Interurban Chiropractic Center

13028 Interurban Ave S. Suite 106
Tukwila, WA 98168-3340

Name _____Sex☐M☐F Date_____

Address(No PO Box)_____City_____State_____Zip_____

H. Phone_____ W. Phone_____ Cell Phone _____

Date of Birth_____Age_____ Marital Status ☐M ☐S ☐D ☐W ☐P Social Security #_____

Email address: _____**Referred by:** _____

Occupation_____ Employer_____

Insurance Company _____ ID#_____ Group#_____

Name of Insured: _____ Your relationship to Insured: _____

Emergency Contact _____1st Phone_____ 2nd Phone_____

Were you injured on the job?☐YES☐NO **Were you injured in an automobile accident?☐YES☐NO**

If YES to either of the above questions, please stop and see the front desk for the appropriate intake form

Purpose of this appointment: _____

_____

Is there any pain present? (No complaint / pain) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (Worst possible pain / Emergency)

How frequent is complaint present? _____How long does it last? _____

Does anything aggravate the complaint? _____ Does anything make it better? _____

Please circle the type of the complaint/pain: ☐dull ☐achy ☐sharp ☐shooting ☐burning ☐throbbing ☐deep ☐nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness, tingling, burning or weakness in your body? Where? _____

Have you lost any days from school/work? ☐YES ☐NO Dates: _____

Have you had this problem before? ☐YES ☐NO If so, when? _____ Is this condition: Worsening - Staying the Same - Improving

Have you consulted other doctors for this condition? ☐YES ☐NO Names and Dates:_____

_____

Please check all that apply*:*

- ❒ Headaches
- ❒ Neck Pain
- ❒ Back Pain
- ❒ Nervousness
- ❒ Tension
- ❒ Irritability
- ❒ Chest Pains
- ❒ Dizziness
- ❒ Face Flushed
- ❒ Neck Stiff
- ❒ Pins & Needles in Legs
- ❒ Pins & Needles in Arms
- ❒ Numbness in Fingers
- ❒ Numbness in Toes
- ❒ Shortness of Breath
- ❒ Fatigue
- ❒ Depression
- ❒ Light Bothers Eyes
- ❒ Loss of Memory
- ❒ Ears Ring
- ❒ Fever
- ❒ Fainting
- ❒ Cold Sweats
- ❒ Loss of Smell
- ❒ Loss of Taste
- ❒ Diarrhea
- ❒ Feet Cold
- ❒ Hands Cold
- ❒ Stomach Upset
- ❒ Constipation
- ❒ Loss of Balance
- ❒ Buzzing in Ears
- ❒ Sleeping Problems

Please list any other Injuries, Traumas, Broken Bones and Surgeries you have had in the past, include dates:

_____

_____

Are you taking any medications or supplements? Please list:_____

Date of your last physical exam: _____ Height: _____ Weight: _____ Date of last chiropractic exam: _____

Females: Date of last menses: _____ Is there a possibility you could be pregnant? ☐YES ☐NO Please initial: _____

Any previous pregnancies? ☐YES ☐NO Any associated complications? Please list _____

_____

Do you have any Allergies? ☐YES ☐NO Please list: _____

Family Health History:

Health problems of relatives: _____

Cause of parents or siblings death: Age at death

_____ _____

_____ _____

6. *Social and Occupational History:*

A. Please describe your daily job duties:_____

B. What is your typical work schedule? _____

C. Recreational activities: _____

D. Please list your level of exercise, alcohol consumption, tobacco use and drug use:_____

_____

Assignment and Release:

I have answered the questions on this form truthfully and to the best of my knowledge. I hereby authorize the doctors at Interurban Chiropractic Center to provide me with chiropractic care in accordance with this state's statutes. I understand and agree that all services rendered to me are my financial responsibility and any health or accident insurance policies which I hold are based on a contract between the carrier and myself. I also understand that I am financially responsible for all non-covered services. I assign to Interurban Chiropractic Center my insurance benefits and authorize this office to use my personal information in accordance with its privacy practices, which were presented to me with this form.

Patient or Guardian Signature _____Date_____

Interurban Chiropractic

"Helping people get the most out of life"

Terms of Acceptance

In order to provide the most effective healing environment and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

We, therefore, ask that you acknowledge the following points regarding Chiropractic care and the services that are offered through our clinic by initialing each statement below.

A) Chiropractic is a specific art and science that addresses the body's health concerns and needs through assessment and treatment of the various systems of the body, most notably, the **nervous system**. ____

B) Chiropractic seeks to maximize the **inherent healing** capacity of the human body by restoring normal nerve function through the adjustment of the **spine** and **extremities**. ____

C) The ***Chiropractic adjustment*** process involves the *application of a specific directional thrust to a region or regions of the* ***spine*** *and* ***extremities*** with the intent of repositioning misaligned segments. ____

D) A thorough **examination** and **full spine x-ray** is part of the standard Chiropractic procedure. The goal of this process is to identify any **spinal** and/or **extremity** health problems and to determine Chiropractic need. If, during this process, any condition or questions arise which are outside the scope of **Chiropractic treatment**, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need. ____

E) **Your compliance** with treatment plans, home exercise and other recommended self care is essential to **maximum healing** and optimal health through Chiropractic. ____

F) We invite you to **speak frankly** to the doctor and our staff on any matter related to your care to maintain a **supporting environment** during your time at our office. _____

Definitions:

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name

Interurban Chiropractic
Helping people get the most out of life.

IN OFFICE CLINICAL SUBMISSION FORM

Name: _____ **Patient ID#:** _____

Symptoms began on: ___/_____/_____

Patient Type:
- ☐ New Patient
- ☐ Established Patient, New Injury
- ☐ Established Patient, New Episode
- ☐ Established Patient, Continuing Care

Nature of the Condition:
- ☐ Initial Onset (Last 3 months)
- ☐ Recurring (Multiple Episodes < 3 months)
- ☐ Chronic (Continuous Duration > 3 months)

Cause:
- ☐ Traumatic
- ☐ Repetitive
- ☐ Post-Surgical
- ☐ Work Related
- ☐ Motor Vehicle
- ☐ Unspecified

If Post-Surgical
Type: ACL, Rotator, Tendon, Spinal Fusion, Joint replacement, Other
Date of Surgery: ___/___/____

Average Pain Intensity: (0 No Pain – 10 worst pain)
Last 24 hrs: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Past Week: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How often are your symptoms:

- ☐ Intermittently (0%-25%)
- ☐ Occasional (26%-50%)
- ☐ Frequent (51%-75%)
- ☐ Constant (76%-100%)

How much have your symptoms interfered with your day:

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

☐ ☐ ☐ ☐ ☐

How much have you improved since starting care at this office:

1 (N/A) – 2 (Worse) – 3 (Worse) – 4 (Little Worse) – 5 ((Little Better) – 6 (Better) – 7 (Much better)

☐ ☐ ☐ ☐ ☐ ☐

How did your symptoms start:

_____
_____
_____
_____
_____

Current Overall Health:

1 (Excellent) – 2 (Very Good) – 3 (Good) – 4 (Fair) – 5 (Poor)

☐ ☐ ☐ ☐ ☐

Signature: _____ Date: ___/___/_____

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*

Name_____ Date_____

Instructions: Please circle the ONE NUMBER in each section which most closely describes your problem.

Section 1- Pain Intensity
1. The pain comes and goes and is very mild.
2. The pain is mild and does not vary much.
3. The pain comes and goes and is moderate.
4. The pain is moderate and does not vary much.
5. The pain comes and goes and is severe.
6. The pain is severe and does not vary much.

Section 2 - Personal Care (Washing, Dressing, etc.)
1. Iwould not have to change my way of washing or dressing in order to avoid pain.
2. Ido not normally change my way of washing or dressing even though it causes some pain.
3. Washing and dressing increase the pain but I manage not to change my way of doing it.
4. Washing and dressing increase the pain and Ifind it necessary to change my way of doing it.
5. Because of the pain I am unable to do some washing and dressing without help.
6. Because of the pain Iam unable to do any washing and dressing without help.

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

Section 4 - Walking
1. Ihave no pain on walking.
2. I have some pain on walking but it does not increase with distance.
3. Icannot walk more than 1 mile without increasing pain.
4. Icannot walk more than % mile without increasing pain.
5. Icannot walk more than % mile without increasing pain.
6. I cannot walk at all without increasing pain.

Section 5 - Sitting
1. I can sit in any chair as long as Ilike.
2. I can sit only in my favorite chair as long as I like.
3. Pain prevents me from sitting more than 1 hour.
4. Pain prevents me from sitting more than % hour.
5. Pain prevents me from sitting more than 10 minutes.
6. Iavoid sitting because it increases pain immediately.

Section 6 - Standing
1. Ican stand as long as Iwant without pain.
2. Ihave some pain on standing but it does not increase with time.
3. Icannot stand for longer than 1 hour without increasing pain.
4. Icannot stand for longer than % hour without increasing pain.
5. Icannot stand for longer than 10 minutes without increasing pain.
6. Iavoid standing because it increases the pain immediately.

