

CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: _____
Home Phone: _____ Cell: _____ Work: _____
Email Address: _____
Street Address: _____ City, State, Zip: _____

PLEASE PRESENT YOUR INSURANCE CARD AND ID FOR SCANNING

Insurance Carrier: _____ ID or Claim Number: _____
Group Number: _____
Subscriber: _____ Date of Birth: _____
Relationship to Subscriber: **Self** **Spouse** **Dependent**
Claims Address: _____

For L&I and Auto Injury, Please specify date of accident:

Auto **Work** **Home** **Other**

To whom have you made a report of your accident?

Auto Insurance **Employer** **Work Comp** **Other**

What is their contact name and number? _____

Please read the following carefully before signing:

I, the undersigned, understand that payment is expected in full at the time of service, including all copay amounts for insurance billing. I authorize the treatment of the person named above to agree to pay all fees for such treatment. I hereby authorize my health care practitioner(s) to receive all benefits to which I and/or my dependents are entitled under my health insurance plan. In addition, I will not withhold or delay payment if my insurance company denies payment of any of my charges. I have also been informed of the \$50.00 fee (per RCW 62A, 3-515 & 520) on all checks returned by my bank NSF.

I, the undersigned, agree that I am obligated to pay for this account. Should the balance of this account exceed an amount I am able to pay in full within 30 days, a 1% per month re-billing fee will be applied (per RCW 19.52) unless a mutually satisfying solution is agreed upon by both the undersigned and my health care practitioner(s).

Signature: _____ Date: _____

CHIROPRACTIC REGISTRATION AND HISTORY

Informed Consent

Please read the following so that we may discuss any questions or concerns you might have.

The Chiropractic Adjustment:

The primary treatment used by doctors of chiropractic is the spinal adjustment. I will be using that procedure to treat you. I use my hands and sometimes a small mechanical device (called the Activator tool) upon your body in such a way as to restore motion and neurologically refresh and stimulate the joints of your body which may be jammed or moving incorrectly. Very often this procedure causes an audible “pop” or “click,” similar to the sensation of your knuckles “cracking.” You may also feel or sense movement.

The Material Risks Inherent in Chiropractic Adjustments:

As with any health care procedure, there are certain complications that may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations and muscle strain, Horner’s syndrome, diaphragmatic spasm, cervical myelopathy and costovertebral separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Probability of Those Risks Occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for through the information in your history forms, during your examination, and when necessary; x-ray studies. Stroke has been the subject of tremendous attention which has resulted in a thorough review of the risks; the retroactive 4 year study indicated that, at most, there is a chance of one per four million office visits to a health care office (including medical offices) of such an outcome. Since even that risk should be avoided if possible, I employ tests in my examination that help to identify whether or not you may be susceptible to that kind of injury. The other complications are also generally described as “rare.”

Ancillary Treatment:

In addition to chiropractic adjustments I routinely use the following treatments:

- Various soft tissue/non-force techniques
- Moist hot packs and moist ice applications (as necessary)

The Availability and Nature of Other Treatment Options:

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization with traction
- Surgery

The Risks and Dangers Attendant to Remaining Untreated:

Remaining untreated allows the formation of adhesions and reduces mobility that sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

CHIROPRACTIC REGISTRATION AND HISTORY

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE

Please **check** the appropriate block and sign below:

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Chevigny and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name (printed): _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Privacy Practice Acknowledgement

I give my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the Notice of Privacy Practices (for more complete description of uses and disclosures) before signing this consent.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that this cannot be enforced retroactively and can only be used moving forward.

