



Dr. Jonathan F. Berns

Dr. Erica D. Berns

Dr. Justin Scott

Dr. Melissa Kolenda

**Application For Patient Care**

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_ / \_\_ / \_\_ Male / Female Email: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Do we have permission to contact your doctor regarding your care in our office? \_\_\_ Yes \_\_\_ No

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

Employer's Address: \_\_\_\_\_

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

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ Spouse's DOB: \_\_\_\_\_

How Many Children Do You Have? \_\_\_\_\_ Children's Ages: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

How Often Do You Drink Alcoholic Beverages? \_\_\_\_\_

Do You Smoke?  Yes  No How Much? \_\_\_\_\_

Do You Exercise?  Yes  No How Often? \_\_\_\_\_

Do You Have Any Allergies? (specify) \_\_\_\_\_

Are You Pregnant? \_\_\_\_\_ Date of Last Menstrual Period? \_\_\_\_\_

Have You Ever Received Chiropractic Care?  Yes  No Last Visit? \_\_\_\_\_

Did They Take X-Rays?  Yes  No

How Did You Hear About This Office?  Existing Patient: \_\_\_\_\_

Walk-In/Drive-By  Radio: \_\_\_\_\_

Shapes  Internet: \_\_\_\_\_

LifeStyles  Ad: \_\_\_\_\_

Massage-A-Teacher: \_\_\_\_\_  Community Event: \_\_\_\_\_

Insurance Company: \_\_\_\_\_  Other: \_\_\_\_\_

What Medications Are You Currently Taking? \_\_\_\_\_

What Surgeries Have You Had? \_\_\_\_\_

List Any Recent Accidents or Falls: \_\_\_\_\_

What Is Your Primary Complaint? \_\_\_\_\_

How Long Have You Been Experiencing This Problem? \_\_\_\_\_

On A Scale of 1 to 10, How Severe Is It At It's Worst? 1 2 3 4 5 6 7 8 9 10

What % of Your Awake Time Do You Experience It? 0 10 20 30 40 50 60 70 80 90 100

What Makes It Feel Better? \_\_\_\_\_

What Makes It Feel Worse? \_\_\_\_\_

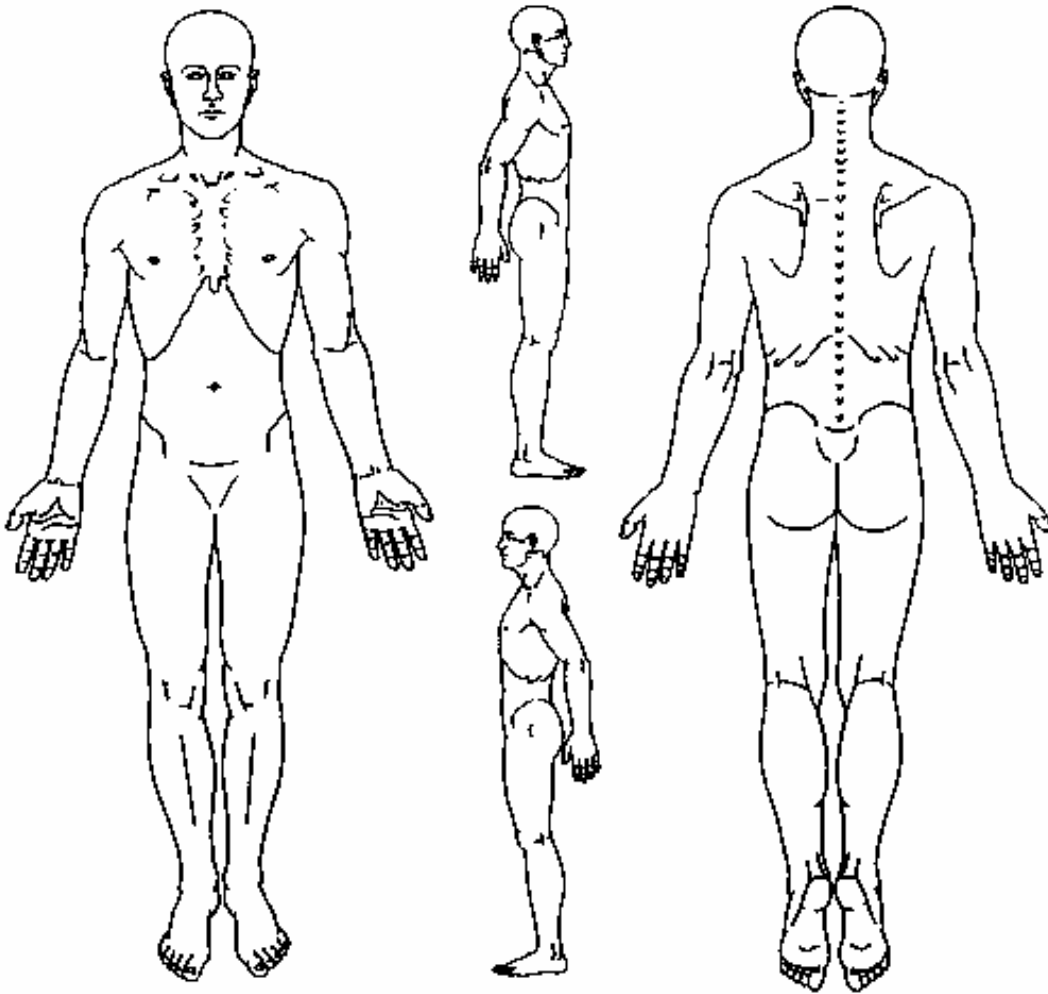
When Do You Notice It Most? (circle) Morning Afternoon Evening

