Cancellation Policy

We do require a 24 hour cancellation notice for Chiropractic and Massage appointments. If cancelling, it must be done prior to 24 hours of your appointment to avoid being charged. Appointments that are not cancelled prior to the 24 hour period will be billed at $80.00 for Chiropractic and $120.00 for Massage.

Thank you in advance for your cooperation.

____ ______________

Patient's name (printed) Date of birth

____ ______________

Patient Signature Date

____ ______________

Office Staff Signature Date

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Examination and Treatment: The doctor will perform a physical examination. The examination will consist of range of motion, orthopedic testing, palpation, and basic neurological testing. During treatment, the doctor will use his/her hands or a mechanical device in order to move your joints. This action may create an audible "pop" or "click", much like the sound when you crack your knuckles. Along with the sound, you may also experience a sense of movement in the joint. The doctor may also recommend procedures such as hot or cold packs, electrical muscle stim, traction, or exercise to enhance your response to treatment.

Anticipated Benefits of Chiropractic Treatment: Many or most patients will feel improvements in motion, decreased muscle and joint pain and improved well-being after a series of chiropractic adjustments.

Possible Risks of Chiropractic Treatment: As with any health care procedures, there are some complications that may arise following a chiropractic manipulation and/or therapy. A small number of patients may experience stiffness, soreness, or bruising following the first few treatments. Less likely complications could include muscle strain, ligament sprain, fracture, joint dislocation, disc, nerve, or spinal cord damage. There has been much debate and research over the association of chiropractic care and occurrence of stroke and arterial dissection. The latest scientific evidence does not establish a causal relationship but rather an association. An extremely small percentage of patients presenting to either a medical or chiropractic physician with head and neck pain, may be in early stages of a stroke. Unfortunately, there is no recognized screening procedure to identify these patients.

Other Treatment Options for the Musculoskeletal conditions:

1. Over-the-counter medication. Risks of these medications could include irritation of the stomach, kidneys, and liver.

2. Medical care anti-inflammatory drugs, pain killers, muscle relaxers, and steroids. The uses of these prescription drugs include all above side effects plus the dependence of the prescription drugs.

3. Hospitalization used with medical care includes all of the above risks, but also the additional risk of medical error, infection, or other complications.

4. Surgery with medical care includes all above risks, with the added risk of adverse reaction to anesthesia.

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment. This informed consent will remain in effect unless there are significant changes in my diagnosis. I have the right to withdraw my consent at any time, upon written notice. I have the right to refuse treatment at any time.

____ _____/_____/______
Patient's name (printed) Date of birth

____ ________________
Signature of patient Date

____ ________________
Signature of parent/guardian (if patient is a minor) Date

__________________________ __________________________ _____________
Doctor Printed Name Doctor Signature Date

PATIENT INTRODUCTION FORM

Today's Date: ______________________

Last Name:	**MI:**	**First Name:**
Home Address:	City:	State Zip:

Date of Birth: Age:	Cell phone:
Height: Weight:	Work phone:
Social Security #:	Employer's Name:
How did you hear about us?	Who can we thank for the referral?
E-mail address:	Can we send you our monthly e-newsletter?
Do you have insurance that you would like us to bill? (Please provide a copy of your card.)	☐ YES ☐NO If yes, name of company:
Emergency Contact: Name: Address:	Relationship: Phone:

IS THIS VISIT RELATED TO A:

- ☐ Work Related Injury
- ☐ Car Crash Injury
- ☐ Home Injury
- ☐ Sports or Recreational Injury
- ☐ Non-Injury Symptoms
- ☐ Check-up Only
- ☐ Other (Describe):

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Our office will provide insurance billing services for you if you so desire as a courtesy.

Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and/or any other balances not paid by your insurance carrier.

Your signature on this document indicates that you:

1) *Agree to pay for any outstanding bills incurred in this office.*
2) *Authorize the release of information necessary to secure the payment of benefits.*
3) *Authorize insurance payments to be made directly to Summit Chiropractic & Massage.*
4) *Authorize the use of this signature on all insurance submissions.*

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR TIME OF SERVICE PATIENTS AND THE CO-PAYMENT, DEDUCTIBLE OR CO-INSURANCE FOR REGULAR INSURANCE PATIENTS.

Signature of responsible party (Patient or Parent): ______________________ Date: ____________

CHIROPRACTIC HISTORY

Name: ______________________________ DOB: ________________ Date: ________________

MAIN COMPLAINT: ____

Do you have any prior history of problems with your neck, midback, or low back? If yes, explain: __________

____

When it began and how: ____

Have you seen any other doctors for your complaint? ________________________________

What makes this complaint worse? ____

What makes this complaint better? ____

Allergies: ____

Date of your last physical exam: ____

Have you experienced headaches? ____

Family Health History

Health problems of relatives: ____

Cardiovascular health history (i.e. stroke, TIA's, heart attack): ___________________________

____

Social & Occupational History

Job description: ____

Have you been able to work? ____

Work schedule: ____

Recreational Activities: ____

Lifestyle (hobbies, alcohol, tobacco & drug use, diet): _______________________________

____

Doctors Use Only

Patient Name: ______________________ DOB: ____________ Date: ____________

GENERAL HEALTH HISTORY

Check only those conditions that apply to you and indicate if you have had in the past or presently have:

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	I bruise easily	☐	☐
☐	I heal slowly	☐	☐
☐	My body temperature is normally low (feel cold)*	☐	☐
☐	Smoke cigarettes or use tobacco products	☐	☐
☐	Diabetic-Hypoglycemic or need to have dialysis.	☐	☐
☐	Do you have a heart pacemaker or neck or chest shunt?	☐	☐
☐	Heart attack	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Dizziness, blacked out, or fainting spell history	☐	☐
☐	Epilepsy-Seizure-Convulsion history	☐	☐
☐	History of gout, lupus, psoriasis, temporary paralysis, or spinal meningitis	☐	☐
☐	Cancer history or treatment of any type	☐	☐
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, disc degeneration, or herniated disc	☐	☐
☐	Told that you have spine bifida, abdominal aneurysm, or vascular conditions	☐	☐
☐	Have you ever been hospitalized? Why:	☐	☐
☐	Thyroid disorders	☐	☐
☐	Coma from head injury or other problem	☐	☐
☐	Told you have osteoporosis of your spine or osteopenia (weak bones)	☐	☐
☐	Told you have osteoarthritis or rheumatoid arthritis of your spine or joints	☐	☐
☐	**Women only: Check this box if you currently have any type of breast implants**	N/A	N/A
☐	**Women only: Check this box if there is any chance that you are currently pregnant**	N/A	N/A

PRIOR INJURY OR MUSCULOSKELETAL PAIN HISTORY

☐ I have no history of previous painful injury or pain.

If you have had prior injuries or pain, please check below:

☐ Work injury	☐ Fall	☐ Sports injury	☐ Lifting injury	☐ Car accident
☐ Motorcycle injury	☐ Bicycle injury	☐ Pedestrian injury	☐ Military injury	☐ Other injury
☐ Headaches/Migraines	☐ Neck pain or arm pain	☐ Middle back pain	☐ Low back/Leg pain	☐ Other pain

FRACTURES/BROKEN BONES

☐ I have never had any broken bones.

If you have broken any bones, indicate where and when:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib bone	
☐ Arm or hand bone		☐ Leg or foot bone	
☐ Pelvis bone		☐ Other	

PREVIOUS SURGERIES

☐ I have never had any surgical procedure.

If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine surgery (neck or back)		☐ Appendix	
☐ Disc surgery in neck or back		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Tonsillectomy		☐ Rib/Collar bone	
☐ Head/Brain		☐ Hernia	
☐ Shoulder/Arm/Leg		☐ Other	

*See common question answers.

