

**Halling Wellness Center  
2781 100th Street  
Urbandale, IA 50322  
(515) 334-0505  
Patient and Insurance Information**

Name(First, MI, Last) : \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Beeper/Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_ Marital Status: M S D Sep

Spouse Name: \_\_\_\_\_ # of Children: \_\_\_\_\_

Email address: \_\_\_\_\_ Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Health Insurance Info IF YOUR INSURANCE IS UNDER SOMEONE ELSE**

Patient Relationship to the Insured: Self Spouse Child Other

Carrier: \_\_\_\_\_ Ins. Co. Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Patient Relationship to the Insured: Self Spouse Child Other

*\* If you are covered under another person's insurance, please complete.*

Name of Insured: \_\_\_\_\_

Address of Insured: \_\_\_\_\_

Phone of Insured: \_\_\_\_\_ Sex: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Plan Name: \_\_\_\_\_

**Auto Accident Insurance IF YOUR VISIT IS THE RESULT OF AN ACCIDENT**

Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Person to Contact: \_\_\_\_\_ Claim #: \_\_\_\_\_

**Patient Registration and Consent for Chiropractic Treatment**

1. **Consent for Health Care Services:** I authorize consent for chiropractic treatment at *Halling Wellness Center*
2. **Authorization for Release or Information:** *Halling Wellness Center* may release information from my chiropractic records to any health care provider involved in my care and treatment. *Halling Wellness Center* may also release information from my chiropractic records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of chiropractic record information to an insurance company or other payer pursuant to this authorization, *Halling Wellness Center* is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by *Halling Wellness Center* which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill, unless other arrangements are made in advance. If Payment is not made within 90 days from the date the bill was mailed from *Halling Wellness Center*, I understand that a delinquent charge of interest rate of 10% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with *Halling Wellness Center*. I understand that I am responsible for a \$25.00 returned check fee in addition to any other associated bank charges.
4. **Preauthorization Requirements:** I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of *Halling Wellness Center* charges.
5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to *Halling Wellness Center* charges not paid.

**I acknowledge that:**

- I have read this form and understand its contents.
- I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.
- I am responsible for the payment and/or co-payment that is due at the time of service.
- I have read a copy of *Halling Wellness Center* HIPAA Policy which is available online at [www.hallingwellnesscenter.com](http://www.hallingwellnesscenter.com)

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Signature of Patient or Legally Responsible Person

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Name (PRINT)

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Relationship/Reason Why Patient is Unable to Sign

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Date

**Halling Wellness Center  
2781 100th Street  
Urbandale, IA 50322**

**CHIROPRACTIC INTAKE FORM**

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Family Physician / Internist: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**MEDICAL INFORMATION: TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE / HAVE HAD :**

- |                               |     |    |                                |     |    |
|-------------------------------|-----|----|--------------------------------|-----|----|
| 1. High Blood Pressure        | yes | no | 28. Blood in Stool / Ulcers    | yes | no |
| 2. Heart Disease Heart Attack | yes | no | 29. Abdominal Pain             | yes | no |
| 3. Chest Pains / Angina       | yes | no | 30. Thyroid Problems           | yes | no |
| 4. High Cholesterol           | yes | no | 31. Polio / Muscle Disease     | yes | no |
| 5. Pacemaker                  | yes | no | 32. Seizures                   | yes | no |
| 6. Shortness of Breath        | yes | no | 33. Migraine/Cluster Headaches | yes | no |
| 7. Asthma                     | yes | no | 34. TMJ Disorders              | yes | no |
| 8. Allergies                  | yes | no | 35. Chills/Fever/Sweats        | yes | no |
| 9. Chronic Bronchitis         | yes | no | 36. Chronic Headaches          | yes | no |
| 10. Blood Disorders           | yes | no | 37. Swelling of Extremities    | yes | no |
| 11. Emphysema                 | yes | no | 38. Sleep Disorders            | yes | no |
| 12. Bleeding/Bruising         | yes | no | 39. Depression                 | yes | no |
| 13. Anemia                    | yes | no | 40. Fibromyalgia               | yes | no |
| 14. Diabetes                  | yes | no | 41. Chronic Fatigue Syndrome   | yes | no |
| 15. Hypoglycemia              | yes | no | 42. Lyme's Disease             | yes | no |
| 16. Lightheadedness           | yes | no | 43. Chronic Pain               | yes | no |
| 17. Dizziness                 | yes | no | 44. Night Pain                 | yes | no |
| 18. Concussion                | yes | no | 45. Unexplained Pain           | yes | no |
| 19. Fainting Disorders        | yes | no | 46. Unexplained Weight Loss    | yes | no |
| 20. Anxiety/Panic Attacks     | yes | no | 47. Cancer/Tumors/Growths      | yes | no |
| 21. Arthritis/Joint Pain      | yes | no | 48. History of Smoking         | yes | no |
| 22. Artificial Joints         | yes | no | 49. Are you pregnant?          | yes | no |
| 23. Kidney Disease/Stones     | yes | no | 50. Gynecological Disorders    | yes | no |
| 24. Hepatitis                 | yes | no | 51. Bladder Incontinence       | yes | no |
| 25. Spinal Cord Injury        | yes | no | 52. Bowel Incontinence         | yes | no |
| 26. Traumatic Brain Injury    | yes | no | 53. Fractures                  | yes | no |
| 27. Ulcers                    | yes | no |                                |     |    |

