Rulli Chiropractic Clinic
7503 Brook Rd
Richmond, VA 23227

Confidential Patient Case History

Name _____ Social Security Number_____-_____-_____

Address_____ City_____ State_____ Zip_____

Home/Cell # (_____)_____ Work #(_____)_____ Email _____
Your email will NOT be shared.

Age _____ Birthdate_____ Marital Status: M S W D #Children_____

Occupation_____ Employer_____ Referred by_____

Emergency Contact Name_____ Emergency Contact's #(_____)_____

HEALTH INFORMATION:

What is your major complaint?_____

_____

Other complaints _____

How long have you had this condition? _____ Have you had this or similar condition in the past?_____

What activities aggravate your condition? ☐ Sitting ☐ Standing ☐ Stress ☐ Walking ☐ Running

☐ Exercise ☐ Bike Riding ☐ Daily Activities ☐ Bending ☐ House Cleaning ☐ Other-please explain

_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other

Other doctors who treated this condition _____

_____

List surgical operations and year _____

_____

Drugs you now take: ☐ Pain Killers ☐ Muscle Relaxers ☐ Anti-Inflammatory ☐ Blood Pressure Medication
☐ Cholesterol Medication ☐ Birth Control Pills ☐ Antidepressants ☐ Others _____

Are you wearing: ☐ Heel lifts ☐ Custom Orthotics ☐ Inner soles ☐ Arch supports

Have you been in an auto accident? ☐ Past five years ☐ Over five years ☐ Never

Have you ever had any other personal injury or accident: ☐ Past year ☐ Past five years ☐ Over five years

Describe _____

Primary Care Physician _____

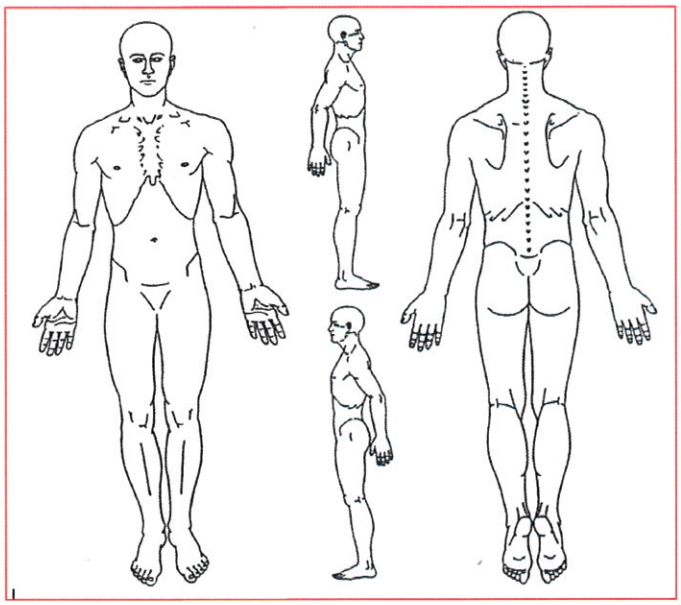
Date of last physical examination _____

Mark the area(s) on the below figures where you feel the described sensations.

Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness Pins & Needles Burning Aching Stabbing

..... 00000 XXXXX ^^^^^ /////



Neck – Shoulder – Arm Pain

On a scale of 0 to 10, I rate my discomfort as follows:

0=no pain 10=severe pain

Mid Back Pain

On a scale of 0 to 10, I rate my discomfort as follows:

0=no pain 10=severe pain

Low Back & Leg Pain

On a scale of 0 to 10, I rate my discomfort as follows:

0=no pain 10=severe pain

Please check all of the following that apply to you:

- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (Date)_____
- ☐ Corticosteroid Use (cortisone, prednisone, etc.)
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (explain)_____
- ☐ Osteoporoses
- ☐ Epilepsy/Seizures
- ☐ Bladder/Bowel Control Problems
- ☐ Blood in Urine
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant, #weeks _____
- ☐ Abnormal Weight Gain Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Other Health Problems (explain)

_____

_____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? ☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No If yes, Name of Company _____

Policy #_____

Are you covered by Medicare? ☐ Yes ☐ No If yes, Medicare #_____

I understand and agree that health and accident policies are an arrangement between an Insurance carrier and myself. Furthermore, I understand that this chiropractic 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 chiropractic 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 payment.