Name: _____

Signature: _____ Date: _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ Date _____

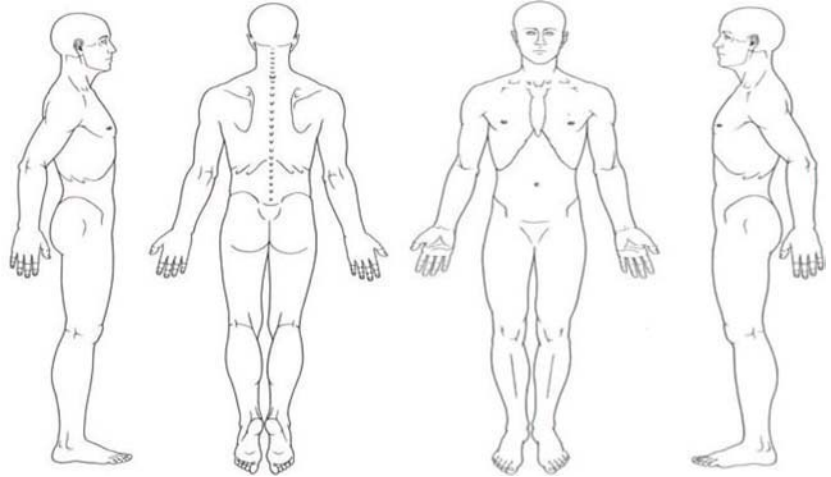
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which 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, 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 with moderate pain.
- 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 which come infrequently.
- I have slight headaches which come frequently.
- I have moderate headaches which come infrequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
 (Score x 2) / (Sections x 10) = %ADL

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 only 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 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 my car 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 moderately disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-4 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 pain in my neck.
- 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 a few of my usual 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.

Comments _____ %ADL

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

Patient's Name _____ Number _____ Date _____

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

Section 1 - Pain Intensity

- I can tolerate the pain without having to use painkillers.
- The pain is bad but I can manage without taking painkillers.
- Painkillers give complete relief from pain.
- Painkillers give moderate relief from pain.
- Painkillers give very little relief from pain.
- Painkillers have no effect on the pain and I do not use them.

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, 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 – Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than one-half mile.
- Pain prevents me from walking more than one-quarter mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from 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 almost all the time.

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 extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than 30 minutes.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 -- Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than 6 hours sleep.
- Even when I take tablets I have less than 4 hours sleep.
- Even when I take tablets I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 – 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. dancing.
- 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 9 – Traveling

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

Section 10 – Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at the present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Comments _____

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.

(Score ___ x 2) / (___ Sections x 10) = _____ %ADL

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

MOTOR VEHICLE ACCIDENT INTAKE FORM

Name: _____ Date: _____

Claim Number: _____ Date of MVA: _____

Adjuster's Name: _____ Phone Number: _____

Lawyer's Name: _____ Phone Number: _____

Patient was seated (circle one): Driver's Seat | Front Passenger | Rear Left | Rear Right

Other: _____

Was anyone else in the car?

Were they injured? _____

Describe the accident: _____

Did any part of your body make contact with the interior of the vehicle? ___ Yes ___ No

If Yes, describe contact: _____

Were you looking straight ahead at time of impact? ___ Yes ___ No

If No, describe position: _____

Did you anticipate the accident? ___ Yes ___ No

Was a seat belt used? ___ Yes ___ No Was there a headrest in the vehicle? ___ Yes ___ No

Did you sustain any seatbelt bruising? ___ Yes ___ No

AS A RESULT OF THE ACCIDENT, THE PATIENT:

Sustained a loss of consciousness: ___ Yes ___ No

If Yes, duration: _____

Complaints of neck pain? ___ Yes ___ No

Complaints of mid back pain? ___ Yes ___ No

Complaints of low back pain? ___ Yes ___ No

Complaints of: ___ nausea ___ sleeplessness ___ light headaches ___ dizziness ___ irritability
___ blurred vision ___ forgetfulness ___ headaches ___ ring/buzz in ears ___ disorientation

Immediately following the accident patient went (circle one): Home | Hospital | Other: _____

Received any medication due to accident? ___ Yes ___ No

If Yes, list medication: _____

Received X-rays due to accident? ___ Yes ___ No

Describe any symptoms or injuries not addressed
above: _____

Any change in household or recreational activities? ___ Yes ___ No

If yes, how has it changed: _____

Since accident are you still able to work? ___ Yes ___ No

If yes, any modifications? _____

Patient Name: _____

Name of Guardian if needed: _____

Signature of patient (or Guardian): _____ Date: _____