Action Chiropractic
284 Lee Street SW Ste. 128 Tumwater, WA 98501
www.actionchiropractictumwater.com 360-489-0469 DATE _____

PATIENT INFORMATION:

FULL NAME_____ DATE OF BIRTH ___/___/____AGE____MALE ☐ FEMALE ☐

ADDRESS_____APT#_____ SSN_____- _____ - _____

CITY_____ STATE_____ ZIP CODE_____ CELL PHONE (_____)_____

ALTERNATE PHONE (___)_____EMAIL ADDRESS _____

EMPLOYER'S NAME _____OCCUPATION _____

DATE SYMPTOMS BEGAN _/____/_____

MARITAL STATUS SINGLE ☐ MARRIED ☐ WIDOWED ☐ HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT _____PHONE (_____)_____

CLAIM INFORMATION:

IS YOU CONDITION DUE TO: AN AUTO ACCIDENT ☐ A WORK INJURY ☐ OTHER ☐

I WILL BE PAYING TODAY BY: CASH ☐ CHECK ☐ CARD ☐ OTHER ☐

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF ☐ SPOUSE ☐ OTHER ☐ CHILD ☐ SPOUSE: _____

INSURED'S EMPLOYER SAME AS ABOVE ☐ _____

INSURED SSN: SAME AS ABOVE ☐ SSN _____- _____- _____ INSURED DOB: SAME AS ABOVE ☐ ____/____/_____

PRIMARY INSURANCE CO _____ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE # (_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

****

SECONDARY INSURANCE CO_____ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE # (_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payments of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to the office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products or services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

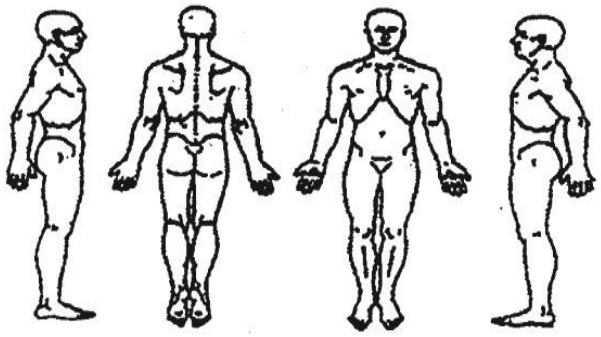
D. All patients with or without insurance, are responsible for full payment at the time of service (unless other arrangements have been made in advance). If a balance remains after 30 days there will be a 1% interest charge for every month it remains delinquent. If the account is sent to a 3rd party collection agency a $50.00 charge will be applied.

Patient's Signature: _____Date: _____

Guardian Signature: _____Date: _____

Height_____ Weight_____ Age_____

1. Indicate on the drawings below where you have pain/symptoms:



2. How would you describe the type of pain?

☐ Sharp
☐ Dull
☐ Diffuse
☐ Achy
☐ Burning
☐ Shooting
☐ Stiff
☐ Numb
☐ Tingly
☐ Sharp with motion
☐ Shooting with motion
☐ Stabbing with motion
☐ Electric like with motion
☐ Other: _____

3. How are your symptoms changing with time?

☐ Getting worse ☐ Staying the same ☐ Getting better

Area of Pain / Symptom & Intensity	**Normal**	**Minimal**	**Slight**			**Moderate**			**Severe**			**Frequency**				
													25%	50%	75%	100%
Neck		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Middle Back		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Lower Back		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Headache		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Other:		1	2	3	4	5	6	7	8	9	10		O	I	F	C

4. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER Physician ☐ Orthopedist ☐ Other: _____
☐ Massage Therapist ☐ Physical Therapist ☐ No one

5. How long have you had this problem? _____Date of onset (if known):_____

6. How do you think your problem began? _____

7. What aggravates your problem? _____

8. List all prescription medications you are currently taking: _____

9. List all the over-the-counter medications you are currently taking:_____

_____

10. List all surgical procedures you have had: _____

_____

11. Anything else pertinent to your visit today? _____

12. For each of the conditions listed below, place a check in the "Past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "Present" column

Past/Present		Past/Present		Past/Present	
☐	☐ Headache	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Upper Back Pain	☐	☐ Chest Pains	☐	☐ Frequent Urination
☐	☐ Mid Back Pain	☐	☐ Stroke	☐	☐ Smoking/Tobacco Use
☐	☐ Low Back Pain	☐	☐ Angina	☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain	☐	☐ Kidney Stones	☐	☐ Allergies
☐	☐ Elbow/Upper Arm Pain	☐	☐ Kidney Disorders	☐	☐ Depression
☐	☐ Wrist Pain	☐	☐ Bladder Infection	☐	☐ Systemic Lupus
☐	☐ Hand Pain	☐	☐ Painful Urination	☐	☐ Epilepsy
☐	☐ Hip Pain	☐	☐ Loss of Bladder Control	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Upper Leg Pain	☐	☐ Prostate Problems	☐	☐ HIV/AIDS
☐	☐ Knee Pain	☐	☐ Abnormal Weight Gain/Loss		
☐	☐ Ankle/Foot Pain	☐	☐ Loss of Appetite		
☐	☐ Jaw Pain	☐	☐ Abdominal Pain	☐	☐ Birth Control Pills
☐	☐ Joint Pain/Stiffness	☐	☐ Ulcer	☐	☐ Hormonal Replacement
☐	☐ Arthritis	☐	☐ Hepatitis	☐	☐ Pregnancy
☐	☐ Rheumatoid Arthritis	☐	☐ Liver/Gall Bladder Disorder		
☐	☐ Cancer	☐	☐ General Fatigue		
☐	☐ Tumor	☐	☐ Muscular In-coordination		
☐	☐ Asthma	☐	☐ Visual Disturbances		
☐	☐ Chronic Sinusitis	☐	☐ Dizziness		
☐	☐ Other:_____				

