Cascade Chiropractic & Massage

CONFIDENTIAL PATIENT DATA

Welcome to our practice. if you need any assistance completing this form, please ask the receptionist.

DATE:_____

NAME:_____ DOB:_____ MALE___ FEMALE___

Address:_____ Phone#_____

SS#_____Age:_____ Marital Status: M S W D Other

Email:_____

EMERGENCY CONTACT:_____ PHONE_____

ADDRESS_____RELATIONSHIP TO YOU_____

Your Occupation:_____Employeer:_____

Referred to this Office by:_____

PAYMENT FOR SERVICES WILL BE BY: CASH____ HEALTH INSURANCE ___

WORKER'S COMP ___ AUTOMOBILE INSURANCE_____

Insurance Company: _____ Insured's Employer_____

Employer's Phone #_____ Insured's SS#_____

Are you covered by more than one insurance company? No Yes Name:_____

MEDICAL / FAMILY HISTORY:

S=Self M= Mother F= Father

(Please Indicate which conditions have been experienced by the above)

Aids ___ Bladder trouble ___ Convulsions ___ Headaches ___
Anemia___ Bone fracture ___ Diabetes ___ Heart trouble ___ Arthritis ___

Cancer ___ Indigestion issues __ Reproductive disorders ___ Asthma ___

Chest pain ___ Dislocated joints ___ High blood pressure ___

Back Pain ___Concussion ___ Epilepsy ___ HIV/ARC ___

Kidney disorder ___ Bowel disorder ___ Menstrual Cramps ___ MS ___

Muscular Dystrophy ___Neck Pain ___ Nervousness ___ Numbness ___

Polio ___ Poor Circulation ___ Hepatitis ___ Rheumatism ___ Sinus Issues __

Have you been treated by a physician for any health conditions within the last year? ____

Condition:_____.

Date of last physical exam:_____ Physician's Name:_____

SURGERY HISTORY:

Date:_____Type of surgery:_____

Date:_____Type of surgery:_____

Date:_____Type of surgery:_____

Have you ever had a metal implant_____ Ever been gun shot ___ Are you pregnant _____

ACCIDENT HISTORY:

Job:____ Auto:_____ Other: ___ Date:_____

Job: ____ Auto:_____ Other: ___ Date:_____

PLEASE DESCRIBE PRESENT MAJOR CONPLAINTS:

(Please rate your pain 0-10) 10 being the worst

Complant:_____ Pain:_____

Complant:_____Pain:_____

Complant:_____Pain:_____

Worse in: Morning ___ Afternoon ___ Night ___

When and how did they occure?

_____

_____

_____

Symptoms/Complaints developed from: Job related injury ___ Auto Accident ___ Accident ___ Illness ___ Unknown cause ___ Gradual Onset ___ Other ___ Date this occurred _____

Symptoms/Complaints have persisted for: Hours ___ Days ___ Weeks ___ Months ___ Years ___

Come & Go ___ Constant ___ Have you had this before:_____ When:_____

What do you think is causing your symptoms/complaints:_____

Check the following activities that **AGGRAVATE** your condition

Bending ___ Reaching ___ Straining ___ Coughing ___ Sitting ___ Turning Head ___

Lifting ___ Sneezing ___ Walking ___ Lying Down ___ Standing ___

Check the following activities that **RELIEVES** your condition

Bending ___ Sitting ___ Standing ___ Lying Down ___ Turning Head ___ Walking ___

ARE YOU EXPERIENCING ANY OTHER SYMPTOMS :

Blurred vision ___ Buzzing in ears ___ Cold Feet ___ Cold Hands ___ Cold Sweats ___

Fainting ___ Head seems heavy ___ Headaches ___ Concentration loss/Confusion ___

Constipation ___ Depression ___ Diarrhea ___ Dizziness ___ Insomnia ___ Light bothers eyes ___

Loss of balance ___ Loss of smell ___ Loss of taste ___ Numbness in fingers/toes ___

Pins & needles in arms/legs ___ Numbness of tongue ___

Names and Locations of Doctors you have seen in the past for this condition:

Name:_____

Location:_____

Name:_____

Location:_____

Medications you are taking:

_____

_____

_____

Medications you are allergic to:

_____

By signing this form. you consent that the above information is correct and true to the best of your ability.

Signature:_____Date:_____

Cascade Chiropractic & Massage

2575 Campus Drive
Klamath Falls, OR 97601
Ph: (541)273-7120

Financial Responsibility

I _____agree to be financially responsible for all charges incurred at the clinic including my insurance deductible,co-payment and any services rejected by my insurance company.