Date: \_\_\_\_\_ Area: \_\_\_\_\_

Date: \_\_\_\_\_ Area: \_\_\_\_\_

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CURRENT MEDICATIONS: \_\_\_\_\_

**ALLERGIES:**

To Medications: \_\_\_\_\_

To Other Substances: \_\_\_\_\_

SURGERY (S) Include Dates: \_\_\_\_\_

X-RAYS, MRI, CAT SCANS (Include Area & Dates):

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SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

# Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev. 3/27/2003

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**1. Describe your symptoms**

\_\_\_\_\_

\_\_\_\_\_

a. When did your symptoms start?

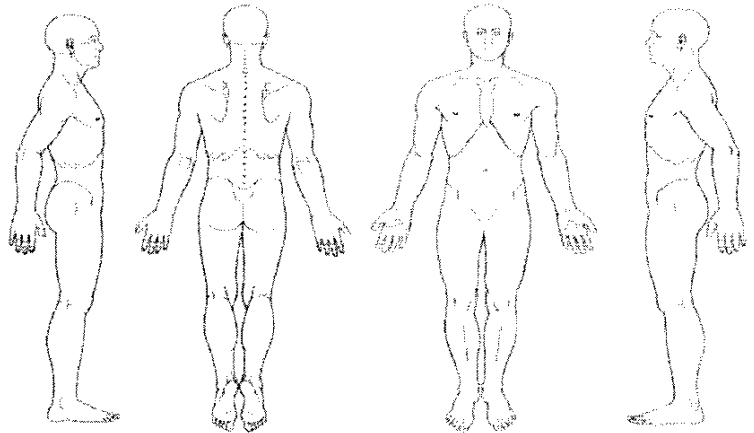
\_\_\_\_\_

b. How did your symptoms begin?

\_\_\_\_\_

**2. How often do you experience your symptoms? Indicate where you have pain or other symptoms**

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



**3. What describes the nature of your symptoms?**

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

**4. How are your symptoms changing?**

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

**5. During the past 4 weeks:**

a. Indicate the average intensity of your symptoms

- None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Unbearable ⑩

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

**6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)**

- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

**7. In general would you say your overall health right now is...**

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

**8. Who have you seen for your symptoms?**

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

\_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan date: \_\_\_\_\_
- ④ Other date: \_\_\_\_\_

**9. Have you had similar symptoms in the past?**

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

**10. What is your occupation?**

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

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

- Ⓐ 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 moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓟ The pain comes and goes and is very severe.
- Ⓡ The pain is very severe and does not vary much.

## 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 sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓟ Because of pain my normal sleep is reduced by less than 75%.
- Ⓡ Pain prevents me from sleeping at all.

## Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit 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 1/2 hour.
- Ⓟ Pain prevents me from sitting more than 10 minutes.
- Ⓡ I avoid sitting because it increases pain immediately.

## Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while 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 1/2 hour without increasing pain.
- Ⓟ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓡ I avoid standing because it increases pain immediately.

## Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓟ I cannot walk more than 1/4 mile without increasing pain.
- Ⓡ I cannot walk at all without increasing pain.

## Personal Care

- Ⓐ I do 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 increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases 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.

## Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes 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 off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓡ I can only lift very light weights.

## 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 cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓟ Pain restricts all forms of travel except that done while lying down.
- Ⓡ Pain restricts all forms of travel.

## Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓟ Pain has restricted my social life to my home.
- Ⓡ I have hardly any social life because of the pain.

## Changing degree 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 improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓟ My pain is gradually worsening.
- Ⓡ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back  
Index  
Score

# Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck  
Index  
Score

## **Informed Consent to Chiropractic Treatment**

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

**Other treatment options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**Unusual risks:** I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**WITNESS:**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**