_____ _____

Patient Signature Date

Action Chiropractic
284 Lee ST. SW Suite 128
Tumwater, WA 98501

FORM: NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your Privacy Rights has also been provided to you.

Action Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes and to evaluate the quality of care that you receive.

Action Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Action Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Action Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulation. You have the right to request restrictions or revoke your authorization and request an accounting of your health records.

You may complain to the Department of Health and Human Services if you believe your privacy right has been violated. You will not be retaliated against for filing a complaint.

Action Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it is unable to agree to the requested restriction on how your information is used or disclosed, and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

_____ _____

Patient Signature Date

ACTION CHIROPRACTIC

284 Lee St. SW Suite 128
Tumwater, WA 98501
Telephone: (360) 489-0469
Fax: (360) 489-0468

LATE POLICY

If a client is late, we will make every effort to give the amount of time scheduled for the session. The scheduled fee shall be paid if all the scheduled time can be made up or not.

If the therapist is late, the session will last the full amount of time originally scheduled.

NO SHOW POLICY

All appointments must be cancelled by the last hour of our work day (hours listed below). By doing this, it will avoid any charges in the event of a no-show or a late cancellation fee. The first no-show appointment will have no charged fee; however, the following appointments that a patient fails to be present at will result in a $35 charge. At Action Chiropractic we consider a no-show appointment any time a patient has not given the advanced notice required above or has failed to arrive within 15 minutes of the appointment time.
We understand emergencies occur and sometimes appointments must be cancelled, but we ask that you respect our time. Please contact us as soon as you must cancel.

PAYMENT POLICY

All massages must be paid for at the time of service. Relaxation massage given with no referral or diagnosis is $70 for one hour. Injury treatment massage will require a referral and a diagnosis from a doctor, and time of service payment will be $180. Insurance co-payments and/or coinsurance will be due at the time of service.

HOURS

Monday: 9-1 and 3-6
Wednesday: 9-1 and 3-6
Friday: 9-1 and 3-4:30

We ask that you read this carefully and sign it, as it will become part of your permanent record. If you have questions, please feel free to ask them before signing this form.

_____ _____

Patient Signature **Date**

_____

Print Name

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ*: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity **A The pain comes and goes and is very mild.** **B The pain is mild and does not vary much.** **C The pain comes and goes and is moderate.** **D The pain is moderate and does not vary much.** **E The pain comes and goes and is severe.** **F The pain is severe and does not vary much.**	***SECTION 6 - Standing*** **A I can stand as long as I want without pain.** **B I have some pain while standing, but it does not increase with time.** **C I cannot stand for longer than one hour without increasing pain.** **D I cannot stand for longer than 1/2 hour without increasing pain.** **E I cannot stand for longer than ten minute without increasing pain.** **F I avoid standing, because it increases the pain straight away.**
SECTION 2 - Personal Care **A I would not have to change my way of washing or dressing in order to avoid pain.** **B I do not normally change my way of washing or dressing even though it causes some pain.** **C Washing and dressing increases the pain, but I manage not to change my way of doing it.** **D Washing and dressing increases the pain and I find it necessary to change my way of doing it.** **E Because of the pain, I am unable to do some washing and dressing without help.** **F Because of the pain, I am unable to do any washing or dressing without help.**	***SECTION 7 - Sleeping*** **A I get no pain in bed.** **B I get pain in bed, but it does not prevent me from sleeping well.** **C Because of pain, my normal night's sleep is reduced by less than one than one quarter.** **D Because of pain, my normal night's sleep is reduced by less than one-half.** **E Because of pain, my normal night's sleep is reduced by less than three-quarters.** **F Pain prevents me from sleeping at all.**
SECTION 3 - Lifting **A I can lift heavy weights without extra pain.** **B I can lift heavy weights, but it causes extra pain.** **C Pain prevents me from lifting heavy weights off the floor.** **D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.** **E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.** **F I can only lift very light weights, at the most.**	***SECTION 8 - Social Life*** **A My social life is normal and gives me no pain.** **B My social life is normal, but increases the degree of my pain.** **C Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc.** **D Pain has restricted my social life and I do not go out very often.** **E Pain has restricted my social life to my home.** **F I have hardly any social life because of the pain.**
SECTION 4 - Walking **A Pain does not prevent me from walking any distance.** **B Pain prevents me from walking more than one mile.** **C Pain prevents me from walking more than 1/2 mile.** **D Pain prevents me from walking more than 1/4 mile.** **E I can only walk while using a cane or on crutches.** **F I am in bed most of the time and have to crawl to the toilet.**	***SECTION 9 - Traveling*** **A I get no pain while traveling.** **B I get some pain while traveling, but none of my usual forms of travel make it any worse.** **C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.** **D I get extra pain while traveling which compels me to seek alternative forms of travel.** **E Pain restricts all forms of travel.** **F Pain prevents all forms of travel except that done lying down.**
SECTION 5 - Sitting **A I can sit in any chair as long as I like without pain.** **B I can only sit in my favorite chair as long as I like.** **C Pain prevents me from sitting more than one hour.** **D Pain prevents me from sitting more than 1/2 hour.** **E Pain prevents me from sitting more than ten minutes.** **F Pain prevents me from sitting at all.**	***SECTION 10 - Changing Degree of Pain*** **A My pain is rapidly getting better.** **B My pain fluctuates, but overall is definitely getting better.** **C My pain seems to be getting better, but improvement is slow at present.** **D My pain is neither getting better nor worse.** **E My pain is gradually worsening.** **F My pain is rapidly worsening.**