Patient Name: ______________________________ DOB: ________________ Date: ________________

GENERAL HEALTH HISTORY (Page 2)

LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
❑ Headaches/Migraines		❑ Upper back pain, soreness, or stiffness	
❑ Neck pain, soreness, or stiffness		❑ Hip pain	
❑ Low back pain, soreness, stiffness		❑ Leg or foot pain, numbness, or tingling	
❑ Arm/hand pain, numbness, or tingling		❑ Other:	

Did your symptoms come on: ❑ Suddenly? or **❑ Gradually?**

SYMPTOM/PAIN DESCRIPTION

Please circle any word or words below that best describes how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious	Unbearable
Ache	Pricking	Shooting	Sickening	Soreness
Cutting	Tingling	Stabbing	Miserable	Pins and needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep pain	Falls asleep
Irritating	Burning-Hot	Dreadful	Superficial pain	Suffocating
Annoying	Drill like	Fearful	Stinging	Punishing
Stiff or tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

Have you ever been to a Chiropractor before for any condition? ❑ Yes ❑ No

If yes, Chiropractors name: ____ Year: ____________________

Problem seen for: ____

Do you have any problems laying face down on an examination table? ❑ Yes ❑ No

If yes, why: ____

ARE YOU TAKING ANY MEDICATIONS?

❑ I am not taking any medications currently.

Check any of the following that you are taking currently.

❑ Muscle relaxants	❑ Blood pressure/Stroke prevention medications	❑ Cortisone injections
❑ Pain/Anti-inflammatory meds	❑ Osteoporosis (bone strengthening) medications	❑ Other:

WHAT ACTIVITIES INCREASE YOUR PAIN LEVELS?

❑ Morning	❑ Bending your back	❑ Walking
❑ Afternoon or evening	❑ Lying down flat	❑ Standing
❑ During sleep hours	❑ Sitting	❑ Exercise/Stretching
❑ Standing up from sitting	❑ Poor posture	❑ Other:

HAS YOUR PAIN BEEN ASSOCIATED WITH:

❑ Excessive fatigue-malaise	❑ Bowel or bladder disorders	❑ Night pain or nighttime sweats
❑ Weight loss	❑ Ovarian pain	❑ Abdominal pain
❑ Low grade fever	❑ Kidney pain/painful urination	❑ Balance problems

DO YOU EXERCISE?

❑ I do no regular exercise.	❑ I exercise 1-2 times a week.	❑ I exercise 3-5 times a week.
❑ I stretch regularly.	❑ I do weight lifting at gym/home.	❑ I do cardiovascular work outs.
❑ I am willing to do exercise.	❑ I am not willing to do exercises.	❑ I do regular sports activities.

Patient Name: ______________________ DOB: ______________ Date: ______________

SYMPTOM QUESTIONNAIRE

Please fill out only the sections that apply to you. Skip sections that do not relate to your condition.

NECK REGION

YES	NO	
❑	❑	1. Does neck and head movement cause your neck pain to intensify?
❑	❑	2. Do you get dizzy when you look up or twist your head? If yes, how often:
❑	❑	3. Do you black out or lose your balance when you look up or twist your head? If yes, how often:
❑	❑	4. Do you have to support your head with your hand or grasp your mouth or hair to be able to lift your head up when you are lying down and attempting to sit up? If your difficulty/inability to lift your head without support is injury related, indicate how soon this occurred after injury? (__________min/hrs)
❑	❑	5. Do you feel your neck pain sends pain downwards between your shoulders?
❑	❑	6. Do you feel your neck pain sending pain downwards to the front of your chest?
❑	❑	7. Have you noticed your head leaning or tilting to one side recently?
❑	❑	8. Have you ever been diagnosed as having a disc bulge or herniation in your neck?

ARM, HAND, OR FINGER REGION

YES	NO	
❑	❑	1. Do you have pain, numbness, or tingling in your shoulder, upper arm, lower arm, or hand? Circle areas
❑	❑	2. Do you have pain, numbness, or tingling in your fingers? If yes, circle finger(s) that are involved: Thumb, Index finger, Middle finger, Ring finger, Little finger
❑	❑	3. Do you get increased arm numbness when lying flat on your back or sleeping on your side recently?
❑	❑	4. Does changing your sitting posture increase your arm/hand symptom intensity?
❑	❑	5. If you sit and slouch forward for several minutes, do your arm symptoms intensify?
❑	❑	6. If you have arm symptoms, do they improve when you lift your arms over your head?
❑	❑	7. If you have arm symptoms, do they worsen when you lift your arms over your head?
❑	❑	8. If you have nighttime hand or arm pain, does it help to shake and massage them?
❑	❑	9. Do your hands feel tender when you grasp objects recently?
❑	❑	10. Do you feel weakness in your grip strength recently?
❑	❑	11. Do you drop objects in your hand recently?
❑	❑	12. Do you have difficulty writing or doing small motions with your fingers recently?
❑	❑	13. Do your hand(s) or wrist get swollen recently?
❑	❑	14. Do your hands burn recently?
❑	❑	15. Are your fingers frequently cold?
❑	❑	16. Have you been diagnosed as having Raynaud's syndrome in your past?

MID BACK AND CHEST WALL REGION

YES	NO	
❑	❑	1. Do you have pain that shoots or radiates outward along your rib cage?
❑	❑	2. Does your mid back or chest wall pain intensify when you take a deep breath in or cough recently?
❑	❑	3. Does your mid back or chest wall pain intensify when you twist your torso, bend, or stoop forward?
❑	❑	4. When you bend your mid back to the left or right side, does your mid back pain or chest pain increase?
❑	❑	5. Have you been diagnosed as having angina before?
❑	❑	6. Do you have a tight band-like chest feeling recently?
❑	❑	7. Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
❑	❑	8. Does your mid back pain mostly bother you during sleep?
❑	❑	9. Does your upper-middle back pain radiate inwards or upwards into your neck?

Patient Name: ______________________ DOB: ______________ Date: ______________

SYMPTOM QUESTIONNAIRE

Please fill out only the sections that apply to you. Skip sections that do not relate to your condition.

LOW BACK, HIP AND LEG/FOOT REGION

Check any of the following body movements that intensify your low back pain or leg symptoms:

❑ Sitting ❑ Standing still	❑ Bending forwards ❑ Bending backwards	❑ Standing up ❑ Lying on your back	❑ Walking ❑ Putting on shoes

Check all locations of any current leg pain, numbness, or tingling:

❑ Hip ❑ Groin area	❑ Buttock ❑ Knee	❑ Back of thigh ❑ Front of thigh	❑ Calf ❑ Foot/toes

YES	NO	
❑	❑	1. When you cough, sneeze, or bear down to have a bowel movement, does your low back pain or leg pain get worse recently?
❑	❑	2. Do you have a consistent pattern of getting severe leg pain after walking for similar distances that is relieved by resting or sitting down? This pain resumes after walking for same distance again.
❑	❑	3. Do you get leg cramping while walking that is relieved by resting, leaning against an object, or sitting? This pain is worse at nighttime and is relieved by walking around for a couple of minutes.
❑	❑	4. Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at nighttime or while sitting.
❑	❑	5. Does your leg or foot drag on the floor recently?
❑	❑	6. Do you get a lot of leg cramps at nighttime recently?
❑	❑	7. Have you had any urinary or bowel incontinence recently or had difficulty urinating or having bowel movements during the same time as your having low back pain or leg pain?
❑	❑	8. Have you had abdominal pain, indigestion, and colicky symptoms with your low back pain?
❑	❑	9. Have you observed that any type of postural change does not relieve your low back pain?
❑	❑	10. Do your feet feel cold recently? If yes, indicate which foot or if both feet:
❑	❑	11. Have you ever been diagnosed as having a herniated or bulging disc in your low back in the past?
❑	❑	12. Have you ever had an injection of a steroid into your discs (spine) in your back or neck?
❑	❑	13. Have you recently noticed that either of your legs occasionally give out on you when you walk?
❑	❑	14. Does one or both of your legs feel weak recently?
❑	❑	15. Have you ever been diagnosed as having a spondylolisthesis in your low back region?
❑	❑	16. Have you or either of your parents ever been diagnosed as having an abdominal aneurysm?
❑	❑	17. If you have radiating leg or foot pain, did you notice low back pain or soreness before your leg symptoms?
❑	❑	18. If you have leg pain, is your leg pain primarily focused in front of your thigh(s)?
❑	❑	19. Has your anal-rectal region been completely numb recently?
❑	❑	**Men only: Do you have any recent prostate or urinary problems?**
❑	❑	**Women only: Do you have any recent ovarian, uterine, or bladder problems?**

