtesy we will file your insurance for you.

In the case of MEDICARE, your visits are counted backwards for the past 365 days. We cannot predict what Medicare will or will not do - you need to be prepared to pay in case Medicare doesn't.

In case of no insurance or extremely high deductibles, we offer a time-of-service discount of 15%. That must be paid at the time of service, not tomorrow or next week or on payday. Again, be prepared to pay the full amount at a later date if you cannot pay at the time of service. We have a $250.00 maximum balance policy: after your balance reaches $250.00 we have the right to not schedule you until the balance is paid off. **ALL NUTRITION SALES ARE FINAL IF OPENED!!**

Date:_____Signature:_____1

Date:_____Signature:_____2

Date:_____Signature:_____3

Date:_____Signature:_____4

Date:_____Signature:_____5

Date:_____Signature:_____6

Date:_____Signature:_____7

Date:_____Signature:_____8

Date:_____Signature:_____9

Date:_____Signature:_____10

Date:_____Signature:_____11

Date:_____Signature:_____12

Date:_____Signature:_____13

Date:_____Signature:_____14

Date:_____Signature:_____15

Date:_____Signature:_____16

Date:_____Signature:_____17

Date:_____Signature:_____18

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EXPRESS CHECK OUT FORM

Patients who would like to utilize a credit card for their payments may do so in our office, we accept American Express, Visa, MasterCard, and Discover. Payments may be paid at the time of service or on the last visit of the week. As a service to you and to keep your account current, we can automatically charge to your designated card below. This procedure will enable you to spread out your payments if you wish and make them smaller while keeping your account current.

CREDIT CARD: ❒ AMEX ❒ VISA ❒ MC ❒ DISCOVER

CARDHOLDER NAME _____

CARD # _____ EXP. DATE _____

ZIP CODE_____

I agree to the above terms and authorize you to charge any payment not paid by the end of each week to the above credit card.

_____ _____

SIGNATURE DATE

Trust Us To Get You Back In Action

Stephenson Chiropractic & Wellness Center, PC

Clinical Evaluation

Patient Name_____ Date_____

A. PHYSICAL EXAMINATION

1. Pulse_____ 2. Blood Pressure_____

B. NEUROLOGICAL ASSESSMENT

1. CEREBROVASCULAR FUNCTION

a. **BRUIT -** [**CAROTID** Right N ABN Left N ABN] [**SUBCLAVIAN** Right N ABN Left N ABN]

b. **CRANIOCERVICAL FUNCTIONAL MANEUVER** [Right + --] [Left + --]

2. DEEP TENDON REFLEXES

	Right	Left
a. BICEPS	0 1 2 3 4	0 1 2 3 4
b. TRICEPS	0 1 2 3 4	0 1 2 3 4
c. BRACHIORADIALIS	0 1 2 3 4	0 1 2 3 4
d. PATELLAR	0 1 2 3 4	0 1 2 3 4
e. ACHILLES	0 1 2 3 4	0 1 2 3 4

3. MOTOR EXAMINATION

a.UPPER EXTREMITY MOTOR FUNCTION

	Right	Left
1. Shoulder Abduction	0 1 2 3 4 5	0 1 2 3 4 5
2. Wrist Extension	0 1 2 3 4 5	0 1 2 3 4 5
3. Wrist Flexion	0 1 2 3 4 5	0 1 2 3 4 5
4. Finger Extension	0 1 2 3 4 5	0 1 2 3 4 5
5. Finger Flexion	0 1 2 3 4 5	0 1 2 3 4 5
6. Finger Abduction	0 1 2 3 4 5	0 1 2 3 4 5
7. Finger Adduction	0 1 2 3 4 5	0 1 2 3 4 5

b. LOWER EXTREMITY MOTOR FUNCTION

	Right	Left
1. Hip Flexion	0 1 2 3 4 5	0 1 2 3 4 5
2. Leg Extension	0 1 2 3 4 5	0 1 2 3 4 5
3. Foot Dorsi-Flexion	0 1 2 3 4 5	0 1 2 3 4 5
4. Great Toe Dorsi-Flexion	0 1 2 3 4 5	0 1 2 3 4 5
5. Foot Plantar-Flexion	0 1 2 3 4 5	0 1 2 3 4 5
6. Great Toe Plantar-Flexion	0 1 2 3 4 5	0 1 2 3 4 5
7. Foot Eversion	0 1 2 3 4 5	0 1 2 3 4 5

C. ORTHOPEDIC EXAMINATION

1. CERVICAL SPINE

a. RANGE OF MOTION

1. Flexion	↓	N	↑	P
2. Extension	↓	N	↑	P
3. Right Lateral Flexion	↓	N	↑	P
4. Left Lateral Flexion	↓	N	↑	P
5. Right Rotation	↓	N	↑	P
6. Left Rotation	↓	N	↑	P

b. COMPRESSION TEST

1. Neutral + - P _____
2. Flexion + - P _____
3.Extension + - P _____
4. Right Lateral Flexion + - P _____
5. Left Lateral Flexion + - P _____

c. VALSALVA + -

d. DISTRACTION + -

2. LUMBAR SPINE

a. **RANGE OF MOTION**

1.Flexion	↓	N	↑	P
2.Extension	↓	N	↑	P
3.Right Lateral Flexion	↓	N	↑	P
4. Left Lateral Flexion	↓	N	↑	P
5. Right Rotation	↓	N	↑	P
6. Left Rotation	↓	N	↑	P

b. ROOT TENSION SIGNS

Full and Pain Free/ Back Pain/Leg Pain

1. Straight Leg Raise Right _____ _____ _____ 30 45 60 90
Left _____ _____ _____ 30 45 60 90

2. Braggard's Right + -- Left + --

3. Well Leg Raise Right + -- Left + --

4. Lindne + --

c. Valsalva + --

d. KEMP'S

1. Full and Pain Free Right _____Left_____

2. To Right-Pain
a. Back + -
b. Right Leg + -
c. Left Leg + -

3. To Left-Pain
a. Back + --
b. Right Leg + --
c. Left Leg + --

e. Fabere Patrick Right + -- Left + --

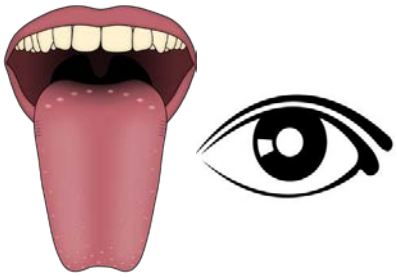
f. Postural Signs Minor's + --
Adam's + --
Antalgia Right_____ Left____Flexion_____

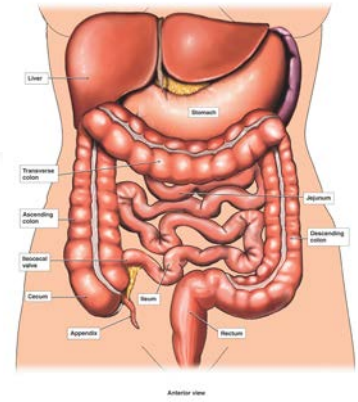
Cervical Dermatomes

C_3	+	-	Rt	Lt
C_4	+	-	Rt	Lt
C_5	+	-	Rt	Lt
C_6	+	-	Rt	Lt
C_7	+	-	Rt	Lt
C_8	+	-	Rt	Lt

Lumbar Dermatomes

L_3	+	-	Rt	Lt
L_4	+	-	Rt	Lt
L_5	+	-	Rt	Lt
S_1	+	-	Rt	Lt





Tissue Calcium

_____Cuff Pressure (240mm optimal)

CALCIUM SOURCE
- **Calcium Lactate**
- Calsol
- Cal-Ma Plus
- Calcifood

HORMONAL
- **Symplex F or M**
- Ovex
- Prostex/Ultrophin PMG
- For- Til B12

DIGESTION
- **Zypan**
- **A-F Betafood/Betafood**

OTHER FACTORS
- **Cataplex D**
- Boist
- Organically Bound Min.
- Trace Minerals B12
- Min-Tran