All patients are expected to pay for each visit at the time of service. This may be Cash, Check, Visa or Master Card.

If you have insurance, we are willing to verify coverage however, this is not a guarantee of payment and YOU are responsible for any portion the insurance does not cover.

(Motor Vehical Accident's, please put claim number in identification number location with date of accident)

Primary Insurance:_____ Policy Holder:_____

ID#_____ Group #_____

Address:_____ Phone#_____

Secondary Insurance:_____ Policy Holder:_____

ID#_____ Group #_____

Address:_____ Phone#_____

We appreciate your trust in us and we promise to serve you in the best way possible.

Signature:_____ Date:_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays and/or other tests on me (or on the patient named below, for whom I am legally responsible) by the doctors of the chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic and/or other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels is appropriate at the time, based upon the facts then known, and is in my best interests.

I have read, or have read to be me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Full Name: _____

Patient Signature: _____ Date: _____

(or patient representative)

Cascade Chiropractic
Innate Wellness

Jefferson Harmon D.C.
Kristine Taylor D.C.

CASCADE CHIROPRACTIC AND MASSAGE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Notice of Privacy Practices that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be use to/for:

- Conduct, plan and direct care and follow-up amoung multiple healthcare providers who may be involved in my care directly or indirectly.
- Obtain payment and or payment information for services, confirming insurance coverage per your request, and billing or collection activities.
- Health care operatons, which include the business aspects of running our practice. (Posting of our daily schedules throught out the office, having a sign in sheet, calling to confirm appointments, leaving messages regarding appointments, sending reminder cards in the mail with our office information, using your or a family members first and last name while servicing you in our office and discuss with/allow immediate family members/guardians into exam or report of findings process to allow for a better understanding of care options when necessary).

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this consent document.

When you sign this consent document, you agree that we can and will use and disclose your health information to care for you, to obtain payment for our services, and to perform health care operations as reviewed above and outlined in our Notice. You can revoke this consent in writing at any time unless we have already cared for you, sought payment for services, or performed health care operatons in reliance upon our ability to use or disclose your health information in accordance with this consent.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF CARE, PAYMENT, AND HEALTH CARE OPERATIONS. I ALLOW CASCADE CHIROPRACTIC AND MASSAGE OR IT'S REPRESENTATIVE TO CONTACT ME AT: HOME__ CELL__ WORK__ EITHER__

DATE:_____

PRACTICE MEMBER SIGNATURE (PATIENT):_____

PRINTED NAME OF PRACTICE MEMBER (PATIENT):_____

RELATIONSHIP TO PRACTICE MEMBER (PATIENT):_____

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 mark in each section the one box 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.

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

- ☐ 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 causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Work

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

Section 6 - Concentration

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

Section 7 - Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

Section 8 - Driving

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

Section 9 - Reading

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all.

Section 10 - Recreation

- ☐ I have no neck pain during all recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I have some neck pain with a few recreational activities.
- ☐ I have neck pain with most recreational activities.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain.

Patient Name _____ Date _____

Score _____ [50] Benchmark -5 = _____

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
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 would 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 extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage 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.

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 cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot 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 than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-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.

TOTAL _____

CASCADE CHIROPRACTIC

PATIENT NAME:_____ DATE:_____

Loss of Enjoyment/Duties Under Duress Summary

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the day-to-day **living or work duties that are painful or difficult for you to perform as a result of the injuries** you sustained. Then check mark the appropriate box designating reason for difficulty. Include those duties/responsibilities, which require that you reduce the time you are capable of performing them.

Please Print Clearly in Black Ink

Job description: _____

N/A	**Work**	**Reason for the Difficulty/Limitation**			
_____	Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Bending	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Sitting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Walking	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Other: _____	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform

N/A	**Studies/School**	**Reason for the Difficulty/Limitation**			
_____	Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Bending	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Sitting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Walking	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Studying	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Other: _____	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform

N/A	**Domestic Duties**	**Reason for the Difficulty/Limitation**			
_____	Vacuuming	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Taking Care of Kids	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Cleaning	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Preparing Meals	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Other: _____	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform

N/A	**Household Duties**	**Reason for the Difficulty/Limitation**			
_____	Yardwork	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Transportation	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Shopping	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Taking Out Trash	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Other: _____	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform

N/A **Sports**
Name Sport: _____
Pre-Accident Level of Participation:

Reason for the Difficulty/Limitation
☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Socially ☐ Competitively ☐ Professional

Patient Signature: _____ Date: _____/_____/20____