

WELCOME TO OUR CLINIC!

(Please Print)

Today's date:		<u>Date and Time of injury:</u>			
WORK RELATED INJURY - PATIENT INFORMATION					
Patient's full name (Last, First Middle):					
If a minor, name of parent/guardian(s):			Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widow		
Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Social Security #:	
Street address:			Cell phone #: ()		
			Home phone #: ()		
Email:			Occupation:		
Employer:			Employer phone #: ()		
Personal Insurance & ID #:			Group #:		
Attorney:		Attorney Phone #: ()		Medicare eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No	
WORK RELATED INSURANCE INFORMATION					
Insurance company:			Agent's name:		
Claim #:		Insurance/Agent's address:			
Policy #:					
Is this an Oregon policy: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what state?			Employer address:		
Has your employer been notified: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Witnesses:			Agent's email:		
			Employer's email:		
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):					
Relationship to patient:			Best phone #: ()		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Corazon Chiropractic Clinic, LLC or insurance company to release any information required to process my claims.					
<u>Patient/Guardian signature:</u>				<u>Date:</u>	

Please read this consent form, discuss it with your clinician if you would like to, and then sign where indicated at the bottom.

Clinicians who use spinal manual therapy techniques, such as for example joint adjustment or manipulation or mobilization, are required to inform patients that there are or may be some risks associated with such treatment.

In particular:

- a) While rare, some patients have experienced muscle and ligament sprains or strains, or rib fractures following spinal manual therapy.
- b) There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and mobilization. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 2-5 million treatments.
- c) There have been reported cases of disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare.

Treatments provided at this clinic, including spinal adjustment, manipulation and/or mobilization, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. Treatment provided at this clinic may also contribute to your overall well-being. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.

Your clinician will evaluate your individual case, provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.

Acknowledgement: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis and extremities (upper limbs and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic.

Signature of Patient: X _____ **Date:** _____

Printed Name of Patient: _____

If Applicable:

Signature of Guardian: X _____ **Date:** _____

Printed Name of Guardian: _____

Signature of Translator: X _____ **Date:** _____

Printed Name of Translator: _____

Assignment of Benefits and Clinic Policy Acknowledgement

1. I, the undersigned, hereafter referred to as “the patient,” do hereby assign all of my rights and interests to Corazón Chiropractic Clinic, LLC, hereafter referred to as the “medical provider,” to pursue and obtain payment from the above mentioned insurance carrier. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of Oregon.
2. I, the patient, irrevocably assign to the medical provider all my rights and benefits under the insurance contract for payment for services rendered to me.
3. I, the patient, do hereby authorize my bodily injury attorney and/or insurance carrier to pay directly to the medical provider any monies due on my account, or the same to be deducted from any settlement made on my behalf.
4. There is no grace period. Default of the Payment Terms and Conditions of this Agreement the undersigned agrees to pay a 30% collection fee against the outstanding balance at the time of assignment to agency and all reasonable attorney fees and other legal costs incurred in the collection of this account. Venue of any action shall be Washington County.
5. If I, the patient miss more that one week of care without notifying the clinic of a reason - family emergency, vacation, etc - the clinic will be forced to close my case.
6. If I, the patient, fail to inform the clinic that I will miss my visit, three or more times during care, the clinic will be forced to close my case. If I, the patient, miss my scheduled visit, I will call the clinic by the end of the day to reschedule and to avoid penalty. I understand that there is a **\$ 50** penalty for missing a visit scheduled for massage, and not informing the clinic **within 24 hours** of the scheduled time.
7. I, the patient, do hereby acknowledge that I will not file suit or pursue arbitration for the payment of the above provider’s medical bills. I understand that the above medical provider has a collection agency and will collect payment on my behalf from the insurance carrier.
8. In the event that the insurance carrier or the vendor designated by the insurance carrier does not accept my assignment or my assignment is challenged for being invalid, I execute this limited/special power of attorney and appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit or pursue arbitration directly against the carrier in my name or allow the medical provider to amend the lawsuit or arbitration to include my name.
9. Further, in response to any reasonable request for cooperation, I agree to cooperate with the medical provider and their collection agency in any attempts by such doctor and attorney to pursue such claims, or to choose inaction, against the patient’s Personal Injury Protection insurance carrier in the patient’s name.

