Offices of Keith S. Overland, DC, CCSP

Patient Health History

Today's Date: ____________________

Patient Title: __Mr. __Mrs. __Ms. __Miss __Dr. __Prof. __Rev.

First Name: ____________________ **Nick Name:** ____________________

Last Name: ____________________ **Middle Name:** ____________________

Address 1 ____

Address 2 ____

City ____________________ **State** __________ **Zip +4** ____________

Mobile Phone ______________ **Home Phone** ____________________

Email ____________________________

- **Contact Method** (check one) **May we leave a message at that number?** _____
  __Mobile Phone __Home Phone __ Email
- **Would you like text or email appointment reminders?** ____ **Yes;** ____ **No**
  Yes, check one ____Text ____ Email

Date of Birth ______________ **Age** ____ **Gender** (check one) ___F ___M

Marital Status (check one) ___Single ___Married ___Divorced ___Widow

Spouse's Name: ____

Emergency Contact (name) ______________________________

(phone) ______________________________

Employment Status (check one)

__Employed __FT Student __PT Student __Other __Retired __Self Employed

Employer/School Name and Address: ________________________

____

Primary Care Physician Name: ______________________________

Address: ______________________________________

Do you currently smoke tobacco of any kind?

__Yes __Former Smoker __Never been a smoker

If yes, what is your level of interest in quitting smoking?

__0 __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

Current medications, including dosage if known

If there are no current medications, check here ____

1. ______________________ 5. ______________________
2. ______________________ 6. ______________________
3. ______________________ 7. ______________________
4. ______________________ 8. ______________________

List any known allergies you have had to any medications

If no allergies are known, check here _____

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

Briefly list your main health problems: ______________________

____

Has any doctor diagnosed you with cardiovascular issues? ___yes ___no

If yes what kind? ______________________

Has any doctor diagnosed you with Diabetes presently? ___yes ___no

If yes, what kind? ___Type I ___Type II ____ A1c>9.0%

What is the reason for your visit today: ______________________

____

Have you seen any other medical or chiropractic physician for this condition? ___Yes ___No

If yes, who/date: ______________________

Have you had an X-ray or CT Scan or MRI? ___Yes ___No ______________ Date

Were you injured due to: Auto Accident _____ Fall ______ Worker's Comp ______

If you checked one of the above, do you have an Attorney? _________

Attorney name and phone number: ______________________

____

Have you missed work due to your injuries? ___Yes ___No _____ For how long?

Who may we thank for referring you? ______________________

Please give our receptionist your insurance card AND a valid ID so that we may copy it for our records and verify your coverage. Thank you.

INFORMED CONSENT WAIVER & AUTHORIZATION TO TREAT

I the undersigned, acknowledge by my signature, that I am aware that Dr. Keith Overland is a licensed Chiropractic Physician and although very rare, injury from treatment or manipulation may have adverse effects. These may include or be associated with stroke, disc herniation, muscle strains or other injuries or complications.

Signature: ________________________________ Date: ____________

****In order to protect you from identity theft, The Federal Trade Commission requires our office to obtain a copy of your valid state/government issued ID to comply with The Fair and Accurate Credit Transactions Act (FACT Act) of 2003.**

030821

To be performed by office staff:

Height: __________ inches **Weight: __________ pounds**
BP: ________ / ________ **Pulse Rate: _____________**

Chiropractic Patient Information Form

Keith S. Overland, DC, CCSP, FICC
83 East Avenue, Ste. 313, Norwalk CT 06851

Patient to complete the following sections:

Patient Last Name	Patient First Name	M.I.	Gender ☐M ☐F	Age	Date of Birth (MM/DD/YYYY) / /

Chief Complaint(s): (1)________________________(2)________________________

(3)________________________ (4)________________________

Describe how condition began: ________________________

____

First Date of Symptoms: ________________________

Any other treatment(s)/Doctors/Hospitals/Therapists for this condition? ________ If yes,

Name(s) ________________________

When ________________________ Due to Auto Accident/Work Injury? ________________________

Were you given a permanent disability rating? _____ If yes, please give rating: ____________

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

Present:
Weight ____________lbs.
Height ______ ft. ________ inches

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

Can you perform your daily activities? ☐ Yes ☐ No (Describe) ________________________

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes Date(s) taken: ____________

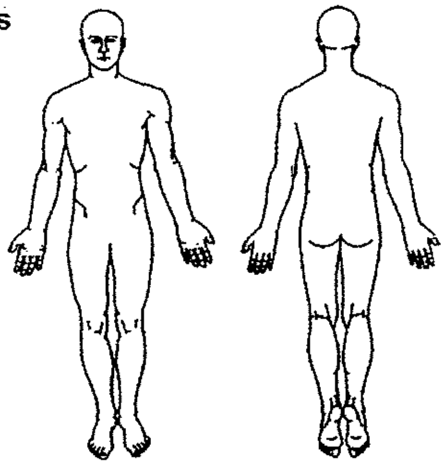
WHAT AREAS WERE TAKEN?________________________