STEPHENSON CHIROPRACTIC

Dr. Jason D. Stephenson & Dr. Kimberly Stephenson

807 Rhodes Street Hartselle, AL 35640

256.773.1113

scwc@att.net

Patient name_____ Date_____

Height _____

Weight_____

Smoker_____ How many_____

Diabetic_____

Please list any medications_____

_____

_____

What are they for_____

Allergic to any
medications_____

Blood Pressure_____

ACCIDENT
V48.5xx_ (ADS) Accident non-collision, Due to loss of control (driver)
V48.6xx_ (ADS) Accident non-collision, due to loss of control (passenger)
W18.49x_ (ADS) Fall from slipping, tripping or stumbling
W10.8xx) (ADS) Fall on or from steps or stairs
V49.88xA Motor vehicle collision with another vehicle (driver)
V49.59xA Motor vehicle collision w/ another vehicle (passenger)
V03.10xA Motor vehicle collision with pedestrian (pedestrian

CERVICAL
M54.2 Cervicalgia
M53.0 Cervicocranial Syndrome
M53.1 Cervicobrachial Syndrome
M54.12 Radiculopathy Cervical
M54.13 Radiculopathy Cervicao-Thoracic
R42 Vertigo (Neuropathic)
CERVICAL DISC
M50.21 Displacement Of Cervical Disc – High Cervical
M50.22 Displacement Of Cervical Disc – Mid Cervical
M50.23 Displacement Of Cervical Disc – Cervico-thoracic
M50.31 Cervical Disc Degeneration – High Cervical
M50.32 Cervical Disc Degeneration – Mid Cervical
M50.33 Cervical Disc Degeneration – Cervic0-thoracic
M50.01 Cervical Disc Disorder With Myelopathy - High Cervical
M50.02 Cervical Disc Disorder With Myelopathy - Mid Cervical
M50.03 Cervical Disc Disorder With Myelopathy – Cervico-thoracic
M50.11 Cervical Disc Disorder With Radiculopathy - High Cervical
M50.12 Cervical Disc Disorder With Radiculopathy - Mid Cervical
M50.13 Cervical Disc Disorder With Radiculopathy – Cervico-thoracic
M48.02 Spinal Stenosis Cervical
M48.03 Spinal Stenosis Cervicao-Thoracic
CERVICAL INJURY
M43.6 Torticollis
G54.0 Thoracic Outlet Syndrome
S13.4xx_ (ADS) Sprain/Strain Injury to Cervical Area

CERVICAL SUBLUXATIONS
M99.00 OcciptoCervical
M99.01 Cervical
CURVATURE
M40.12 Postural Kyphosis, - Cervical
M40.14 Postural Kyphosis, - Thoracic
M40.46 Postural Lordosis, - Lumbar
FOREARM/ELBOW
M25.521 Pain in Right Elbow
M25.522 Pain in Left Elbow
M25.621 Stiffness of Right Elbow
M25.622 Stiffness of Left Elbow
M25.721 Osteophyte Right Elbow
M25.722 Osteophyte Left Elbow
M77.01 Medial Epicondylitis – Right Elbow
M77.02 Medial Epicondylitis – Left Elbow
M77.11 Lateral Epicondylitis – Right Elbow
M77.12 Lateral Epicondylitis – Left Elbow
M99.07 Subluxation of Upper Extremity
HEADACHES
G44.211 Episodic Tension Headache – Intractable
G44.219 Episodic Tension Headache – Not Intractable
R51 Headache (unspecified)
HIP JOINT
M16.0 Bilateral PrimaryOsteoarthritis of the Hip
M16.11 Unilateral PrimaryOsteoarthritis of the Right Hip
M16.12 Unilateral PrimaryOsteoarthritis of the Left Hip
M25.551 Pain in Right Hip
M25.552 Pain in Left Hip
JAW
S03.4xx_ (ADS) Sprain of Jaw
M26.63 Articular Disc Disorder of TMJ
KNEE
M22.01 Recurrent Subluxation of Right Patella
M22.02 Recurrent Subluxation of Left Patella
M25.661 Stiffness of Right Knee
M25.662 Stiffness of Left Knee
M99.06 Subluxation of Lower Extremity
M25.561 Pain in Right Knee
M25.562 Pain in Left Knee
R25.2 Cramps, Leg (general)