COMMENTS:_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____

Fairbank J, Davies J, et al. The Oswestry Low Back Pain Disability Questionnaire. Physiother 1980; 66(18): 271-273.

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ*: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity **A I have no pain at the moment.** **B The pain is very mild at the moment.** **C The pain is moderate at the moment.** **D The pain is fairly severe at the moment.** **E The pain is very severe at the moment.** **F The pain is the worst imaginable at the moment.**	***SECTION 6 - Concentration*** **A I can concentrate fully when I want to with no difficulty.** **B I can concentrate fully when I want to with slight difficulty.** **C I have a fair degree of difficulty in concentrating when I want to.** **D I have a lot of difficulty in concentrating when I want to.** **E I have a great deal of difficulty in concentrating when I want to.** **F I cannot concentrate at all.**
SECTION 2 -Personal Care (Washing, Dressing, etc.) **A I can look after myself normally without causing extra pain.** **B I can look after myself normally, but it causes extra pain.** **C It is painful to look after myself and I am slow and careful.** **D I need some help, but manage most of my personal care.** **E I need help every day in most aspects of self care.** **F I do not get dressed, I wash with difficulty and stay in bed.**	***SECTION 7 - Work*** **A I can do as much work as I want to.** **B I can only do my usual work, but no more.** **C I can do most of my usual work, but no more.** **D I cannot do my usual work.** **E I can hardly do any work at all.** **F I cannot do any work at all.**
SECTION 3 - Lifting **A I can lift heavy weights without extra pain.** **B I can lift heavy weights, but it gives extra pain.** **C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.** **D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.** **E I can lift very light weights.** **F I cannot lift or carry anything at all.**	***SECTION 8 - Driving*** **A I can drive my car without any neck pain.** **B I can drive my car as long as I want with slight pain in my neck.** **C I can drive my car as long as I want with moderate pain in my neck.** **D I cannot drive my car as long as I want because of moderate pain in my neck.** **E I can hardly drive at all because of severe pain in my neck.** **F I cannot drive my car at all.**
SECTION 4 - Reading **A I can read as much as I want to with no pain in my neck.** **B I can read as much as I want to with slight pain in my neck.** **C I can read as much as I want to with moderate pain in my neck.** **D I cannot read as much as I want because of moderate pain in my neck.** **E I cannot read as much as I want because of severe pain in my neck.** **F I cannot read at all.**	***SECTION 9 - Sleeping*** **A I have no trouble sleeping.** **B My sleep is slightly disturbed (less than 1 hour sleepless).** **C My sleep is mildly disturbed (1-2 hours sleepless).** **D My sleep is moderately disturbed (2-3 hours sleepless).** **E My sleep is greatly disturbed (3-5 hours sleepless).** **F My sleep is completely disturbed (5-7 hours)**
SECTION 5 - Headaches **A I have no headaches at all.** **B I have slight headaches which come infrequently.** **C I have moderate headaches which come infrequently.** **D I have moderate headaches which come frequently.** **E I have severe headaches which come frequently.** **F I have headaches almost all the time.**	***SECTION 10 - Recreation*** **A I am able to engage in all of my recreational activities with no neck pain at all.** **B I am able to engage in all of my recreational activities with some pain in my neck.** **C I am able to engage in most, but not all of my recreational activities because of pain in my neck.** **D I am able to engage in a few of my recreational activities because of pain in my neck.** **E I can hardly do any recreational activities because of pain in my neck.** **F I cannot do any recreational activities at all.**

COMMENTS:_____

_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____