For each complaint listed above, please check if it is better or worse with any of the following:

	HEAT better	HEAT worse	COLD better	COLD worse	REST better	REST worse	ACTIVITY better	ACTIVITY worse	OTHER (please describe on line below) better	OTHER worse
Complaint 1	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑ ____________
Complaint 2	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑ ____________
Complaint 3	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑ ____________
Complaint 4	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑ ____________

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

+++ Sharp or stabbing
ooo Pins and needles
vvv Dull or aching
/// Numbness



Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	**Normal**	**Somewhat limited**	**Severely limited**
Lifting	❑	❑	❑
Bending	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑
Sitting	❑	❑	❑
Climbing stairs	❑	❑	❑
Running	❑	❑	❑
Resting in bed	❑	❑	❑
Sports Activities	❑	❑	❑
Computer work/typing	❑	❑	❑
Normal work	❑	❑	❑
Household activities	❑	❑	❑
Recreational activities	❑	❑	❑
Other (list below)	❑	❑	❑

____

-Please Continue on Page 2-

Chiropractic Patient Information Form

Please continue ...

a. During what time of the day do you feel worse? ______

b. Do you sleep well? ❑ Yes ❑No What are your normal sleeping hours? ______to ______

c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
❑ No ❑ Yes → For what condition? ______

Name of doctor/provider ______ Phone number ______

d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
❑ No ❑ Yes If yes, please describe each event below:

Event ______ Year ______

Event ______ Year ______

e. Do you exercise? ❑ Yes ❑ No If yes, please describe activity ______

How many days a week? ______ How many minutes per session?______

List all current medications: ______

______

Personal history

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

Pain in body

- ❑ Neck pain with difficulty swallowing
- ❑ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- ❑ Leg pain that worsens with exercise but is relieved by resting
- ❑ Loss of feeling in inner thighs
- ❑ Back pain with urinary problems

Types of pain

- ❑ Severe pain interrupts sleep
- ❑ Constant pain that doesn't improve by changing positions or lying down

Current conditions

- ❑ Unable to balance when walking
- ❑ Recent unexplained weight loss
- ❑ Recent progressive muscle weakness or shaking
- ❑ Recent or current fever over 102°F
- ❑ Loss of bowel or bladder control
- ❑ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ❑ Recent major accident such as a fall from height, whiplash or blow to the head
- ❑ Memory loss after injury

Previously diagnosed condition/ medical history

- ❑ Congenital bone or joint disorder
- ❑ Rheumatoid arthritis
- ❑ Severe degenerative arthritis
- ❑ History of compression fracture
- ❑ History of heart attack
- ❑ History of stroke or aneurysm
- ❑ Past history of cancer or currently diagnosed with cancer
- ❑ Diabetes with cold, burning or numb feet
- ❑ Gout
- ❑ Lupus
- ❑ Ankylosing spondylitis
- ❑ Immune suppression such as from chemotherapy, organ transplant, etc.
- ❑ 3 or more months use of steroid medications or intravenous drugs (past or recent)

Tobacco Use - Y___ N ___ Alcohol Use - Y___ N ___ Pregnant - Y ___ N ___

Family history

❑ Autoimmune disorders ❑ Arthritis ❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Kidney disease ❑ Mental illness ❑ Seizure disorder

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature ______ Today's date:____/____/____

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name ______ Relationship ______ Today's date:____/____/____

Modified Neck Disability Index Questionnaire

Patient Name (please print): ____________________________

Please Read: This questionnaire is designed to give your doctor important information about how much your pain has affected your ability to manage everyday activities. Please answer each question by circling the **ONE CHOICE** that best describes the condition today. When finished, please complete the reverse side of this form. **Thank you.**

PAIN INTENSITY

0. I have no pain at the moment
1. The pain is mild at the moment
2. The pain comes and goes and is moderate
3. The pain is moderate and doesn't vary too much
4. The pain is severe but comes and goes
5. The pain is severe and doesn't vary too much

PERSONAL CARE (Washing, Dressing, etc.)