Patient Signature: _____ Date: _____

Name: _____
(Please print name of **patient**)

Signature of **Guardian** (when applicable): _____ Date: _____

Name: _____
(Please print name of **guardian**)

In the instance a translator was needed, please fill out below:

Signature of **Translator**: _____ Date: _____

Name: _____
(Please print name of **Translator**)

Name: _____
(Please print name of **Translator**)

Medical Records Request Form

Patient Name: _____

Date of Birth: _____ Today's Date: _____

I hereby authorize: _____

To release copies of:

- All Medical Records, to include chart notes, examinations, imaging and reports
- Medical Records to include everything EXCEPT imaging materials
- Other _____

Release medical records by mail or fax (preferred) to:

Corazon Chiropractic Clinic, LLC
2251 SE Tualatin Valley Highway
Hillsboro, OR 97123
Ph: 503-648-4357
Fax: 503-648-4358

Purpose or need for information: To continue medical care/ treatment.

I place no limitation on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, psychiatric disorders, or HIV infection.

This authorization can be revoked, but not retroactive to the release of information made in good faith.

Please contact this clinic with any questions or comments.

Signature: _____ Date: _____

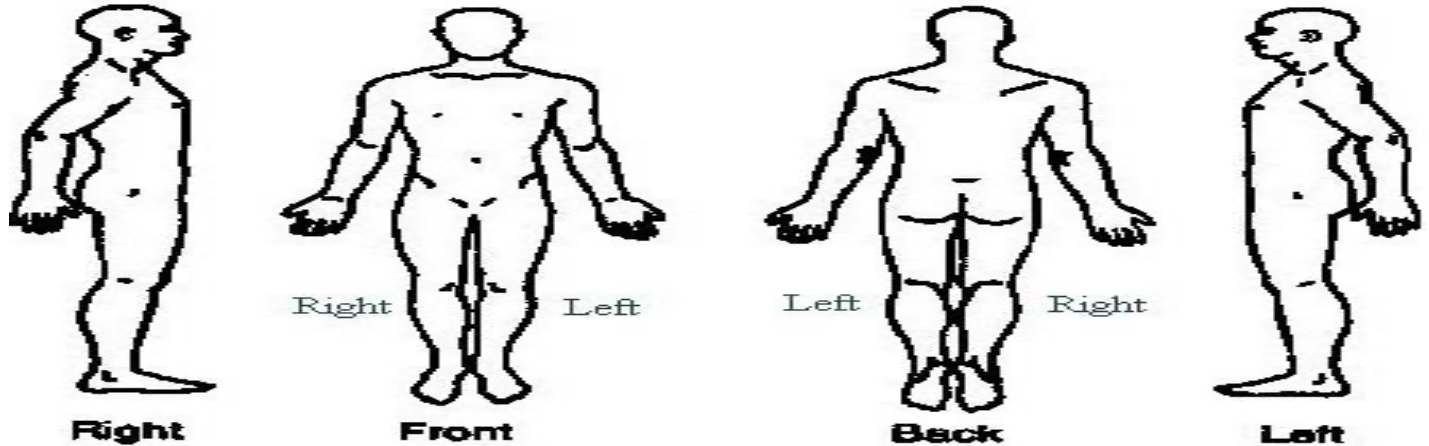
Witness: _____ Relationship: _____

Work Related Injury



<u>General Information</u>		
Patient name:	Birth date:	
Day & time of injury:		
Exact location of incident:		
Please describe the event with as much detail as possible:		
Did you tell your supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was a report filed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If your employer made any comments, please include them here:		
What did you do immediately after the incident? (did you use ice, go home and rest, continue working, for how many hours and doing what, etc...)		
The incident happened during: <input type="checkbox"/> Regular/customary duties <input type="checkbox"/> Unusual duties		
Did you lose consciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No For how long:		
Describe damage to your property and/or work property:		
Was an ambulance called? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did you go to the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What tests did they do?		
What was their diagnosis?		
What did they give you, if anything?		
Did the police respond? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did they file a report? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did they issue any citations? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<u>Symptoms Since the Incident</u>		
How soon did you start feeling symptoms?		
What did you feel?		
Please check all symptoms you have felt since the incident: <input type="checkbox"/> Pain <input type="checkbox"/> Headache <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Faint <input type="checkbox"/> Fever		
<input type="checkbox"/> Dizziness <input type="checkbox"/> Confusion <input type="checkbox"/> Chest pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Swelling <input type="checkbox"/> Discoloration or Bruising <input type="checkbox"/> Cuts <input type="checkbox"/> Bowel or bladder changes		
<input type="checkbox"/> Sleep disruption <input type="checkbox"/> Changes to vision <input type="checkbox"/> Changes to hearing <input type="checkbox"/> Other - Describe:		

