DORLAND CHIROPRACTIC CLINIC

CONFIDENTIAL PATIENT INFORMATION

Dear Patient,

Please complete this questionnaire. This information is a confidential record between your Doctor and you. Illness doesn't just happen, it accumulates. The information below is important to our analysis of your care. We only accept patients that we sincerely feel we can help.

Name _____ Ph.#(H)_____(W) _____(C)_____

Address _____ City_____ Zip_____

Age____ Birthdate_____ Status M S W D Number of Children_____

Occupation_____ Employer Name &City_____

Emergency Name and Phone (office, relatives, etc.)_____

Medical Insurance_____ ID#_____

Email: _____ May we add you to our email list? Yes ☐ No ☐

Who may we thank for referring you? _____

Please notify receptionist if you have been in an accident or injured.

PRESENT HEALTH CONCERN

Purpose of this appointment (briefly describe symptoms)_____

_____

Possible cause?_____

How long have you had this condition? _____ What aggravates your condition?_____

Have you had this or similar conditions in the past?_____

Is condition getting worse? Yes No ☐ Constant_____

Is condition interfering with work? ___Sleep___ Daily routine?_____

What treatment have you received for this? _____

HEALTH HISTORY

Date of last physical exam_____ Date of last x-rays_____

Family Doctor, Current Medications_____

Surgical operations and dates_____

Previous Chiropractic care? Yes ☐ No☐ When_____ Results_____

Involved in auto accident? Yes☐ No☐Year(s)_____

How long has it been since you have really felt good?_____

FAMILY HEALTH HISTORY

Health problems of parents _____

Health problems of children_____

Health problems of spouse_____

HABITS

Sleep (Hrs. per night)_____Sweets (How much) _____Coffee/Tea (Cups per day)_____

Tobacco (How much)_____ Soda Pop (How much)_____ Alcohol (How much)_____

What % of diet is fruits &vegetables_____What % is raw_____

What do you do for exercise?_____

What do you do to rest & recharge?_____

Nutritional supplements taken_____

HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS? PLEASE CHECK.

GENERAL
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Hyperactivity
- ☐ Frequent Colds
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Bruise Easily
- ☐ Allergies
- ☐ Skin Conditions
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Bed Wetting
- ☐ Kidney Problems
- ☐ Prostrate Problems
- ☐ Asthma
- ☐ Sinus Congestion
- ☐ Thyroid Trouble
- ☐ Sore Throats
- ☐ Difficult Swallowing
- ☐ Hiatal Hernia
- ☐ Gall Bladder Trouble
- ☐ Nervousness
- ☐ Irritability
- ☐ Depression
- ☐ Fatigue
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ General Run down Feeling

HEAD
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Pain in eyes
  - ☐ Headache
  - ☐ Entire head
  - ☐ Back of head
  - ☐ Forehead
  - ☐ Temples
  - ☐ Migraine
- ☐ Light bother eyes
- ☐ Loss of smell

HEADCON'T
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears

NECK
- ☐ Pain in neck
- ☐ Neck pain with movement
- ☐ Stiff neck
- ☐ Muscle spasms in neck
- ☐ Grinding sound in neck

SHOULDERS
- ☐ Pain in shoulder joints (R L)
- ☐ Pain across shoulders
- ☐ Bursitis (R L)
- ☐ Can't Raise arm
  - ☐ Above shoulder
  - ☐ Overhead
- ☐ Tension in shoulders
- ☐ Muscle spasm

ABDOMEN
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas Constipation
- ☐ Diarrhea
- ☐ Ulcers

ARMS AND HANDS
- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins &needles
  - ☐ in arms
  - ☐ in hands
  - ☐ fingers go to sleep
- ☐ Numbness in fingers
- ☐ Hands cold
- ☐ Loss of grip strength

CHEST
- ☐ Pain around ribs
- ☐ Cough Chest pain

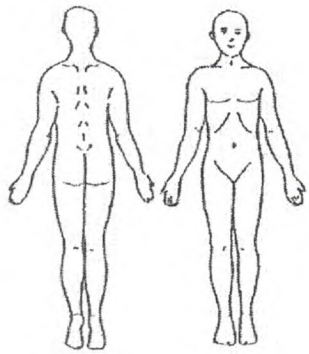
MID-BACK
- ☐ Mid-back pain
- ☐ Muscle spasm

WOMEN ONLY
- ☐ Menstrual pain
- ☐ Cramping
- ☐ Irregularity
- ☐ Pregnant?
  - ☐ If not, I'm able to take whatever x-rays may be necessary

LOW BACK
- ☐ Low back pain
- ☐ Low back pain is worse:
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ coughing
  - ☐ lying down
- ☐ Pinched nerves in low back
- ☐ Slipped disc
- ☐ Low back feels out of place
- ☐ Muscle Spasm

HIP, LEGS AND FEET
- ☐ Pain in buttocks (R L)
- ☐ Pain in hip joint (R L)
- ☐ Pain down leg (R L)
- ☐ Pain down both legs
- ☐ Leg cramps
- ☐ Pins/needles in leg (R L)
- ☐ Numbness in legs (R L)
- ☐ Numbness in feet (R L)
- ☐ Feet feel cold
- ☐ Cramps in feet (R L)
- ☐ Swollen ankle/feet (R L)
- ☐ Painful joints in toes

Please mark on the diagram the area of your discomfort



I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I understand that the Chiropractor's office will prepare the forms to assist me in making collection from the insurance company. However, I understand and agree that all services rendered me are charged directly to me and I am personally responsible for services rendered me will be immediately due and payable.

Patient's Signature_____Date_____

Patient's Guardian/Spouse's
Signature Authorizing Care_____Date_____

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____

Patient Name _____ Patient Signature _____

Examinner _____ Date _____ Score _____ (70)

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

Inmates or individuals in custody. If you are an inmate of a correction institution or other custody of the law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with healthcare; 2) to protect your health and safety or the health and safety of others, or, 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to inspect and copy: You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our privacy Officer.

Right to Amend: If you feel that Health Information, we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request in writing, to our Privacy Officer.

Right to Accounting of Disclosure: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of Disclosures, you must make your request in writing to our Privacy Officer.

Right to Request Restrictions: You have the right to request restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have the right to request a limit on Health Information we disclose to someone involved in you care or the payment for your care., like a family member or spouse. To request a restriction, you must make a request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication: you have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable request.

Right to a Paper Copy of This Notice: you have a right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future, we will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints: if you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

By signing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature Date

Dorland Chiropractic Clinic
713 SE Everett Mall Way Suite #B
Everett, WA 98208

Patient Messaging Consent

By supplying my home number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balance due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages individuals you have provided with access to your digital devices or email accounts) limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

_____ _____

Print Name Date

_____ _____

Signature Cell Phone Carrier

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understands both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not more properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of the force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache and dizziness.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name Signature Date

Dorland Chiropractic Clinic
713 SE Everett Mall Way, STE #B
Everett, WA 98208
425-337-5588