LUMBAR-DISC
M51.16 Lumbar Disc Disorder w/ Radiculopathy
M51.17 LumboSacral Disc Disorder w/ Radiculopathy
M51.26 Lumbar Disc Disorder w/o Radiculopathy
M51.27 LumboSacral Disc Disorder w/o Radiculopathy
M51.36 Lumbar Intervertebral Disc Degeneration
M51.37 LumboSacral Intervertebral Disc Degeneration
M48.06 Lumbar Spinal Stenosis
LUMBAR-PAIN
G57.01 Sciatic Nerve Lesion - Right
G57.02 Sciatic Nerve Lesion - Left
M54.5 Low Back Pain-Lumbago
M54.31 Sciatic Neuritis - Right
M54.32 Sciatic Neuritis - Left
M54.41 Lumbago w/Sciatica - Right
M54.42 Lumbago w/Sciatica - Left
LUMBAR-VERT DISPLACEMENT
M47.816 Lumbar Spondylosis Without Myelopathy
M47.16 Lumbar Spondylosis With Myelopathy
M99.03 Subluxation of the Lumbar Spine
Q76.2 Spondylolithesis [congenital]

SUBLUXATIONS
M99.00 OcciptoCervical
M99.01 Cervical
M99.02 Thoracic
M99.03 Lumbar
M99.04 Sacral
M99.05 Ilium (Pelvic)
M99.06 Lower Extremity
M99.07 Upper Extremity
M99.08 Rib
SHOULDER/HUMERUS
M25.511 Right Shoulder Joint Pain
M25.512 Left Shoulder Joint Pain
M25.611 Right Shoulder Stiffness
M25.612 Left Shoulder Stiffness
THORACIC/RIBS
G54.0 Thoracic Outlet Syndrome
G54.3 Thoracic Root Disorder
M54.6 Pain in Thoracic Spine
M99.02 Thoracic Subluxation
M99.08 Rib Subluxation
R07.1 Chest Pain on Breathing
R07.82 Intercostal Pain

G8783-Normal Blood Press(Redo 1 yr) G8950-Hypertens.(Redo 30 day) **Nutrition visit** **Nutrition follow-up**

G8730-Pain Assessment G8539-Functional Outcome Assessment (every 30 days) G8942-in file for 30days

98940 98941 98942 98943(sh, elb, wri, hip, knee, ankle, jaw) **99201 99202 99203 99211 99212 99213**

72040-C 72070-T 72100-L 73020-Sh 73070-El 73100-Wr 73560-Kn 73600-ank **Cold Laser** **Color Therapy**

97010-CRY 97012-TRX 97014/G0283-EMS EMS Wellness/S8990 97110-EXE 97112-NMR PRN

1 day 2 day 3 day 4 day 5 day 1 wk 2 wk 3wk 4wk 5wk 6wk / 1x 2x 3x 4x 5x this wk 1x 2x 3x 4x 5x nxt wk

DR. SIGNATURE_____ New injury date_____

Welcome

Patient Name:_____Date:____/_____/_____

Has there been a **new** incident/fall/accident? _____Date _____

What **Activity** led to today's visit?(Lifting, yard work, bent over, slept funny...?)_____

Where do you hurt **today**? _____Right Left Middle Upper Lower

What does it feel like: dull, stiff, sore, tight, sharp, stabbing, burning, shooting, pins and needles, tingling, numb, other_____

What part of day (or night) does your pain regularly occur?_____

What is it affecting in your life: sitting, standing, getting up and down, laying, bending over, walking, sleeping, driving, climbing stairs, lifting, yard work, house work, laundry, vacuuming, grooming, dressing, putting on shoes, computer, exercise, sports, shopping,

Does anything make your symptoms **better?** nothing, cold, chiropractic, massage, medication, movement, resting, sleeping, walking, warmth, heat,_____

Does anything make your symptoms **worse?** nothing, resting, sleeping, walking, working, movement, lifting, stress, standing, driving, sitting, house work, laundry, vacuuming, grooming, dressing, computer work_____

Please Rate your pain

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10