I understand that interest, in the amount of 2% will be added to my balance if payment is not received within thirty (30) days of bill date and will continue to accrue until my balance is paid in full ($0). I understand and agree to pay any and all attorney and collection fees, in the event it is necessary to forward my account to an attorney for collection proceeding.

I understand that it is my responsibility to cancel or reschedule my appointment(s) within 24 hours of the time scheduled. Failure to do so will result in a "no show" fee of $25.00 that is the sole responsibility of the patient.

Patient/Guardian's Signature_____ Date_____

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Oswestry Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please check the box for ***the one statement*** in each section that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that ***most closely*** describes your present-day situation.

Patient name _____ Date _____

*Please check **one** box in each section.*

Section 1 – Pain Intensity
- ☐ 0 I have no pain at the moment.
- ☐ 1 The pain is very mild at the moment.
- ☐ 2 The pain is moderate at the moment.
- ☐ 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.

Section 2 – Personal Care (washing, dressing, etc.)
- ☐ 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; I am slow and careful.
- ☐ 3 I need some help but 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.

Section 3 – Lifting
- ☐ 0 I can lift heavy weights without extra pain.
- ☐ 1 I can lift heavy weights, but it gives me extra pain.
- ☐ 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned - for example on a table.
- ☐ 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ 4 I can lift only very light weights.
- ☐ 5 I cannot lift or carry anything at all.

Section 4 - Reading
- ☐ 0 I can read as much as I want to with no pain in my neck.
- ☐ 1 I can read as much as I want to with slight pain in my neck.
- ☐ 2 I can read as much as I want with moderate neck pain.
- ☐ 3 I can't read as much as I want because of moderate neck pain.
- ☐ 4 I can hardly read at all because of severe pain in my neck.
- ☐ 5 I cannot read at all.

Section 5 – Headaches
- ☐ 0 I have no headaches at all.
- ☐ 1 I have slight headaches that come infrequently.
- ☐ 2 I have moderate headaches that come infrequently.
- ☐ 3 I have moderate headaches that come frequently.
- ☐ 4 I have severe headaches that come frequently.
- ☐ 5 I have headaches almost all the time.

Section 6 – 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 in concentrating when I want to.
- ☐ 3 I have a lot of difficulty in concentrating when I want to.
- ☐ 4 I have a great deal of difficulty in concentrating when I want to.
- ☐ 5 I cannot concentrate at all.

Section 7 – Work
- ☐ 0 I can do as much work as I want to.
- ☐ 1 I can only do my usual work but no more.
- ☐ 2 I can 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 can't do any work at all.

Section 8 – Driving
- ☐ 0 I can drive my car without any neck pain.
- ☐ 1 I can drive my car as long as I want with slight pain in my neck.
- ☐ 2 I can drive my car as long as I want with moderate pain in my neck.
- ☐ 3 I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ 4 I can hardly drive at all because of severe pain in my neck.
- ☐ 5 I can't drive my car at all.

Section 9 – 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).

Section 10 – Recreation
- ☐ 0 I am able to engage in all my recreation activities with no neck pain at all.
- ☐ 1 I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ 2 I am able to engage in most but not all of my usual recreation activities because of pain in my neck.
- ☐ 3 I am able to engage in a few of my recreation activities because of pain in my neck.
- ☐ 4 I can hardly do any recreation activities because of pain in my neck.
- ☐ 5 I can't do any recreation activities at all.

Score: _____ (50) Benchmark -5 = _____

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Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | 0 1 2 3 4 5 6 7 8 9 10 | ***Unbearable pain***

Patient name _____ Date _____

*Instructions: Please check **one box** in each section which most closely describes your problem.*

Section 1 – 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 severe.
- ☐ 5 The pain is severe and does not vary much.

Section 2 – Personal Care (washing, dressing, etc.)

- ☐ 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 increase the pain but I manage not to change my way of doing it.
- ☐ 3 Washing and dressing increase 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.

Section 3 – Lifting

- ☐ 0 I can lift heavy weights without extra pain.
- ☐ 1 I can lift heavy weights, but it gives me extra pain.
- ☐ 2 Pain prevents me from lifting heavy weights off the floor.
- ☐ 3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned, e.g., on a table.
- ☐ 4 Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ 5 I can only lift very light weights at most.

