Oxford Health and Wellness Center
5144 College Corner Pike, Suite A
Oxford, OH 45056
(P) 513-524-4800
(F) 513-523-8631

Patient Profile

PERSONAL INFORMATION

Full Name: _____ Jr/Sr
Last *First* *M.I.*

Address: _____
Street Address *Apt/Unit*

_____
City *State* *Zip Code*

Primary Phone: _____ H/M/B Alternate Phone: _____ H/M/B

Birth Date: ____/____/____ Social Security #: ____-____-____

Gender at Birth: ☐ Male ☐ Female

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Declined ☐ Unknown/Unavailable
☐ Other _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined ☐ Unknown/Unavailable

Primary Language: _____

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you have any dependents? ☐ Yes ☐ No

Are you a full-time student? ☐ Yes ☐ No

Do you have Health Insurance? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If Yes, how many cigarettes daily? _____

How did you hear about our office? _____

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Patient Profile

PERSONAL INFORMATION

Patient Name: _____

What is the #1 thing that brings you here today?

_____

_____

How has this been affecting you:

Personally?

_____

_____

_____

Professionally?

_____

_____

_____

Have you been told this is something you have to live with? ☐ Yes ☐ No

Have you been told that surgery is your only option? ☐ Yes ☐ No

Do you take medications of any kind to ease the symptoms you are experiencing with this? ☐ Yes ☐ No

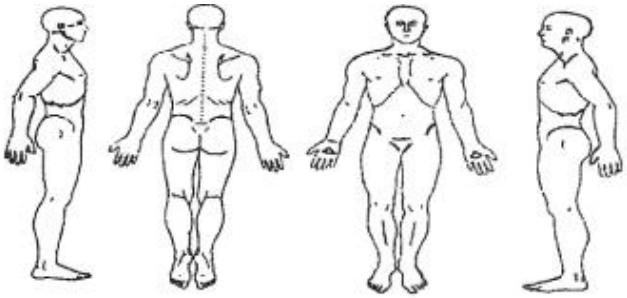
CASE HISTORY

Patient Name: _____

1. Circle the severity (0 = No Pain, 10 = Very Severe Pain) and Frequency of Pain (% of the week you experience the pain)

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of the week) (Occasional → Constant)
a._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Please mark the figures where you experience pain.



2. Symptoms are **worse** in the: (circle all that applies)

Morning	Increase during the day
Afternoon	Same all day
Evening	Decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

5. When did your symptoms begin? (onset date) _____

6. How did your symptoms begin? _____

7. Have you experienced these before? _____

8. Do your symptoms radiate? _____

9. Has your condition: ___ Improved ___ Gotten Worse ___ Stayed the same since it began

10. Circle the things that make your problems worse:
Bending / Lying / Walking / Standing / Sitting / Moving / Twisting / Lifting / Sleeping

11. Is there anything you can do to relieve the pain? Describe: _____
If no, what have you tried that did not help? _____

12. Have you been treated for this before? ___Yes ___No How long ago? _____

13. What treatment did you receive? _____

14. Results of previous treatment? ___Good ___Poor Comments: _____

15. Is this condition interfering with: ___Work ___Sleep ___Daily Routine ___Recreation

16. List any other major injuries you have had (other than those mentioned above):

_____

17. Any other Musculoskeletal problems? ___Yes ___No Describe:_____

18. Any other Neurological problems? ___Yes ___No Describe:_____

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Authorizations and Releases

Patient Name: _____

Consent to Professional Treatment
I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the Patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may I may refuse treatment at any time.
Initial ____

Consent to Perform and Interpret X-Rays
I hereby consent to the performance of diagnostic X-Rays as deemed necessary by the attending Physician and acknowledge that certain risks are associated with X-Rays. If applicable, I certify that I am a parent or legal guardian of the Patient and I hereby authorize the performance of diagnostic X-Rays on said minor as requested by the Physician.

I further agree that this practice may seek outside interpretation of my X-Rays by a qualified Professional not employed by this practice. I agree to any additional fees associated with this service and assign benefits to be paid directly to that professional by my third-party payer.
Initial ____

Females: Regarding Possibility of Pregnancy
This is to certify that, to the best of my knowledge, I am NOT pregnant. The Doctor and certified staff have permission to perform diagnostic X-Rays. I am aware that taking X-Rays, particularly those involving the pelvis, can be hazardous to a fetus.
Initial ____

Females: Consent to X-Ray During Pregnancy
This is to certify that, I am or may be pregnant and the Doctor or certified staff has my permission to perform diagnostic X-Rays involving and cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be used for over the trunk of my body. I have been advised that certain X-Rays, particularly those involving the pelvis, can be hazardous to a fetus.
Initial ____

Assignment of Benefits and Release of Records
I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my Insurance carrier(s), including Medicare and other government sponsored programs, if applicable, private Insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payers, including government agencies, Insurance carriers, or any other entities necessary to determine Insurance benefits or benefits payable for related services and supplies provided to me by the practice.
Initial ____

Financial Obligation
I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of Insurance coverage. I understand that my Insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract of State or Federal law. In some cases, exact Insurance benefits cannot be determined until the Insurance company receives the claim.

Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

You may direct any questions regarding this financial obligation to the Clinic manager or Physician.
Initial ____

Signature:_____ **Date:**_____

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Health Insurance Information

Patient Name: _____

Are you the Insured party? ☐ Yes ☐ No (if No, please fill out the Policy Holder information)

POLICY HOLDER INFORMATION

Full Name: _____ *Jr/Sr*
Last *First* *M.I.*

Address: _____
Street Address *Apt/Unit*

_____
City *State* *Zip Code*

Birth Date: ____/____/____

Social Security #: ____-____-____

Insured's Occupation: _____

Insured's Employer: _____

Employer Address: _____
Street Address *Unit #*

_____
City *State* *Zip Code*

Employer Phone: _____Ext.____

INSURANCE COMPANY INFORMATION

Insurance Company Name: _____

Address: _____
Street Address *Apt/Unit*

_____
City *State* *Zip Code*

Phone: _____Ext.____ Fax: _____

Group #: _____

Policy/Subscriber #: _____

Effective Date: ____/____/____ Expiration Date: ____/____/____

RESPONSIBLE PARTY INFORMATION

Relationship to You: _____

Full Name: _____ *Jr/Sr*
Last *First* *M.I.*

Address: _____
Street Address *Apt/Unit*

_____
City *State* *Zip Code*

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Employer Form

EMPLOYER INFORMATION

Patient Name: _____

Most Recent Employment

Your Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Not Employed ☐ Retired ☐ Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address *Apt/Unit*

_____
City *State* *Zip Code*

Employer Phone: _____ Ext. _____ Fax: _____

Start Date: ____/____/____ End Date: ____/____/____

Previous Employment

Your Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Not Employed ☐ Retired ☐ Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address *Apt/Unit*

_____
City *State* *Zip Code*

Employer Phone: _____ Ext. _____ Fax: _____

Start Date: ____/____/____ End Date: ____/____/____

Authorization, Assignment, Acknowledgment and Understanding

AUTHORIZATION TO RELEASE INFORMATION: Oxford Health & Wellness Center is authorized to release any information that it deems appropriate concerning my physical condition to any Insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Oxford Health & Wellness Center, including its designated associates and assistants. I hereby release Oxford Health & Wellness Center from any consequence and/or liability concerning the same.

ASSIGNMENT OF PAYMENT: My attorney and/or Insurance company are hereby requested to pay directly to Oxford Health & Wellness Center and monies due on the account, the same to be deducted from any settlement made of my behalf. Further, it is understood and agreed that I shall pay the full amount of the charges, should my condition be such that is not covered by my Insurance policy or if for any reason the Insurance company and/or attorney refuse and/or fails to pay my claim.

UNPAID INSURANCE BALANCE: I understand and agree that should there be any unpaid Insurance balance for sixty (60) days, such balance shall automatically become my responsibility.

MEDICARE ASSIGNMENT: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I authorize a copy of this authorization to be used in place of the original and request payment of medical Insurance benefits either to myself or to the party who accepts assignment below.

CONSENT TO CARE FOR A MINOR: I hereby authorize Oxford Health & Wellness Center to administer care as deemed necessary to: _____.

OBLIGATIONS AS TO SERVICES: I hereby acknowledge that I am receiving (or about to receive) health care services at Oxford Health & Wellness Center and that I have been advised that Oxford Health & Wellness Center is willing to wait for payment for these services so long as there continues to be a likelihood that payment will be made either by my Insurance company and/or out of the settlement of my liability case.

I understand and agree that, in the event that:

A. It is determined that there is no Insurance company obligation to pay for Oxford Health & Wellness Center's services;
B. The Insurance company for the undersigned refuses to acknowledge an assignment to Oxford Health & Wellness Center to take other actions for the protection of the interest of Oxford Health & Wellness Center.
C. My attorney fails and/or refuses to agree to protect the interest of Oxford Health & Wellness Center as determined in its sole discretion; or
D. I fail to retain an attorney

Then payment of services at Oxford Health & Wellness Center will be made on a current basis and my bill paid in full within sixty (60) days from my last treatment.

INTEREST AND COLLECTION: I acknowledge and agree that, should my account become more than thirty (30) days overdue, I will incur interest on my past due balance of ten percent (10%) per annum. I further acknowledge and agree that Oxford Health & Wellness Center shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all effort to collect on any past due account with Oxford Health & Wellness Center.

By my signature below, I make the foregoing authorizations, assignments, and agreements.

_____	_____	_____
Patient Name (Please Print)	**Patient Signature**	**Date Signed**

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Health History Form

PRESCRIPTION MEDICATIONS

Patient Name: ____

Prescription medications taken on a regular or ongoing basis:

Medication: ____________________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(if Other, please describe): ______________________________

Medication: ____________________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(if Other, please describe): ______________________________

Medication: ____________________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(if Other, please describe): ______________________________

Medication: ____________________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(if Other, please describe): ______________________________

Medication: ____________________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(if Other, please describe): ______________________________

Medication: ____________________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(if Other, please describe): ______________________________

Medication: ____________________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(if Other, please describe): ______________________________

Medication: ____________________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(if Other, please describe): ______________________________

Medication: ____________________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(if Other, please describe): ______________________________

Medication: ____________________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(if Other, please describe): ______________________________

Neck Index

Form N1-100

DOB:

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

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.

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

Neck Index Score

Back Index

Form BI100

DOB:

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

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.

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

Back Index Score