0. I can look after myself 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 manage most of my personal care
4. I need help everyday 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 objects without extra pain
1. I can lift heavy objects, but it causes extra pain
2. Pain prevents me from lifting heavy objects off the floor, but I can if they are conveniently positioned, for example on a table
3. Pain prevents me from lifting heavy objects, but I can manage light to medium objects if they are conveniently positioned
4. I can lift very light objects
5. I cannot lift or carry anything at all

READING

0. I can read as much as I want without pain in my neck/arm
1. I can read as much as I want with slight pain in my neck/arm
2. I can read as much as I want with moderate pain in my neck/arm
3. I cannot read as much as I want because of moderate pain in my neck/arm
4. I cannot read as much as I want because of moderate pain in my neck/arm
5. I cannot read at all

HEADACHE

0. I have no headache 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

CONCENTRATION

0. I can concentrate fully when I want to with no difficulty
1. I can concentrate fully when I want to with slight difficulty
2. I have a fair degree of difficulty concentrating when I want to
3. I have a lot of difficulty concentrating when I want to
4. I have a great deal of difficulty concentrating when I want to
5. I cannot concentrate at all

DRIVING

0. I can drive my car without 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 cannot drive my car as long as I want because of severe neck pain
5. I cannot drive my car at all

SLEEPING

0. pain does not prevent me from sleeping well
1. I get pain in bed, but it does not prevent me from sleeping well
2. Even when I take tablets I have less than 6 hours sleep
3. Even when I take tablets I have less than 4 hours sleep
4. Even when I take tablets I have less than 2 hours sleep
5. Pain prevents me from sleeping at all

SOCIAL AND RECREATIONAL LIFE

0. My social and recreational life is unchanged
1. My social/recreational life is unchanged, but increases pain
2. My social/recreational life is unchanged, but severely increases pain
3. Pain has restricted by social/recreational life
4. Pain has severely restricted my social/recreational life
5. I have essentially no social/recreational life because of pain

EMPLOYMENT/HOMEMAKING

0. My normal job/homemaking activities do not cause pain
1. My normal job/homemaking activities increase my pain, but I still perform all that is required of me
2. I can perform most of my job/homemaking activities, but pain prevents me from performing more physically stressful duties (vacuuming/lifting)
3. Pain prevents me from doing anything but light duties
4. Pain prevents me from doing even light duties
5. Pain prevents me from performing any job/homemaking activities

(OVER)

Modified Oswestry Back Pain Questionnaire

Patient Name (please print): ______________________________

Please Read: This questionnaire is designed to give your doctor important information about how much your pain has affected your ability to manage everyday activities. Please answer each question by circling the **ONE CHOICE** that best describes the condition today. When finished, please complete the reverse side of this form. **Thank you.**

PAIN INTENSITY

0. I have no pain at the moment
1. The pain is mild at the moment
2. The pain comes and goes and is moderate
3. The pain is moderate and doesn't vary too much
4. The pain is severe but comes and goes
5. The pain is severe and doesn't vary too much

PERSONAL CARE (Washing, Dressing, etc.)

0. I can look after myself 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 manage most of my personal care
4. I need help everyday 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 objects without extra pain
1. I can lift heavy objects, but it causes extra pain
2. Pain prevents me from lifting heavy objects off the floor, but I can if they are conveniently positioned, for example on a table
3. Pain prevents me from lifting heavy objects, but I can manage light to medium objects if they are conveniently positioned
4. I can lift very light objects
5. I cannot lift or carry anything at all

WALKING

0. I have no pain when walking
1. I have pain when I am walking, but I can still walk my required normal distances
2. Pain prevents me walking long distances more than 1 mile
3. Pain prevents me walking intermediate distances more than ½ mile
4. Pain prevents me walking short distances more than ¼ mile
5. Pain prevents me from walking 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 sitting more than 1 hour
3. Pain prevents me sitting more than ½ hour
4. Pain prevents me sitting more than 10 minutes
5. Pain prevents me sitting at all

STANDING

0. I can stand as long as I want without extra pain
1. I can stand as long as I want but it gives me extra pain
2. Pain prevents me standing for more than 1 hour
3. Pain prevents me standing for more than 30 minutes
4. Pain prevents me standing for more than 10 minutes
5. I avoid standing because it increases my pain right away

SLEEPING

0. Pain does not prevent me from sleeping well
1. I get pain in bed, but it does not prevent me from sleeping well
2. Even when I take tablets I have less than 6 hours sleep
3. Even when I take tablets I have less than 4hours sleep
4. Even when I take tablets I have less than 2hours sleep
5. Pain prevents me from sleeping at all

SOCIAL AND RECREATIONAL LIFE

0. My social and recreational life is unchanged
1. My social/recreational life is unchanged, but increases pain
2. My social/recreational life is unchanged, but severely increases my pain
3. Pain has restricted by social/recreational life
4. Pain has severely restricted my social/recreational life
5. I have essentially no social/recreational life because of pain

TRAVELING

0. I can travel anywhere without extra pain
1. I can travel anywhere but it gives me extra pain
2. Pain is bad but I manage journeys over 2 hours
3. Pain restricts me to journeys of less than 1 hour
4. Pain restricts me to short necessary journeys under 30 minutes
5. Pain prevents me from traveling except to the doctor or hospital

EMPLOYMENT/HOMEMAKING

0. my normal job/homemaking activities do not cause pain
1. my normal job/homemaking activities increase my pain, but I still perform all that is required of me
2. I can perform most of my job/homemaking activities, but pain prevents me from performing more physically stressful duties (vacuuming/lifting)
3. Pain prevents me from doing anything but light duties
4. Pain prevents me from doing even light duties
5. Pain prevents me from performing any job/homemaking activities

(OVER)

Keith S. Overland, DC, CCSP

Office Financial Policy

As a service to our patients, we will submit claims directly to your insurance carrier. To do so efficiently, we require your insurance information.