Please use the diagram to mark your current symptoms: Legend = Pain (circle) Ache (a) Spasm (S) Numbness (N) Burning (B) Tingling (t) Edema (e)



Did you have any symptoms in injured areas **IMMEDIATELY PRIOR** to this incident? Yes No If yes, what:

First complaint area:	Describe the symptoms:	
What makes it feel worse?	What makes it feel better?	
What percentage of your waking hours do you feel symptoms (0-100%) ?	Pain Scale: 1 2 3 4 5 6 7 8 9 10	
	Describe the symptoms:	
What makes it feel worse?	What makes it feel better?	
What percentage of your waking hours do you feel symptoms (0-100%) ?	Pain Scale: 1 2 3 4 5 6 7 8 9 10	
Third complaint area:	Describe the symptoms:	
What makes it feel worse?	What makes it feel better?	
What percentage of your waking hours do you feel symptoms (0-100%) ?	Pain Scale: 1 2 3 4 5 6 7 8 9 10	
Fourth complaint area:	Describe the symptoms:	
What makes it feel worse?	What makes it feel better?	
What percentage of your waking hours do you feel symptoms (0-100%) ?	Pain Scale: 1 2 3 4 5 6 7 8 9 10	
Fifth complaint area:	Describe the symptoms:	
What makes it feel worse?	What makes it feel better?	
What percentage of your waking hours do you feel symptoms (0-100%) ?	Pain Scale: 1 2 3 4 5 6 7 8 9 10	

Past Health History

Please list any serious and/or chronic illnesses you have or have had:

Please list any prior hospitalizations or surgeries, with dates for each:

Please list any medications you currently take or took for an extended period:

Please list any prior work-related injuries with dates and duration of any treatment received:

Please list any prior motor vehicle injury or other physical trauma with dates and duration of any treatment received:

Please state your total number of pregnancies:

How many pregnancies came to term:

Please list any complications:

Please list any allergies you have:

Have you seen a chiropractor before? Yes No

If yes, whom, when and why?

What was your experience?

When was your last physical?

Please list any findings or remarks:

Please check all conditions you have and approximately when it was diagnosed, in the space nearby: Anemia Asthma Cancer Diabetes

Epilepsy Glaucoma Heart disease High blood pressure Kidney disease Lung disease/Chronic cough Musculoskeletal disorder

Night sweats Psychological disorders Skin disorder Tuberculosis Unexplained weight loss

Family Health History

Please check all conditions found in your family, state who has it (their relation to you), and approximately when it was diagnosed, in the space nearby:

Anemia Asthma Cancer Diabetes Epilepsy Glaucoma Heart disease High blood pressure Kidney disease

Psychological disorders Tuberculosis

Personal/Social History

Please briefly describe your work duties:

How would you describe your home life?

How many children do you have and what ages are they?

Are you on any special diets? Yes No

If yes, what?

How would you describe your diet?

Do you exercise regularly? Yes No

Has this injury affected your routine? Yes No If yes, how so?

Do you have regular hobbies? Yes No

Has this injury affected your hobbies? Yes No If yes, how so?

Do you drink alcohol? Yes No

How much and how often?

Do you use tobacco products? Yes No

How much, how often and for how long?

All Done!



