

BP: \_\_\_\_\_



P:

### WELCOME TO OUR CLINIC!

Today's date:	Check any you've had in the last 12mo: <input type="checkbox"/> Motor vehicle collision <input type="checkbox"/> Work related injury <input type="checkbox"/> Other injury
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#### PATIENT INFORMATION

Patient's full name (Last, First, Middle):

Marital status:  Single  Married  Separated  Widow

If a minor, name of parent/guardian(s):

Birth date:     /     /

Age:

Sex:  M  F

Social Security #:

Address:

Cell phone #: (     )     )

Home phone #: (     )     )

Email:

Occupation:

Employer:

Employer phone #: (     )     )

Medicare eligible:  Yes  No

#### INSURED INFORMATION

Insurance name:

Mailing address:

Phone #: (     )     )

ID#: \_\_\_\_\_

Fax #: (     )     )

Group#:

Email:

Patient's relationship to insured:  Self  Spouse  Child  Other (If "Self," please skip to "IN CASE OF EMERGENCY")

Insured's name:

Address (if different):

Birth date:     /     /

Best phone #: (     )     )

#### IN CASE OF EMERGENCY

Name of local friend or relative :

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 or insurance company to release any information required to process my claims.

***Patient/Guardian signature:*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

**Informed Consent to Chiropractic Treatment**

*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**)



## 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.

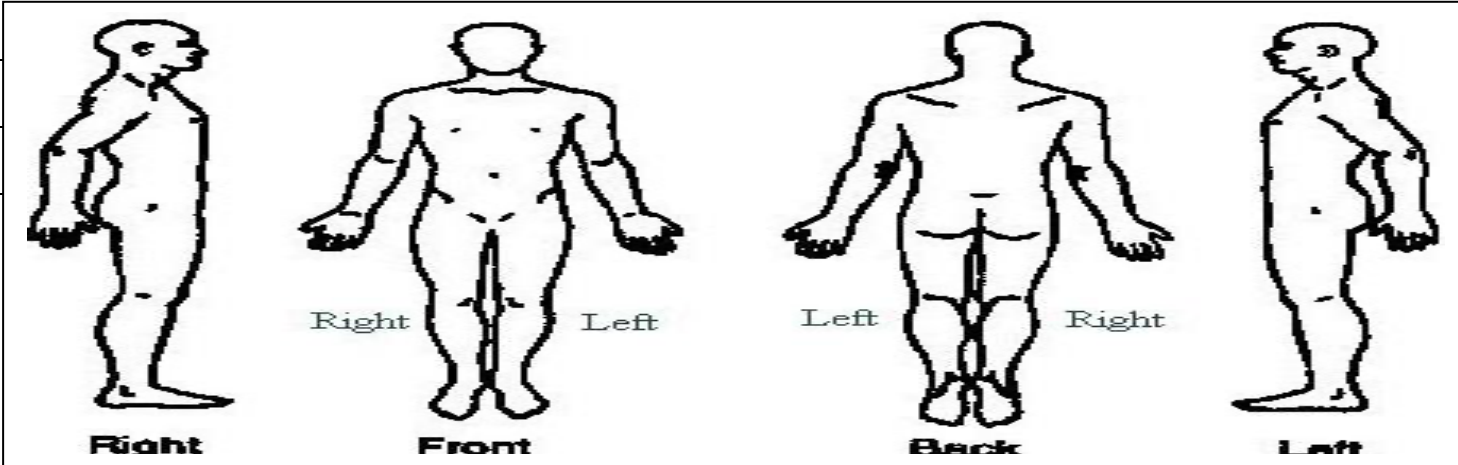
This authorization can be revoked, but not retroactive to the release of information made in good faith.

Please contact this clinic with any questions or comments.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Health Intake

<b>General Information</b>		
Please describe your current symptoms and/or recent injury in detail:		
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 was their diagnosis?
What tests did they do?	What did they give you, if anything?	
<b>My Symptom Picture</b>		
When was the first time <u>ever</u> feeling symptoms there?	Has it changed over time? <input type="checkbox"/> Y <input type="checkbox"/> N	
How so?	Is it getting: <input type="checkbox"/> Better <input type="checkbox"/> Staying the same <input type="checkbox"/> Getting worse	
Please check all symptoms you have felt in the past 12 months: <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"/> Bowel or bladder changes		
<input type="checkbox"/> Cuts <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)		
		
Primary 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%) ?	How bad are the symptoms: 1 2 3 4 5 6 7 8 9 10	
Second 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%) ?	How bad are the symptoms: 1 2 3 4 5 6 7 8 9 10	

<b>Third complaint area:</b>	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%) ?	How bad are the symptoms: 1 2 3 4 5 6 7 8 9 10	
<b>Fourth complaint area:</b>	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%) ?	How bad are the symptoms: 1 2 3 4 5 6 7 8 9 10	
<b>Fifth complaint area:</b>	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%) ?	How bad are the symptoms: 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 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 are their ages?

Are you on any special diets?  Yes  No

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!





### Oswestry Low Back Pain Questionnaire

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Score (Staff to complete): \_\_\_\_\_

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

### Neck Disability Questionnaire

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Score (Staff to complete):** \_\_\_\_\_

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