I Have:  Been Hospitalized  Been Seen By Another Chiropractor

Been Seen By Another Doctor  Never Received Treatment For This Problem.

On the diagram below, label ALL areas you are experiencing symptoms using the appropriate letter from the box below.

**A=Aching    C=Cramping    R=Throbbing Pain    N=Numbness    O=Other**  
**B=Burning    D=Dull Pain    S=Stiffness    T=Tingling**



**Additional Complaints**

Mark with an "X" Current Symptoms and "O" Past Symptoms

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Arthritis                                | <input type="checkbox"/> Shoulder Pain           | <input type="checkbox"/> PMS                 |
| <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> Ear Infections          | <input type="checkbox"/> Menopausal Problems |
| <input type="checkbox"/> Swollen/Painful Joints                   | <input type="checkbox"/> Low Back Pain           | <input type="checkbox"/> Foot Trouble        |
| <input type="checkbox"/> Cancer                                   | <input type="checkbox"/> Pain with Cough/Sneeze  | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Depressed                                | <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> Coughing Blood      |
| <input type="checkbox"/> Allergies/Sinus                          | <input type="checkbox"/> Hip Pain                | <input type="checkbox"/> Pacemaker           |
| <input type="checkbox"/> Trouble Sleeping                         | <input type="checkbox"/> Gall Bladder            | <input type="checkbox"/> HIV Positive        |
| <input type="checkbox"/> Headaches                                | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Tumors              |
| <input type="checkbox"/> Trouble Concentrating                    | <input type="checkbox"/> Ulcers                  | <input type="checkbox"/> Eating Disorder     |
| <input type="checkbox"/> Learning Disability                      | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Mood Changes                             | <input type="checkbox"/> Heartburn               | <input type="checkbox"/> Congenital Disease  |
| <input type="checkbox"/> Dizziness                                | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Alcoholism          |
| <input type="checkbox"/> Neck Pain                                | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Drug Addiction      |
| <input type="checkbox"/> Numbness/Tingling<br>Hands / Legs / Feet | <input type="checkbox"/> Bed Wetting             | <input type="checkbox"/> Excessive Bleeding  |
| <input type="checkbox"/> Shoulders Feel Tired                     | <input type="checkbox"/> Diarrhea/Constipation   | <input type="checkbox"/> Heart Attack        |
| <input type="checkbox"/> TMJ Pain                                 | <input type="checkbox"/> Tremors                 | <input type="checkbox"/> Migraines           |
| <input type="checkbox"/> Asthma                                   | <input type="checkbox"/> Colon Trouble           | <input type="checkbox"/> Broken Bones        |
| <input type="checkbox"/> Loss of Balance                          | <input type="checkbox"/> Prostate Problems       | List: _____                                  |
| <input type="checkbox"/> Upper/Mid Back Pain                      | <input type="checkbox"/> Menstrual Problems      | <input type="checkbox"/> ADD/ADHD            |
|   |  | <input type="checkbox"/> Thyroid Problems    |

# Health History of Family Members

The reason for this form is to assist the doctor by providing past health history information for review.

<b>Condition</b>	<b>Self</b>	<b>Father</b>	<b>Mother</b>	<b>Spouse</b>	<b>Brothers</b>	<b>Sisters</b>	<b>Children</b>
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Difficulty Sleeping							
Disc Problems							
Ear Problems							
Emphysema							
Epilepsy/Seizures							
Fatigue							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neck Pain							
Numbness							
Pinched Nerve							
Scoliosis							
Sinus & Allergies							
Stomach Trouble							



LIFESOURCE  
HEALTH & WELLNESS

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**OFFICE POLICIES**

1. It is our office policy that any patient and /or insurance company that pays up-front or in advance is entitled to an administrative discount.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There may be a fee for copying of the x-rays.
3. If you have any out of pocket responsibility what will be your method of payment?