Neck Disability Questionnaire

Patient Name: _____

Date: _____

Patient Signature: _____

Score (Staff to complete): _____

<p>Pain Intensity</p> <p><input type="checkbox"/> I have no neck pain at the moment.</p> <p><input type="checkbox"/> The pain is very mild at the moment.</p> <p><input type="checkbox"/> The pain is moderate at the moment.</p> <p><input type="checkbox"/> The pain is fairly severe at the moment.</p> <p><input type="checkbox"/> The pain is very severe at the moment.</p> <p><input type="checkbox"/> The pain is the worst imaginable at the moment.</p>	<p>Concentration</p> <p><input type="checkbox"/> I can concentrate fully without difficulty.</p> <p><input type="checkbox"/> I can concentrate fully with slight difficulty.</p> <p><input type="checkbox"/> I have a fair degree of difficulty concentrating.</p> <p><input type="checkbox"/> I have a lot of difficulty concentrating.</p> <p><input type="checkbox"/> I have a great deal of difficulty concentrating.</p> <p><input type="checkbox"/> I can't concentrate at all.</p>
<p>Personal Care</p> <p><input type="checkbox"/> I can look after myself normally without causing extra neck pain.</p> <p><input type="checkbox"/> I can look after myself normally, but it causes extra neck pain.</p> <p><input type="checkbox"/> It is painful to look after myself, and I am slow and careful.</p> <p><input type="checkbox"/> I need some help but manage most of my personal care.</p> <p><input type="checkbox"/> I need help every day in most aspects of self-care.</p> <p><input type="checkbox"/> I do not get dressed. I wash with difficulty and stay in bed.</p>	<p>Work</p> <p><input type="checkbox"/> I can do as much work as I want.</p> <p><input type="checkbox"/> I can only do my usual work, but no more.</p> <p><input type="checkbox"/> I can do most of my usual work, but no more.</p> <p><input type="checkbox"/> I can't do my usual work.</p> <p><input type="checkbox"/> I can hardly do any work at all.</p> <p><input type="checkbox"/> I can't do any work at all.</p>
<p>Lifting</p> <p><input type="checkbox"/> I can lift heavy weights without causing extra neck pain.</p> <p><input type="checkbox"/> I can lift heavy weights, but it gives me extra neck pain.</p> <p><input type="checkbox"/> Neck pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, i.e. on a table</p> <p><input type="checkbox"/> Neck pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.</p> <p><input type="checkbox"/> I can lift only very light weights.</p> <p><input type="checkbox"/> I cannot lift or carry anything at all.</p>	<p>Driving</p> <p><input type="checkbox"/> I can drive my car without neck pain.</p> <p><input type="checkbox"/> I can drive my car with only slight neck pain.</p> <p><input type="checkbox"/> I can drive as long as I want with moderate neck pain.</p> <p><input type="checkbox"/> I can't drive as long as I want because moderate neck pain.</p> <p><input type="checkbox"/> I can hardly drive at all because of severe neck pain.</p> <p><input type="checkbox"/> I can't drive my car at all because of neck pain.</p>
<p>Reading</p> <p><input type="checkbox"/> I can read as much as I want with no neck pain.</p> <p><input type="checkbox"/> I can read as much as I want with slight neck pain.</p> <p><input type="checkbox"/> I can read as much as I want with moderate neck pain.</p> <p><input type="checkbox"/> I can't read as much as I want because of moderate neck pain.</p> <p><input type="checkbox"/> I can't read as much as I want because of severe neck pain.</p> <p><input type="checkbox"/> I can't read at all.</p>	<p>Sleeping</p> <p><input type="checkbox"/> I have no trouble sleeping.</p> <p><input type="checkbox"/> My sleep is slightly disturbed for less than 1 hour.</p> <p><input type="checkbox"/> My sleep is mildly disturbed for up to 1-2 hours.</p> <p><input type="checkbox"/> My sleep is moderately disturbed for up to 2-3 hours.</p> <p><input type="checkbox"/> My sleep is greatly disturbed for up to 3-5 hours.</p> <p><input type="checkbox"/> My sleep is completely disturbed for up to 5-7 hours.</p>
<p>Headaches</p> <p><input type="checkbox"/> I have no headaches at all.</p> <p><input type="checkbox"/> I have slight headaches that come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches that come infrequently.</p> <p><input type="checkbox"/> I have moderate headache that come frequently.</p> <p><input type="checkbox"/> I have severe headaches that comes frequently.</p> <p><input type="checkbox"/> I have headaches almost all the time.</p>	<p>Recreation</p> <p><input type="checkbox"/> I am able to engage in all my recreational activities with no neck pain.</p> <p><input type="checkbox"/> I am able to engage in all my recreational activities with some neck pain</p> <p><input type="checkbox"/> I am able to engage in most, but not all activities with some neck pain.</p> <p><input type="checkbox"/> I am able to engage in a few of my recreational activities because of neck pain.</p> <p><input type="checkbox"/> I can hardly do recreational activities due to neck pain.</p> <p><input type="checkbox"/> I can't do any recreational activities due to neck pain.</p>

