Dr. Anthony G Rump, D.C. QN

TELL US ABOUT YOU **(PLEASE PRINT CLEARLY)**

NAME:		SOCIAL SECURITY #:		DATE:
DATE OF BIRTH:	AGE:	SEX: M F	MARITAL STATUS: M S D W	# OF CHILDREN:
ADDRESS:				
CITY:		STATE:	ZIP:	
HOME PHONE #:		CELL PHONE #:		
E-MAIL ADDRESS:		OCCUPATION:		
COMPANY NAME:		LENGTH OF EMPLOYMENT:		
TYPE OF WORK:	OFFICE/CLERICAL	LIGHT LABOR	MODERATE LABOR	HEAVY LABOR
SPOUSES NAME:		SOCIAL SECURITY#		DATE OF BIRTH:
IN CASE OF EMERGENCY CONTACT NAME:			HOME PHONE #:	

TELL US ABOUT YOUR *PAST* HEALTH

Y	N	Frequent Neck Pain	Y	N	Alcohol / Drug Abuse	Y	N	Stroke
Y	N	Lower Back Pain	Y	N	Hepatitis	Y	N	Heart Surgery / Pacemaker
Y	N	Severe / Frequent Headaches	Y	N	HIV / Aids	Y	N	Heart Murmur
Y	N	Fainting / Seizures / Epilepsy	Y	N	Shingles	Y	N	Congenital Heart Defect
Y	N	Arm / Leg Pain	Y	N	Cancer	Y	N	Mitral Valve Prolapse
Y	N	Arthritis	Y	N	Chemotherapy	Y	N	Artificial Valves
Y	N	Artificial Limbs / Joints	Y	N	Anemia	Y	N	Rheumatic Fever
Y	N	Asthma / Emphysema	Y	N	Difficulty Breathing	Y	N	Diabetes / Tuberculosis
Y	N	Ulcers / Colitis	Y	N	Psychiatric Problems	Y	N	High / Low Blood Pressure
Y	N	Kidney Problems	Y	N	Heart Attack	Y	N	Fractures
Y	N	Workers Comp injuries	Y	N	Personal Injuries	Y	N	Sports or Other Injuries to Head, Neck or Back
Y	N	Hospitalized	Y	N	Chiropractic Care	Y	N	Surgery

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY VITAMINS YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY SERIOUS MEDICAL CONDITIONS YOU HAVE EVER HAD:

PRIMARY CARE PHYSICIAN:	PHONE #:
DATE OF LAST DOCTOR VISIT:	
LIST ANY THING YOU MAY BE ALLERGIC TO:	
LIST PAST SERIOUS ACCIDENTS:	

FAMILY HEALTH HISTORY:	DIABETES	CANCER	HEART DISEASE / STROKE	OTHER:	
DO YOU SMOKE?	Y N	HOW LONG?		PACKS PER DAY:	
ALCOHOL CONSUMPTION?	NEVER	SOCIAL	LIGHT	MODERATE	HEAVY

FOR WOMEN ONLY

DO YOU TAKE BIRTH CONTROL?	Y	N	IF YES, FOR HOW LONG?			
ARE YOU NURSING?	Y	N	ARE YOU PREGNANT	Y	N	DELIVERY DATE?

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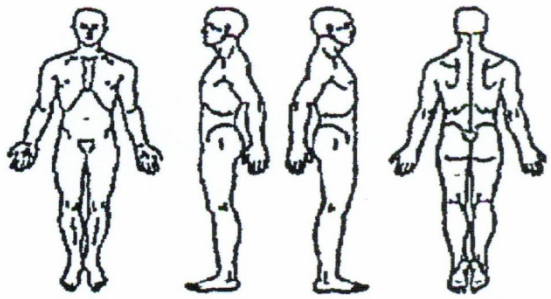
Name _____ **REASON FOR THIS VISIT Date** _____

THE REASON FOR THIS VISIT IS A RESULT OF (PLEASE CIRCLE): (If there is more then meets the eye – do you care?)	AUTO ACCIDENT	WORK INJURY	TRAUMA	SPORTS
	GRADUAL ONSET	CHRONIC	OTHER:	
DATE OF INJURY / WHEN DID THE CONDITION BEGIN?				
IS THE CONDITION GETTING WORSE? Y N STAYING THE SAME? Y N GETTING BETTER? Y N				
EXPLAIN WHAT HAPPENED:				
IS THIS CONDITION INTERFERING WITH YOUR (PLEASE CIRCLE):	WORK	SLEEP	DAILY ROUTINE	OTHER:
IF SO, PLEASE EXPLAIN:				

Please darken the body part(s) in which you are currently experiencing symptoms:



CHIEF COMPLAINTS

	Where does it hurt/symptoms?	ONSET (When did the pain start?)	PROVOCATIVE (What makes it worse?)	PALLIATIVE (What makes it better?)	QUALITY (Achy, stiff, sharp, burning, etc.)	RADIATION (Does the pain go down your arm / leg?)	SEVERITY (1 – 10)	TEMPORAL (When does it hurt? Constant, On and off)
1.								
2.								
3.								
4.								
5.								
6.								
7.								

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AUTHORIZATIONS: Name:_____ Date:_____

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment of this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon 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 payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable. Unpaid balance of more than 90 days will be turned over to a collections agency or Attorney. I understand that I will be responsible for all attorney, court and collection fees.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

INSURANCE INFORMATION (Please Present Your ID and Insurance Card to the Office Assistant)

WHO IS RESPONSIBLE FOR THIS ACCOUNT:

Signature_____ **Date** _____

Guardian Signature_____ **Date** _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Anthony Rump DC, LLC
3021 Harding Hwy. Ste. D Lima, Ohio
419-224-2221
www.docrump.com

Patient Name:_____ **Date:**_____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read below and if you have any questions please feel free to ask one of our staff members.

Informed Consent

A patient, in coming to the chiropractic/Quantum Neurologist Certified Practitioner (QNCP), gives the doctor permission and authority to care for the patient in accordance with the chiropractic/QN tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through the healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. Dr. Rump is a chiropractic doctor and a Quantum Neurologist Certified Practitioner that provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by Dr. Anthony Rump DC QNCP, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic/QN treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I AM / AM NOT (circle one) pregnant and **give my permission /do NOT give my permission** (circle one) to x-ray me for diagnostic interpretation.

Missed Appointments:

There is a possible fee charged for all appointments that are not cancelled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event we would need to communicate your healthcare information, to whom do we do so?

Spouse_____

Children_____

Others_____

No One_____

May we leave messages regarding your personal healthcare information on any answering devices?
I.e. home answering machines or voicemails Yes_____ No_____

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name_____ Signature_____

Date_____

Patient #:_____

General Pain Disability Index Questionnaire

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed: **PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.** A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

1. ***Family/Home Responsibilities.*** This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										*Totally unable to function*

2. ***Recreation.*** This category includes hobbies, sports, and other similar leisure time activities.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										*Totally unable to function*

3. ***Social Activity.*** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										*Totally unable to function*

4. ***Occupation.*** This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a homemaker or volunteer worker.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										*Totally unable to function*

5. ***Self Care.*** This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.).

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										*Totally unable to function*

6. ***Life-Support Activity.*** This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										*Totally unable to function*

Total Score: _____ **Signature:** _____ **Date:** _____