Yearly deductible, HSA payments and patient's portion of treatments can be paid by cash, check or credit card (all major cards accepted). **Co-Pays are due and payable at the time of each visit. Any check which is returned by your bank for non-sufficient funds will be subject to a $35.00 fee.**

Any or all portions of a rejected claim by an insurance company or managed care organization may be the responsibility of the patient. **Patient's who do not get a referral from their primary care doctor, when it is a requirement of their contract, will be responsible for their entire balance if the insurance carrier refuses to pay**. Patients may also be responsible for services not paid in full by your insurance company as well as non-covered procedures i.e., physical therapy, massage therapy, exercise prescriptions, etc., as well as services that are routinely covered, but determined to be not medically necessary by your insurance company.

We send monthly statements that will reflect all of your treatments and any payment made by you and/or your insurance company. Patients who fail to make payments for non-reimbursed services within 30 days will be responsible for costs of collection, 18% annual late fees, and reasonable attorney fees.

Please review your statement and feel free to call Dr. Overland's Office Manager with any questions or problems at (203) 838-9795. We are here to help.

I have read and understand the office financial policy and know that I am responsible for all the treatments that I receive.

Patient's Signature: ______________________________ Date: ____________

Patient's Printed Name: ____

Parent's Signature: ______________________________ Date: ____________
(If patient is a minor)

070720

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by the Office of Dr. Keith S. Overland for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Office of Dr. Keith S. Overland. I understand that diagnosis or treatment of me by Dr. Keith S. Overland may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Office of Dr. Keith S. Overland is not required to agree to the restrictions that I may request. However, if the Office of Dr. Keith S. Overland agrees to a restriction that I request, the restriction is binding on the Office of Dr. Keith S. Overland and Dr. Keith S. Overland.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Keith S. Overland or the Office of Dr. Keith S. Overland has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Office of Dr. Keith S. Overland's Notice of Privacy Practices prior to signing this document. The Office of Dr. Keith S. Overland's Notice of Privacy Practices has been made available to me. The Notice of Privacy Practices described the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Office of Dr. Keith S. Overland. The Notice of Privacy Practices for the Office of Dr. Keith S. Overland is provided at the front desk. This Notice of Privacy Practices also described by rights and the Office of Dr. Keith S. Overland's duties with respect to my protected health information.

The Office of Dr. Keith S. Overland reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

______________________________ ______________________
Signature of Patient or Personal Representative Date

______________________________ ______________________
Name of Patient or Personal Representative List Representatives Authority

Massage Therapy

Therapeutic massage provides relief of stress, pain and muscular discomfort. In our office, massage is often used as adjunct to other treatment options. We believe that integrating massage into your care would be of great benefit.

Below are some of our Office Policies with regards to massage:

- Therapeutic massage is offered by appointment on Monday, Friday and Saturday. We have several established State Licensed Massage Therapists who have worked in our office for up to 20 years. All are highly recommended.
- If the doctor prescribes massage, or if you decide this is an option you would like to explore, please make an appointment with the front desk.
- On the day of your massage, wear comfortable clothing and drink plenty of water before and after your scheduled massage.
- If for any reason you need to **cancel** your massage appointment, you are asked to do so **the day before**. Since same day appointments are difficult to fill, **cancellations made the same day are charged at full price**. Please be aware, if you have massage coverage through auto or worker's compensation insurance, it has been our experience that insurance companies will not pay for no-show appointments. So ultimately, this will become an out-of-pocket expense.
- **All massages are payable at time of service**. While health insurance did cover massage therapy at one time, that is no longer the case. If you feel that this should be a covered service under your health insurance, we can provide you with a statement that you can submit to them for reimbursement.
- **Auto and Worker's Compensation patients -** If covered, **insurance** companies typically **pay** for a short acute care **30-minute massage only**. No reduction of fee will be applied if your insurance company processes the fee at a lesser rate; **the reduction is transferred to you as non-covered**. If you would like an hour massage and it is not covered in full any balance after payment will be transferred to you. You will be responsible for payment on all non-covered services after your insurance has processed your claim (any part of the massage that your insurance does not cover).

Your signature at the bottom of this page confirms you are aware and agree to this policy.

Kindly let us know if we can make your therapeutic massage experience more beneficial.

Signed: ______________________________ Date: ____________________

Printed Name: ________________________

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