Section 4 - Walking

- ☐ 0 I have no pain on walking.
- ☐ 1 I have some pain on walking but it does not increase with distance.
- ☐ 2 I cannot walk more than 1 mile without increasing pain.
- ☐ 3 I cannot walk more than ½ mile without increasing pain.
- ☐ 4 I cannot walk more than ¼ mile without increasing pain.
- ☐ 5 I cannot walk at all without increasing pain.

Section 5 – Sitting

- ☐ 0 I can sit in any chair as long as I like.
- ☐ 1 I can sit only 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 ½ hour.
- ☐ 4 Pain prevents me from sitting more than 10 minutes.
- ☐ 5 I avoid sitting because it increases pain immediately.

TOTAL _____

Section 6 – Standing

- ☐ 0 I can stand as long as I want without pain.
- ☐ 1 I have some pain on standing but it does not increase with time.
- ☐ 2 I can't stand for longer than 1 hour without increasing pain.
- ☐ 3 I can't stand for longer than ½ hour without increasing pain.
- ☐ 4 I can't stand for longer than 10 minutes without increasing pain.
- ☐ 5 I avoid standing because it increases the pain immediately.

Section 7 – 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 nights sleep is reduced by less one-quarter.
- ☐ 3 Because of pain, my normal nights sleep is reduced by less than on-half.
- ☐ 4 Because of pain my normal nights sleep is reduced by less than three-quarters.
- ☐ 5 Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ 0 My social life is normal and gives me no pain.
- ☐ 1 My social life is normal but it increases the degree of pain.
- ☐ 2 Pain has no significant effect 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.

Section 9 – Traveling

- ☐ 0 I get no pain when traveling.
- ☐ 1 I get some pain when traveling but none of my usual forms of travel make it any worse.
- ☐ 2 I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ☐ 3 I get extra pain while traveling which compels to seek alternative forms of travel.
- ☐ 4 Pain restricts me to short necessary journeys under ½ hour.
- ☐ 5 Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain

- ☐ 0 My pain is rapidly getting better.
- ☐ 1 My pain fluctuates but 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.

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Informed Consent for Chiropractic and Acupuncture Services

Patient Name: _____ Date of Birth:_____

Purpose of Consent

You are being asked to consent to receive chiropractic and/or acupuncture care provided by licensed professionals at this clinic. This document is intended to inform you of the nature of the procedures, potential risks, benefits, and alternatives so you can make an informed decision.

Description of Services

Chiropractic Care

Chiropractic care involves the diagnosis and treatment of musculoskeletal disorders, primarily through manual adjustments and manipulations of the spine and other joints.

Common procedures may include:

- Spinal and extremity adjustments
- Physiotherapies such as electric muscle stimulation, ultrasound, hot/cold packs
- Dry needling
- Therapeutic exercises
- Postural and lifestyle counseling

Acupuncture

Acupuncture is a traditional Chinese medicine technique involving the insertion of fine needles into specific points on the body to promote healing and balance.

Common procedures may include:

- Needle insertion at acupuncture points
- Electroacupuncture
- Cupping or moxibustion (if applicable)

Potential Risks

While both chiropractic and acupuncture treatments are generally safe, some risks may include:

Chiropractic Risks:

- Temporary soreness or discomfort
- Muscle or ligament strain
- Rare risk of fracture, disc injury, or stroke (especially with cervical manipulation)

(over)

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Acupuncture/Dry Needling Risks:

- Minor bleeding or bruising
- Temporary soreness at needle sites
- Rare risk of infection or organ puncture

Potential Benefits

- Pain relief and improved mobility
- Reduced muscle tension and stress
- Enhanced overall wellness and energy
- Improved function of the nervous and immune systems

Alternatives

You may choose not to receive chiropractic or acupuncture care. Alternatives include:

- Conventional medical treatment
- Physical therapy
- Massage therapy
- Self-care and lifestyle modifications

Patient Rights

- You have the right to ask questions and receive answers regarding your care.
- You may withdraw consent and discontinue treatment at any time.
- You are encouraged to report any adverse reactions or concerns promptly.

Consent and Acknowledgment

I understand the nature of the chiropractic and acupuncture procedures proposed and the risks involved. I acknowledge that no guarantees have been made regarding the outcome of treatment. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.

I voluntarily consent to receive chiropractic and/or acupuncture care.

Signature of Patient (or Legal Guardian): _____

Date: _____

Signature of Provider: _____ Date: _____

(over)

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SHORT FORM
Privacy Consent Form
Required by Federal HIPAA Law #101-191
For Use or Disclosure of Private Health Information

- Trust is the foundation of a doctor/patient relationship.
- The information that you provide us is kept in the strictest of confidence.
- While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use of disclose your health care information:
    1. It may be necessary to use or disclose your private health information to another health care provider or hospital if it is necessary to refer you to hem for the diagnosis, assessment or treatment of your health information.
    2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services.
    3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes.

Please Note: We have a more detailed "Notice of Privacy for Private Health Information" and you have the right to review the detailed notice before you sign this consent form. We have the right to change our privacy practices as described in the detailed notice. If any changes occur in reference to our privacy practices, you will be notified by a posting of the change in the office or a notice will be sent to you in the mail. You may request a copy of our privacy notices at any time.

Patient Rights Under HIPAA Law

1. You have the right to request that we do not disclose your private health information to specific individuals, companies or organizations under the following circumstances:
    a. All requests must be in writing.
    b. By law we are not required to agree with your restrictions HOWEVER
    c. If we agree with your restrictions, the restriction is binding on us.
2. You have the right to REVOKE your Authorization under certain conditions:
    a. It must be in writing.
    b. The request will not be honored if we have already released your private health information before we received your request to revoke the authorization.
    c. If you were required to give your authorization as a condition of obtaining insurance, the insurance may have the right to your private health information should they decide to contest any of your claims.

I have read your consent policy and agree to its terms.
I also acknowledge that once I sign this consent form I will receive a copy of this completed form for my own records.

Printed Patient Name	Printed Authorized Witness Name
Signature	Signature
Date	Date

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SHORT FORM
AUTHORIZATION FOR APPOINTMENT REMINDERS & HEALTHCARE INFORMATION

There may be times when the doctor or members of the doctor's office, may need to use your private health information such as your name, address, phone number or clinical records for the following purposes:

- Appointment reminders,
- Birthday cards,
- Newsletters,
- "Thank you for your Referral" board,
- Patient sign in sheets,
- Social media, including Facebook,
- Information about alternative treatment and/or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder call, a message could be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and or/information.

Your Rights

You may restrict the individuals or organizations to which your PHI is released OR you may revoke your authorization to us at any time with the following rules:
Your revocations must be in writing and mailed to us at our office address.

We will not be able to honor your revocation request if:
If we have already released your private health information before we received your request to revoke the authorization.
If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your private health information should they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone that has access to the reminder or other information and may no longer be protected by the federal privacy rules.

If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for services rendered to you.

You have the right to inspect or copy the information that we use to contact you for appointment reminders, newsletters, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____.
I have read your authorization and agree to its terms.
My signature authorizes you to disclose my private health information in the manner described above and acknowledges that I will receive a copy of this completed form for my own records.

_____
Printed Patient Name

_____
Patient Signature

_____
Date

_____
Month/Day/Year

Nicholas Rulli, DC, CCSP, FIAMA
Printed Authorized Provider Name

_____
Signature of Authorized Provider Name

_____
Date

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FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS FORM

Eligibility Guarantee:

I, _____ hereby certify that I am eligible for
(Name of Patient/member/guardian)

chiropractic benefits offered by _____
(Name of Health Plan)

as of _____.
(Today's Date)

I understand that Rulli Chiropractic Clinic will file a claim to my insurance carrier as a courtesy to me, however, it is my responsibility to be knowledgeable regarding my insurance coverage and benefits.

Financial Responsibility:

I understand that if I am not eligible for benefits under the terms of my private or group health insurance, Medicare, workers' compensation or other health plan, I am liable for all charges for services rendered. In addition, if I am not eligible for medical benefits as noted above, I agree to pay in full for all services received within thirty (30) days of receiving a bill from the above chiropractor or health plan.

I understand that interest, in the amount of 2%, will be added to my balance if payment is not received within thirty (30) days of the bill date and will continue to accrue until my balance is paid in full ($0). I understand and agree to pay any and all attorney, collection fees and court costs, in the event it is necessary to forward my account to an attorney for collection proceedings.

Assignment of Benefits:

I authorize the release of any health information necessary to process my claims. A photo copy of this authorization shall be as effective and valid as the original.

I authorize and request my insurance company to make all medical benefits payments, otherwise payable to me, directly to Dr. Nicholas Rulli, c/o Rulli Chiropractic Clinic.

_____ _____
(Date) (Signature of Patient)