SLEEPING PATTERNS

YES	NO	
❑	❑	Do you sleep poorly at night recently?
❑	❑	Do you sleep on your stomach?
❑	❑	Do you consistently feel extremely tired when you wake up in the morning recently? How old is your mattress? ______________ What make? ______________ How old is your pillow? ______________

SYMPTOM INTENSITY AND FREQUENCY FORM

PATIENT: ______________________________________ DATE: __________________________

For **SECTION 1**, describe on a scale of 1-10 how intense your pain or symptoms are. This includes the amount of aching, soreness, hurting, pain, numbness, and/or tingling levels present currently. A ***zero (0)*** indicates that no symptoms exist. ***1-3 pain level*** is a minimum level and indicates that your pain is an annoyance only. A ***4 pain*** is a slight level or where pain-doing activity begins to cause some disability. A ***5-7 pain*** is moderate in severity and has or restrict of limit your activity ability to a significant degree. An ***8-10 pain*** level is severe and indicates that your pain intensity is to point where you have complete inability to perform some tasks. For **SECTION 2**, describe how frequent you have symptoms such as pain, numbness, and tingling in the respected areas. Please pay attention to the headache portion.

SECTION 1. CURRENT PAIN INTENSITY LEVELS

Circle the box following the area of pain that best indicates your overall average-usual pain severity today.

Pain Intensity	None	MINIMAL Discomfort/Ache/Stiff			SLIGHT-TO-MODERATE Hurts/Sore/Bearable Sensation				SEVERE Sharp/Intense Pain		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck pain/Soreness	0	1	2	3	4	5	6	7	8	9	10
Arm/hand symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid-back pain	0	1	2	3	4	5	6	7	8	9	10
Low back pain	0	1	2	3	4	5	6	7	8	9	10
Leg/foot symptoms	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

SECTION 2a. CURRENT PAIN FREQUENCY LEVELS

Circle the box following the area of pain that best indicates the average percentage of time you have pain today.

Pain Frequency	None	Occasional			Intermittent			Frequent		Constant	
Neck pain/Soreness	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/hand symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid-back pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low back pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/foot symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Other	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

SECTION 2b. CURRENT HEADACHE FREQUENCY & DURATION

During the past week or since the accident/injury, if applicable (if less than one week), indicate how frequently you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.

A. How frequently do you have headaches/migraines currently?

- ❑ No headaches
- ❑ One a month
- ❑ Twice a month
- ❑ Once a week
- ❑ Twice a week
- ❑ 3 times a week
- ❑ 4 times a week
- ❑ 5 times a week
- ❑ Almost daily

B. How many hours does your typical headache/migraine last? ____________ hours

Neck Disability Index

Neck Index Score

Patient Name ______________________ Date ______________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help everyday in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights, but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Revised Oswestry Questionnaire