Oswestry Low Back Pain Questionnaire

Patient Name: _____ Date: _____ Score (Staff to complete): _____

<p>Pain Intensity</p> <ul style="list-style-type: none"> <input type="checkbox"/> The pain comes and goes and is very mild. <input type="checkbox"/> The pain is mild and does not vary much. <input type="checkbox"/> The pain comes and goes and is moderate. <input type="checkbox"/> The pain is moderate and does not vary much. <input type="checkbox"/> The pain comes and goes and is severe. <input type="checkbox"/> The pain is severe and does not vary much. 	<p>Standing</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can stand as long as I want without pain. <input type="checkbox"/> I have some pain while standing, but it does not increase with time. <input type="checkbox"/> I cannot stand for longer than one hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than 1/2 hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than ten minutes without increasing pain. <input type="checkbox"/> I avoid standing, because it increases the pain straight away.
<p>Personal Care</p> <ul style="list-style-type: none"> <input type="checkbox"/> I would not have to change my way of washing or dressing in order to avoid pain. <input type="checkbox"/> I do not normally change my way of washing or dressing even though it causes some pain. <input type="checkbox"/> Washing and dressing increases the pain, but I manage not to change my way of doing it. <input type="checkbox"/> Washing and dressing increases the pain and I find it necessary to change my way of doing it. <input type="checkbox"/> Because of the pain, I am unable to do some washing and dressing without help. <input type="checkbox"/> Because of the pain, I am unable to do any washing or dressing without help. 	<p>Sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> I get no pain in bed. <input type="checkbox"/> I get pain in bed, but it does not prevent me from sleeping well. <input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than one than one quarter. <input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than one-half. <input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than three-quarters. <input type="checkbox"/> Pain prevents me from sleeping at all.
<p>Lifting</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights, but it causes extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table. <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can only lift very light weights, at the most. 	<p>Social Life</p> <ul style="list-style-type: none"> <input type="checkbox"/> My social life is normal and gives me no pain. <input type="checkbox"/> My social life is normal but increases the degree of my pain. <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, my e.g., dancing, etc. <input type="checkbox"/> Pain has restricted my social life and I do not go out very often. <input type="checkbox"/> Pain has restricted my social life to my home. <input type="checkbox"/> I have hardly any social life because of the pain.
<p>Walking</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain does not prevent me from walking any distance. <input type="checkbox"/> Pain prevents me from walking more than one mile. <input type="checkbox"/> Pain prevents me from walking more than 1/2 mile. <input type="checkbox"/> Pain prevents me from walking more than 1/4 mile. <input type="checkbox"/> I can only walk while using a cane or on crutches. <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet. 	<p>Traveling</p> <ul style="list-style-type: none"> <input type="checkbox"/> I get no pain while traveling. <input type="checkbox"/> I get some pain while traveling, but none of my usual forms of travel make it any worse. <input type="checkbox"/> I get extra pain while traveling, but it does not compel me to seek alternative forms of travel. <input type="checkbox"/> I get extra pain while traveling which compels me to seek alternative forms of travel. <input type="checkbox"/> Pain restricts all forms of travel. <input type="checkbox"/> Pain prevents all forms of travel except that done lying down.
<p>Sitting</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can sit in any chair as long as I like without pain. <input type="checkbox"/> I can only sit in my favorite chair as long as I like. <input type="checkbox"/> Pain prevents me from sitting more than one hour. <input type="checkbox"/> Pain prevents me from sitting more than 1/2 hour. <input type="checkbox"/> Pain prevents me from sitting more than ten minutes. <input type="checkbox"/> Pain prevents me from sitting at all. 	<p>Changing Degree of Pain</p> <ul style="list-style-type: none"> <input type="checkbox"/> My pain is rapidly getting better. <input type="checkbox"/> My pain fluctuates, but overall is definitely getting better. <input type="checkbox"/> My pain seems to be getting better, but improvement is slow at present. <input type="checkbox"/> My pain is neither getting better nor worse. <input type="checkbox"/> My pain is gradually worsening. <input type="checkbox"/> My pain is rapidly worsening.