Patient Intake Form

Name:	DOB:
Address:	City/Zip Code:
Phone:	
Email:	
How'd you hear about us?	

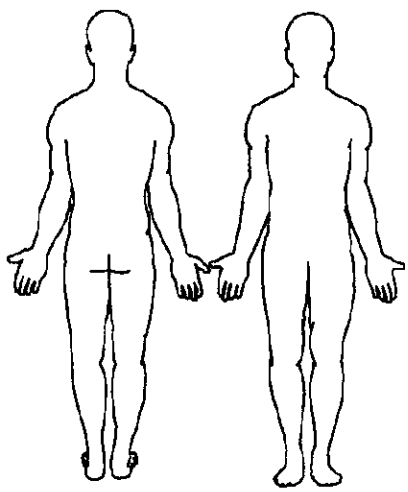
Brief description of the problem you are experiencing: _____

When did the problem first start? _____

Rate your pain on a scale of 1-10 _____

List any medical history that pertains to this visit: _____

Please mark on the bodies where you are feeling pain:



Signing below indicates you agree to treatment and services.

Signature: _____ Date: _____

Straight Up
CHIROPRACTIC
Massage & Rehab

Patient HIPPA Consent

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without your authorization is limited to situations that include emergency care, quality assurance, public health, and law enforcement. Any other disclosures for treatment, payment or practice operations will be made only after obtaining your written consent. You may request restrictions on your disclosures. You may also inspect and receive copies of your records within 30 days with a written request. You may request to view charges to your account. We may contact you for appointment reminders, announcements or to inform you about changes being made to our practice or staff. I, the patient, understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that my health information can be used to conduct, plan, and direct my treatment and follow up care with other healthcare providers who may be directly or indirectly involved, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments.

Printed Name: _____

Date of birth: _____

Signature: _____

Date: _____

Straight Up
CHIROPRACTIC
Massage & Rehab

Consent to Treatment

I, as the undersigned patient, or parent/guardian for the undersigned patient acknowledge that I will be entering/maintaining treatment with Straight Up Chiropractic for the purpose of receiving chiropractic treatment. If I have already undergone chiropractic treatment with this office, I hereby consent to receiving continued chiropractic care for purposes of maintenance, supportive, or general healthcare while or while not also receiving concurrent healthcare from another chiropractor or healthcare provider. I authorize any of the chiropractors, massage therapists, acupuncturists or naturopaths associated with Straight Up Chiropractic to administer and provide me with such treatment which is determined to be necessary and/or appropriate for my condition and/or appropriate for my condition and/or appropriate for ongoing treatment as determined by the treating practitioner. This consent includes my consent for diagnostic procedures, all forms of chiropractic treatment, and ancillary procedures which are administered under the instructions of my treating practitioner; including but not limited to, procedures and modalities of treatment including ultrasound, traction, cold/hot therapy, physical therapy, massage, and acupuncture.

I understand that the practice of chiropractic, massage, acupuncture and/or naturopathic is not an exact science and the rendition of the treatment at this clinic may involve risks of injury. I acknowledge that no guarantees have been made to me with respect to the results of my examinations and/or treatment at this office. I acknowledge that I have freely and voluntarily read and signed the informed consent either on my behalf or on the behalf of my minor child or ward.

I understand that I may be asked to sign healthcare authorization forms which are necessary to either release my confidential healthcare information to third parties or otherwise access such healthcare information from such third parties. I understand that I may review and obtain a copy of my billing charges at no expense and copies of my healthcare treatment records at an expense which shall be disclosed in advance by this office.

The undersigned hereby acknowledges reading this document and freely and voluntarily agreeing to sign this document with acceptance of all terms and provisions of the agreement.

_____ _____

Printed Name Date of Birth

_____ _____

Signature Today's Date

Straight Up Chiropractic, LLC

Financial Agreement

By signing this document, I acknowledge that I have been informed of the chiropractic and physical therapy benefits available to me based on the coverage of the insurance plan I have. I have also been made aware of the Time of Service (TOS) payment option. All questions have been answered to my satisfaction.

Option A: Bill Insurance

I request that Straight Up Chiropractic process the claims through my health insurance company for the services provided. I understand that if I have not yet met the deductible on my plan, I am responsible for paying the allowable amount for the services provided. This may include, but is not limited to charges for exams, spinal manipulation, extremity manipulation, therapeutic activities, manual therapy, and therapeutic exercise. I will be billed for the allowable amount after the claim has been processed, and this amount will be applied to my deductible. If my deductible has not been met, I will make a payment towards deductible as services are rendered. These monies will go towards my deductible at each appointment until my deductible is met.

Option B: Time of Service

I request to pay the Time of Service (TOS) rates for the services provided to me. I understand that Straight Up Chiropractic will not process any claims through my health insurance company and no amount will be applied to my deductible. I am responsible for paying for services on the date the services are rendered. This may include but is not limited to charges for exams, spinal manipulation, extremity manipulation, therapeutic activities, manual therapy, and therapeutic exercise.

Option: A B (Please circle one)

Services rendered including but not limited to chiropractic* and physical therapy**

*Chiropractic may include exams, re-exams, spinal manipulation, and extremity manipulation.

**Physical therapy may include manual and soft tissue therapy, therapeutic exercises, therapeutic activities, and extremity manipulation.

Printed name:_____ Date of Birth:_____

Signed:_____ Today's date:_____



Straight Up Chiropractic

12700 SW North Dakota St #180 Tigard, OR 97223

Phone: 503-716-8281

Patient Acknowledgement: No Show Policy

_____ I acknowledge that there will be a $100 cancellation fee if my appointment is not cancelled 24 hours before the scheduled time with one of our Licensed Massage Therapists (LMT). This is my responsibility and cannot be billed to my insurance company.

_____ I acknowledge that if my insurance plan does not allow missed appointment fees to be collected (including Oregon Health Plan), I am expected to maintain consistent attendance.

_____ **ONE** missed appointment or late cancellation (not cancelled 24 hours before scheduled time) will result in a verbal or written warning.

_____ **SECOND** missed appointment or late cancellation will result in the inability to continue scheduling future visits at our office.

_____ I understand that special circumstances may be considered, and decisions will be made by the clinic based on each individual situation.

By initialing and signing - I acknowledge I have read, understand and agree to all terms.

Print Name: _____

Signature of Patient/Guardian: _____

Date: _____

Neck Disability Index

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR **NECK PAIN** AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU.
ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ☐ I have no neck pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

- ☐ I can look after myself normally without causing extra neck pain.
- ☐ I can look after myself normally, but it causes extra neck pain.
- ☐ It is painful to look after myself, and I am slow and careful
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self -care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ☐ I can lift heavy weights without causing extra neck pain.
- ☐ I can lift heavy weights, but it gives me extra neck pain.
- ☐ Neck pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Neck pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – READING

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

SECTION 5 – HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

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

SECTION 7 – WORK

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

SECTION 8 – DRIVING

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

SECTION 9 – SLEEPING

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

SECTION 10 – RECREATION

- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all my recreational activities with some neck pain.
- ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my recreational activities because of neck pain.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain.

PATIENT NAME _____ **DATE** _____

SCORE _____ [50]

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HVERNON@CMCC.CA

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | 0 1 2 3 4 5 6 7 8 9 10 | ***Unbearable pain***

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____