Name: ______________________________

Date: ______________________________

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

Pain Intensity	**Personal Care (Washing, Dressing, Etc.)**
❑ The pain comes and goes and is very mild. ❑ The pain is mild and does not vary much. ❑ The pain comes and goes and is moderate. ❑ The pain is moderate and does not vary much. ❑ The pain comes and goes and is severe. ❑ The pain is severe and does not vary much.	❑ I would not have to change my way of washing or dressing in order to avoid pain. ❑ I do not normally change my way of washing or dressing even though it causes some pain. ❑ Washing and dressing increases the pain, but I manage not to change my way of doing it. ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it. ❑ Because of the pain, I am unable to do some washing and dressing without help. ❑ Because of the pain, I am unable to do any washing or dressing without help.
Lifting	**Walking**
❑ I can lift heavy weights without extra pain. ❑ I can lift heavy weights, but it causes extra pain. ❑ Pain prevents me from lifting heavy weights off the floor. ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table. ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. ❑ I can only lift very light weights at the most.	❑ Pain does not prevent me from walking any distance. ❑ Pain prevents me from walking more than one mile. ❑ Pain prevents me from walking more than ½ mile. ❑ Pain prevents me from walking more than ¼ mile. ❑ I can only walk while using a cane or on crutches. ❑ I am in bed most of the time and have to crawl to the toilet.
Sitting	**Standing**
❑ I can sit in any chair as long as I like without pain. ❑ I can only sit in my favorite chair as long as I like. ❑ Pain prevents me from sitting more than one hour. ❑ Pain prevents me from sitting more than ½ hour. ❑ Pain prevents me from sitting more than ten minutes. ❑ Pain prevents me from sitting at all.	❑ I can stand as long as I want without pain. ❑ I have some pain while standing, but it does not increase with time. ❑ I cannot stand for longer than one hour without increasing pain. ❑ I cannot stand for longer than ½ hour without increasing pain. ❑ I cannot stand for longer than ten minutes without increasing pain. ❑ I avoid standing because it increases the pain straight away.

Revised Oswestry Questionnaire Patient Name: ___________________________ DOB:_____________

Sleeping	**Social Life**
❑ I get no pain in bed. ❑ I get pain in bed, but it does not prevent me from sleeping well. ❑ Because of pain, my normal night's sleep is reduced by less than one-quarter. ❑ Because of pain, my normal nights sleep is reduced by less than one-half. ❑ Because of pain, my normal night's sleep is reduced by less than three-quarters. ❑ Pain prevents me from sleeping at all.	❑ My social life is normal and gives me no pain. ❑ My social life is normal but increases the degree of my pain. ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc. ❑ Pain has restricted my social life and I do not go out very often. ❑ Pain has restricted my social life to my home. ❑ I have hardly any social life because of the pain.
Traveling	**Changing Degree of Pain**
❑ I get no pain while traveling. ❑ I get some pain while traveling, but none of my usual forms of travel make it any worse. ❑ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel. ❑ I get extra pain while traveling which compels me to seek alternative forms of travel. ❑ Pain restricts all forms of travel. ❑ Pain prevents all forms of travel except that done lying down.	❑ My pain is rapidly getting better. ❑ My pain fluctuates, but overall is definitely getting better. ❑ My pain seems to be getting better, but improvement is slow at present. ❑ My pain is neither getting better nor worse. ❑ My pain is gradually worsening. ❑ My pain is rapidly worsening.

Patient Acknowledgement of Privacy Notice

The Notice of Privacy Policy of **Summit Chiropractic and Massage** of West Linn describes how health information about me may be used and disclosed. The following is a summary of our Notice of Privacy Policy:

Your Rights - As examples, you have the right to:
- Get a copy of the privacy notice.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a copy of your paper or electronic medical record.
- File a complaint if you believe your privacy rights have been violated.

Your Choices - You have some choices in the way that we use and share information. With your permission, we may tell family and friends about your condition.

Our Uses and Disclosures - We may use and share your information as we:
- Treat you.
- Run our organization.
- Bill for your services.
- Help with public health and safety issues.
- Comply with the law.
- Respond to lawsuits and legal actions.

For further details, you may obtain a full copy of our Notice of Privacy Policy.

I, ______________________________ hereby acknowledge that I have had an opportunity to review the Notice of Privacy Policy and may obtain a copy of the Notice of Privacy Policy at will from **Summit Chiropractic and Massage** of West Linn. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

I authorize the following people access to my treatment and financial information and I authorize **Summit Chiropractic and Massage** to discuss treatment and finances with them:

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

I authorize Summit Chiropractic and Massage to leave detailed voice messages for me ❑

____ ____/____/_____

Patient's name (printed) Date of birth

____ ________________

Signature of patient Date

____ ________________

Signature of parent/guardian (if patient is a minor) Date