Section 7 - Sleeping
1. Iget no pain in bed.
2. I get pain in bed but it does not prevent me from sleeping well.
3. Because of pain my normal nights sleep is reduced by less than one-quarter.
4. Because of pain my normal nights sleep is reduced by less than one-half.
5. Because of pain my normal nights sleep is reduced by less than three-quarters.
6. Pain prevents me from sleeping at all.

Section 8 - Social Life
1. My social life is normal and gives me no pain.
2. My social life is normal but it increases the degree of pain.
3. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
4. Pain has restricted my social life and I do not go out very often.
5. Pain has restricted my social life to my home.
6. I have hardly any social life because of the pain.

Section 9 - Traveling
1. Iget no pain when traveling.
2. I get some pain when traveling but none of my usual forms of travel make it any worse.
3. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
4. Iget extra pain while traveling which compels to seek alternative forms of travel.
5. Pain restricts me to short necessary journeys under % hour.
6. Pain restricts all forms of travel.

Section 10 - Changing Degree of Pain
1. My pain is rapidly getting better.
2. My pain fluctuates but is definitely getting better.
3. My pain seems to be getting better but improvement is slow.
4. My pain is neither getting better or worse.
5. My pain is gradually worsening.
6. My pain is rapidly worsening.

TOTAL_____

Neck Pain Disability Index

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*

Name _____ Date----------

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 mark the ONE NUMBER in each section which most closely describes your problem. We realize you may consider that two of the statements in any one section relate to you, but only mark the box which most closely describes your problem.

Section 1-Pain Intensity
1. Ihave no pain at the moment.
2. The pain is very mild at the moment.
3. The pain is moderate at the moment.
4. The pain is fairty severe at the moment.
5. The pain is very severe at the moment.
6. The pain is the worst imaginable at the moment.

Section 2- Personal Care (Washing, Dressing, etc.)
0. Ican look after myself normally without causing extra pain.
1. Ican look after myself normally but it causes extra pain.
2. It is painful to look after myself and Iam slow and careful.
3. Ineed some help but manage most of my personal care.
4. Ineed help every day in most aspects of self-care.
5. Ido not get dressed, Iwash with difficulty and stay in bed.

Section 3-Lifting
0. Ican lift heavy weights without extra pain.
1. Ican lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor. but Ican manage if they are conveniently positioned, e.g., on a table
3. Pain prevents me lifting heavy weights. but I can manage light to medium weights if they are conveniently positioned.
4. Ican lift very light weights.
5. Icannot lift or carry anything at all.

Section 4- Reading
0. Ican read as much as Iwant to with no pain in my neck.
1. Ican read as much as Iwant to with slight pain in my neck.
2. Ican read as much as Iwant with moderate pain in my neck.
3. Ican't read as much as Iwant because of moderate pain in my neck.
4. Ican hardly read at all because of severe pain in my neck.
5. Icannot read at all.

Section 5-Headaches
1. Ihave no headaches at all.
2. Ihave slight headaches which come in-frequently.
2. Ihave moderate headaches which come in-frequently.
3. Ihave moderate headaches which come frequently.
4. Ihave severe headaches which come frequently.
5. Ihave headaches almost all the time.

Section 6- Concentration
1. Ican concentrate fully when Iwant to with no difficulty.
2. Ican concentrate fully when Iwant to with slight difficulty.
3. Ihave a fair degree of difficulty in concentrating when Iwant to.
3. Ihave a lot of difficulty in concentrating when Iwant to.
4. Ihave a great deal of difficulty in concentrating when Iwant to.
5. Icannot concentrate at all.

Section 7-Work
0. Ican do as much work as Iwant to.
1. Ican only do my usual work. but no more.
2. Ican do most of my usual work, but no more.
3. Icannot do my usual work.
4. Ican hardly do any work at all.
5. Ican't do any work at all.

Section 8-Driving
1. Ican drive my car without any neck pain.
2. Ican drive my car as long as Iwant with slight pain in my neck.
3. Ican drive my car as long as Iwant with moderate pain in my neck.
4. Ican't drive my car as long as Iwant because of moderate pain in my neck.
4. Ican't drive my car as long as Iwant because of moderate pain in my neck.
5. Ican't drive my car at all because of the pain.

Section 9-Sleeping
0. Ihave no trouble sleeping.
1. My sleep is slightly disturbed (less than 1hr. sleepless).
2. My sleep is mildly disturbed (1-2 hrs. sleepless).
3. My sleep is moderately disturbed (2-3 hrs. sleepless).
4. My sleep is greatly disturbed (3-5 hrs. sleepless).
5. My sleep is completely disturbed (5-7 hrs. sleepless).

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

TOTAL_____