Cash      Check      Credit Card/Debit Card      Attorney /Letter of Protection.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and my self. Furthermore, I understand LifeSource Health & Wellness will prepare any necessary reports, and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to LifeSource Health & Wellness 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 at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.*

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature (or Guardian authorizing care): \_\_\_\_\_ Date: \_\_\_\_\_

In case of emergency notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

State: \_\_\_\_\_ Phone Number: \_\_\_\_\_



**Jonathan Berns, D.C.**  
**Justin Scott, D.C.**

**LIFESOURCE**  
HEALTH & WELLNESS

**Erica Berns, D.C.**  
**Melissa Kolenda, D.C.**

*“New Tampa’s Source for Maximizing Living”*

**TERMS OF ACCEPTANCE AND CONSENT FOR CARE**  
**THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR**  
**CHIROPRACTIC CARE**

Our office has one goal, to aid the patient in achieving optimal health as quickly and safely as possible, through the removal of interference in their body. We do this through safe and gentle chiropractic care.

We will attempt to identify and diagnose any ailments you may have that may be corrected through chiropractic care, massage therapy and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

Our primary focus is the detection and correction of vertebral subluxation. This is the misalignment of one spinal bone or multiple bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms. Again, our focus is to correct the cause, not the symptom.

Vertebral subluxations come on from physical, chemical, and/or emotional stress or trauma. Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It is also important to note that the sooner we are able to treat your subluxations and the degenerative processes that are involved the faster and more completely your body will heal. It may be necessary to examine an individual each time a new injury occurs and often x-rays are necessary to maintain the utmost safety when dealing with your body. The risks of chiropractic care or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

I have read and I accept the terms above and understand them fully. I hereby give consent to the LIFESOURCE HEALTH & WELLNESS to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at anytime discontinue with the exam and/or x-rays or any treatment if I so choose.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(PRINT NAME)

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)

Complete if patient is a minor child. \_\_\_\_\_  
(PRINT CHILD’S NAME)

I, \_\_\_\_\_ being the parent or legal guardian of the aforementioned child, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment.

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)



## **Privacy Notice**

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at LifeSource Health & Wellness, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive

chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Erica Berns or Dr. Jonathan Berns.

If you would like further information about our privacy policies and practices please contact: Dr. Erica Berns or Dr. Jonathan Berns.

This notice is effective as of January 1<sup>st</sup>, 2007. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Print)	Signature	Date

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Representative Name (Print)	Representative Signature	Date

\_\_\_\_\_  
Description of the authority to act on behalf of the patient.

# The Neck Disability Index

Patient name: \_\_\_\_\_ File# \_\_\_\_\_ Date: \_\_\_\_\_

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

## SECTION 1-PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

## SECTION 2-PERSONAL CARE (Washing, Dressing, etc.)

- I can look after myself normally, without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed; I wash with difficulty and stay in bed.

## SECTION 3-LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, 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 lift very light weights.
- I cannot lift or carry anything at all.

## SECTION 4-READING

- I can read as much as I want to, with no pain in my neck.
- I can read as much as I want to, with slight pain in my neck.
- I can read as much as I want to, with moderate pain in my neck.
- I can't read as much as I want, because of moderate pain in my neck.
- I can hardly read at all, because of severe pain in my neck.
- I cannot read at all.

## SECTION 5-HEADACHES

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

## SECTION 6-CONCENTRATION

- I can concentrate fully when I want to, with no difficulty.
- I can concentrate fully when I want to, with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

## SECTION 7-WORK

- I can do as much work as I want to.
- I can do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

## SECTION 8-DRIVING

- I can drive my car without any neck pain.
- I can drive my car as long as I want, with slight pain in my neck.
- I can drive my car as long as I want, with moderate pain in my neck.
- I can't drive my car as long as I want, because of moderate pain in my neck.
- I can hardly drive at all, because of severe pain in my neck.
- I can't drive my car at all.

## SECTION 9-SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

## SECTION 10-RECREATION

- I am able to engage in all my recreation activities, with no neck pain at all.
- I am able to engage in all my recreation activities, with some neck pain at all.
- I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- I am able to engage in few of my recreation activities, because of pain in my neck.
- I can hardly do any recreation activities, because of pain in my neck.
- I can't do any recreation activities at all.

# Low Back Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

## Section 1: Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

## Section 2: Personal Care (eg. washing, dressing)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, wash with difficulty and stay in bed

## Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

## Section 4: Walking\*

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 2 kilometres
- Pain prevents me from walking more than 1 kilometre
- Pain prevents me from walking more than 500 metres
- I can only walk using a stick or crutches
- I am in bed most of the time

## Section 5: Sitting

- I can sit in any chair as long as I like
- I can only sit in my favourite chair as long as I like
- Pain prevents me sitting more than one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

## Section 6: Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

## Section 7: Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

## Section 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

## Section 9: 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 effect on my social life apart from limiting my more energetic interests e.g. sport
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

## Section 10: Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment