INITIAL HEALTH STATUS

Milwaukie Chiropractic Center
Keith D. Johns, D.C., P.C. • Steve L. Sebers, D.C., F.A.C.O. • Theresa White, D.C. • Erica Staehle, M.S., D.C.

Patient Name: ______________________ **Birthdate:** ______________ **Sex: M / F**

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

____

____

____

DATE PROBLEM BEGAN: ______________________

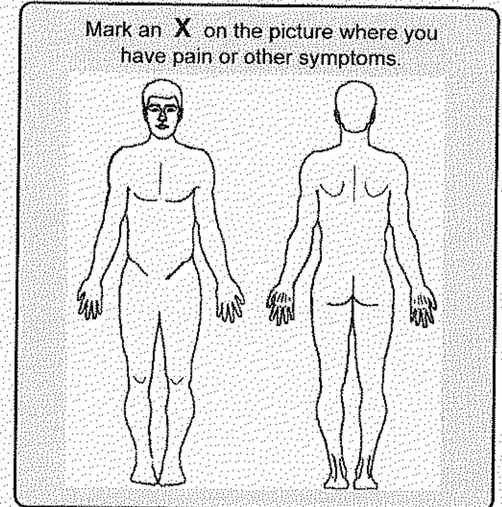
Is this? ❑ Work Related ❑ Auto Related ❑ N/A

How do you feel today? ______________________

No Pain **0 1 2 3 4 5 6 7 8 9 10** Excruciating

(please circle)

Mark an **X** on the picture where you have pain or other symptoms.



How often are your symptoms present? ❑ **0-25%** ❑ **26-50%** ❑ **51-75%** ❑ **76-100%**

Can you perform your daily activities? ❑ **Yes** ❑ **No**

If **No**, describe: ______________________________

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ❑ **Yes** ❑ **No** **Date(s) taken:** ____________

WHAT AREAS WERE TAKEN? ______________________________

FAMILY HISTORY: ❑ Cancer ❑ Diabetes ❑ High Blood Pressure ❑ Cardiovascular Problems/Stroke

PLEASE CHECK ALL OF THE FOLLOWING THAT MAY APPLY TO YOU:

Past	Present		Past	Present	
❑	❑	Numbness in Groin/Buttocks	❑	❑	Visual Disturbances
❑	❑	History of Recent Infection	❑	❑	Low/Mid Back Pain
❑	❑	High Blood Pressure	❑	❑	Frequent Urination
❑	❑	Corticosteriod Use	❑	❑	Prostate Problems
❑	❑	Dizziness/Fainting	❑	❑	Epilepsy/Seizures
❑	❑	Urinary Retention	❑	❑	Tobacco Use
❑	❑	Birth Control Pills	❑	❑	Alcohol Use
❑	❑	Aortic Aneurysm	❑	❑	Neck Pain
❑	❑	Cancer/Tumor	❑	❑	Arthritis
❑	❑	Osteoporosis	❑	❑	Pregnancy, # of births: ________
❑	❑	HIV/AIDS	❑	❑	Abnormal Weight: ❑ Gain ❑ Loss
❑	❑	Diabetes	❑	❑	Surgeries/Medications *(please list)*:
❑	❑	Trauma			________________
❑	❑	Fever			________________
❑	❑	Stroke (date) ________			________________

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: ______________________ **Date:** ______________

WRITE LEGIBLY

WRITE LEGIBLY

POLICY AND PATIENT DATA

- **PAYMENT** is due at the time of service, unless other arrangements have been made.
- An **INSURANCE CONTRACT** is between the patient and the patient's insurance company; therefore, it is the responsibility of the patient to keep the account current.
- Patients involved in **LITIGATION** (lawsuits) are, as others, responsible for their services here at the clinic.
- We reserve the right to **BILL FOR MISSED APPOINTMENTS**.
- Personal cleanliness is requested due to the close interpersonal nature of this work.
- **SMOKING IS PROHIBITED**.

PATIENT INFORMATION

❑ MALE ❑ FEMALE

❑ SINGLE ❑ MARRIED ❑ OTHER

PATIENT'S NAME (Last Name, First Name, Middle Initial)			DATE OF BIRTH	AGE	SSN	
PATIENT'S ADDRESS (No., Street)			DRIVER'S LICENSE NUMBER	STATE OF ISSUE	HEIGHT	WEIGHT
CITY	STATE	ZIP CODE	EMAIL ADDRESS		BY WHOM WERE YOU REFERRED?	
HOME PHONE (Include Area Code)	WORK PHONE (Include Area Code)		CELL PHONE (Include Area Code)		OCCUPATION	
PREVIOUS ADDRESS			CITY	STATE	ZIP CODE	
EMPLOYER'S NAME OR SCHOOL'S NAME	❑ FULL TIME ❑ PART TIME		EMPLOYER'S ADDRESS OR SCHOOL'S ADDRESS			

CIRCLE ONE OF THE FOLLOWING: SPOUSE / PARENT / INSURANCE SUBSCRIBER INFORMATION

NAME (Last Name, First Name, Middle Initial)		DATE OF BIRTH	AGE	SSN
WORK PHONE (Include Area Code)	CELL PHONE (Include Area Code)	EMAIL ADDRESS		
OCCUPATION	EMPLOYER'S NAME OR SCHOOL'S NAME	EMPLOYER'S ADDRESS OR SCHOOL'S ADDRESS		

EMERGENCY INFORMATION

IN THE EVENT OF AN EMERGENCY WHOM SHOULD WE NOTIFY?	RELATIONSHIP TO PATIENT	DAYTIME PHONE (Include Area Code)

PATIENT'S SIGNATURE	DATE
X	

THE ABOVE SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE POLICIES ABOVE AND AGREE TO ABIDE BY THE SAME.

GUARDIAN'S SIGNATURE	DATE
X	

IF PATIENT IS A MINOR: PERMISSION IS HEREBY GIVEN BY ME, TO YOUR PROVIDER TO TREAT THE PATIENT. I AM HIS/HER LEGAL GUARDIAN.

YOU ARE AUTHORIZED TO RELEASE ANY INFORMATION YOU DEEM APPROPRIATE CONCERNING MY PHYSICAL CONDITION TO ANY INSURANCE COMPANY, ATTORNEY, PRIMARY CARE PROVIDERS, OR ADJUSTER IN ORDER TO PROCESS ANY CLAIM FOR REIMBURSEMENT OF CHARGES INCURRED BY ME AS A RESULT OF PROFESSIONAL SERVICES RENDERED BY YOU, AND I HEREBY RELEASE KEITH D. JOHNS, D.C., P.C., DBA MILWAUKIE CHIROPRACTIC CENTER, ITS PROVIDERS AND ASSOCIATES OF ANY CONSEQUENCES THEREOF.

PATIENT'S SIGNATURE	DATE
X	

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE ABOVE STATEMENT AND PERMISSION IS HEREBY GIVEN BY ME.

OFFICE POLICIES & FINANCIAL AGREEMENT

Welcome to Milwaukie Chiropractic Center. We are committed to providing you with the best possible services and we also want you to understand our policies regarding professional fees, your financial responsibility, and our billing practices. Please feel free to ask the office staff or your doctor for clarification should you have any questions. A copy of this signed financial agreement will be given to you for your records upon request.

Professional Fees

Our fee schedule is based on prevailing standards in the community. Some fees vary slightly because they are governed by contracts with managed health care companies. Fees may be charged for, but not limited to:

1. Examination and consultation.
2. Medical services rendered:
   - Electrical Muscle Stimulation
   - Massage
   - Manipulation
   - Ultrasound
   - Traction
   - IV Therapy
   - Lab
   - X-rays
   - Supplements
   - IM Injections
   - Exercise Instruction
3. Telephone consultation with attorneys or other providers regarding your case.
4. Appointments that are broken without notice or rescheduled with less than 24 hour notice.

Financial Agreement

Many people believe that when they use their health insurance that it is the insurance company that owes the doctor for his services. This is not the case. The health insurance contract is ***between you and your insurance company***. Therefore, you are responsible for payment of all fees regardless of any insurance coverage. As a courtesy to our patients we bill all insurance companies if chiropractic services are covered. If you are using your health insurance, you must supply us with complete information about your coverage and a copy of your health insurance card. If you belong to a managed healthcare plan, all co-payments are due at the time of service. Most health insurance plans do not cover 100% of the cost for medical treatment. If your insurance has not paid for covered services within 60 days of the service, you will need to make full payment to this office and be reimbursed when insurance pays.

Payment for uncovered fees is due in full by the 10th of each month or payable according to an agreement that you have made with the office manager. You will receive a monthly statement showing any balance due.

Clients who are not insured are expected to pay fees in full at the time of service unless other arrangements have been made with the office manager. Payments by all clients may be made with cash, check, Visa, or Mastercard. Delinquent accounts will be referred for collection at the discretion of the office manager.

Please sign and return this form to the receptionist.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If I am using my health insurance benefits, I hereby assign my insurance benefits to Milwaukie Chiropractic Center and I authorize the staff to provide to my insurance company any information regarding myself or my minor child that is required or necessary for the submission of a claim for services provided. I understand that I have access to any and all information provided. I agree to the above terms and conditions and I acknowledge that I have received a copy of these office policies and financial agreement upon request.

____
Please print your name

____________________________________ ***Date:*** ____________________
Sign here

Milwaukie Chiropractic Center

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

PLEASE READ THIS CONSENT FORM, DISCUSS IT WITH THE DOCTOR IF YOU WOULD LIKE, THEN SIGN WHERE INDICATED AT THE BOTTOM.

Clinicians who use spinal manual therapy techniques, e.g., joint adjustment, manipulation, 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 one time per one million treatments.

c. There have been reported cases of disc injuries following spinal manual therapy, although no specific scientific study has ever demonstrated that such injuries are caused or may be caused by adjustments or manipulative techniques and such cases are also very rare.

Treatment provided at this clinic including spinal adjustment, manipulation and/or mobilization have been the subject of much research 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 wellbeing. 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.

The doctor 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 the doctor 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 the doctor including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic.

Name: ______________________________ Date: ____________

Please Print Name of Patient

____

Patient Signature

PARQ ____________ ______________________________ Date: ____________

Provider Signature

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office which is required to provide you with quality care and tc comply with certain legal requirements. This notice will tell you about the ways we may use and share this medical information about you. We also describe your rights and certain duties we have regarding the use and disclosures of medical information. We are required by law to keep your medical information private, give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information. We have the right to change our privacy practices and the terms of this notice anytime, provided that the changes are permitted by law. Before we make an important change in our privacy practices we will change this notice and make the new notice available to you upon request. Any specific written authorization you provide may be revoked by writing to us.

USE AND DISCLOSURE OF MEDICAL INFORMATION:

Your protected health information may be used and disclosed by our office to others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you, e.g. referrals to other physicians. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice, e.g. insurance companies often require chart notes for payment or authorization of treatment, managed care groups often require release of nformation for physician performance evaluation.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT:

- **Required by law:** We may disclose your protected health information to the extent that the use or disclosure is required by law.
- **Public Health:** Disclosure for public health activities and purposes to a public health authority, e.g. to prevent or control a disease.
- **Communicable Disease:** Disclosure pertaining to risk of contracting or spreading a communicable disease or condition.
- **Health Oversight:** Disclosure to agencies authorized by law such as government agencies, regulatory programs, etc. for audits, inspections, investigations, etc.
- **Abuse or Neglect:** Disclosure to a public health authority authorized by law to receive reports of child abuse or neglect. In addition we may disclose this information if we believe you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive this information and will be made consistent with applicable state and federal laws.
- **Food and Drug Administration:** Disclosure for the purpose of quality, safety, or effectiveness of FDA related products or activities.
- **Legal Proceedings:** Disclosure for judicial or administrative proceedings, in response to a court order, response to subpoena, discovery request o- other lawful process.
- **Law Enforcement:** Disclosure for legal processes, limited information for identification and location purposes, pertaining to victims of a crime, suspicion that death has occurred as a result of criminal conduct, if a crime occurs on our premises, medical emergency (not on our premises) that it is likely a crime has occurred.
- **Coroners, Funeral Directors, Organ Donation:** Disclosure for identification purposes, cause of death or for the entity to perform their duties authorized by law. Disclosure also for cadaveric organ, eye or tissue donation purposes.
- **Research:** Disclosure to researchers when approved by institutional review board which has established the research protocols ensure the privacy of your protected health information.
- **Criminal Activity:** Disclosure consistent with applicable federal and state laws.
- **Military Activity and National Security:** Disclosure for Armed Forces personnel for activities deemed necessary by military command authorities, determination of eligibility benefits by the Dept of Veteran Affairs, foreign military authority if you are a member of that service. Disclosure to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation:** Disclosure as authorized to comply with workers' compensation laws and other similar programs.
- **Inmates:** Disclosure for correctional facilities.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT REQUIRE PROVIDING YOU THE OPPORTUNITY TO AGREE OR OBJECT:

Others Involved in Your Health Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it's in your best interest based on our professional judgment. We may use or disclose this information to notify or assist in notifying a family member, personal representative or any other person responsible for your care of your location, general condition or death. Finally, we may use or disclose this information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

(OVER)

YOUR INDIVIDUAL RIGHTS:

- **The Right to Inspect and Copy Your Protected Health Information:** You must make your request in writing and submit it to the contact person listed at the end of this notice (if you request copies, there is a charge of $3.50 for each page, plus postage if you would like the copies mailed to you).
- **You Have the Right to Request a Restriction of Your Protected Health Information:** You may ask us not to use or disclose any part of your information for the purposes of treatment, payment or health care operation. You may also request that any part of your information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. This must be requested in writing. Your physician is not required to agree to a restriction, however if they do agree, that restriction may be voided for the purposes of providing emergency treatment.
- **You May Have the Right to Have Your Physician Amend Your Protected Health Information:** You may request an amendment in your health record. In certain cases we may deny this and you will have the right to file a statement of disagreement to which we may prepare a rebuttal and provide you a copy of any such rebuttal. Please inform the contact person at the end of this notice for specific questions about amending your record.
- **You Have the Right to Receive an Accounting of Certain Disclosures We Have Made, if any, of Your Protected Health Information:** This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures made to you if you authorized us to make the disclosure to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule or correctional facilities, as part of a limited data set disclosure).

QUESTIONS AND COMPLAINTS:

If you have any questions about this notice or think that we may have violated your privacy rights, contact the person named below. You may also submit a written complaint to the US Dept of Health and Human Services. We will not retaliate against you for filing a complaint.

Milwaukie Chiropractic Center
3716 SE International Way
Milwaukie, OR 97222
Phone: 503-659-0073 • Fax: 503-659-7471

ACKNOWLEDGMENT FORM:

I acknowledge that I have reviewed, understand and agree to the Notice of Privacy Practices of Milwaukie Chiropractic Center.

Signature: ______________________________ Date: ____________________

MILWAUKIE CHIROPRACTIC CENTER
3716 SE INTERNATIONAL WAY
MILWAUKIE, OREGON 97222
503-659-0073

MASSAGE THERAPY & REHABILITATION POLICY

Dear Patient:

Your physician may recommend Massage Therapy and / or exercise instruction by a Licensed Massage Therapist or Certified Exercise Specialist.

Your doctor has determined the length of each session, the frequency per week and a specific number of weeks. After that time, your condition will be re-evaluated.

If an appointment has been scheduled at a specific time for your massage and rehab exercises and you are unable to make that appointment for **ANY** reason and do not provide us with 12 hours notice in order for us to fill your appointment time, **YOU**, not your insurance carrier, will be charged a $15.00 per 1/2 hour appointment fee. This fee will be paid to the therapist for their time.

Thank you for your courtesy and understanding of our therapists's time.

Sincerely,

Keith D. Johns, D.C., P.C.

Erica Staehle, M.S., D.C.

Theresa White, D.C.

Joseph Brignac, D.C.

Steve L. Sebers, D.C., F.A.C.O.

PATIENT'S SIGNATURE	DATE
PLEASE PRINT NAME	

THE ABOVE SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE POLICIES ABOVE AND AGREE TO ABIDE BY THE SAME.

NAME: ______________________ DATE: ______________ SCORE: __________

OSWESTRY DISABILITY INDEX 2.0

PLEASE READ: Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer ***every section***. Mark ***one box only*** in each section that most closely describes you ***today***.

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 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 is very painful.
- 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, wash with difficulty and stay in bed.

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, but I can manage if they are conveniently positioned, e.g. 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 only lift very light weights, at the most.
- F I cannot lift or carry anything at all.

SECTION 4 - Walking
- A Pain does not p revent me from walking any distance.
- B Pain prevents me from walking more than one mile.
- C Pain prevents me from walking more than 1/4 mile.
- D Pain prevents me from walking more than 100 yards.
- E I can only walk while using a stick or crutches.
- F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting
- A I can sit in any chair as long as I like.
- B I can only sit in my favorite chair as long as I like.
- C Pain prevents me from sitting more than 1 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 6 - Standing
- A I can stand as long as I want without extra pain.
- B I can stand as long as I want but it gives me extra pain.
- C Pain prevents me from standing for more than 1 hour.
- D Pain prevents me from standing for more than 1/2 hour.
- E Pain prevents me from standing for more than 10 minutes.
- F Pain prevents me from standing at all.

SECTION 7 - Sleeping
- A My sleep is never disturbed by pain.
- B My sleep is occasionally disturbed by pain.
- C Because of pain I have less than 6 hours' sleep.
- D Because of pain I have less than 4 hours' sleep.
- E Because of pain I have less than 2 hours' sleep.
- F Pain prevents me from sleeping at all.

SECTION 8 - Sex Life (if applicable)
- A My sex life is normal and causes me no extra pain.
- B My sex life is normal, but causes some extra pain.
- C My sex life is nearly normal but is very painful.
- D My sex life is severely restricted by pain.
- E My sex life is nearly absent because of pain.
- F Pain prevents any sex life at all.

SECTION 9 - Social Life
- A My social life is normal and causes me no extra pain.
- B My social life is normal, but increases the degree of pain.
- C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.
- D Pain has restricted my social life and I do not go out as often.
- E Pain has restricted my social life to my home.
- F I have no social life because of the pain.

SECTION 10 - Traveling
- A I can travel anywhere without pain.
- B I can travel anywhere but I gives extra pain.
- C Pain is bad but I manage journeys over 2 hours.
- D Pain restricts me to journeys of less than 1 hour.
- E Pain restricts me to short necessary journeys under 30 minutes.
- F Pain prevents me from traveling except to receive treatment.

COMMENTS: ____

Fairbank JCT, Davies JB, Couper J, O'Brien JP (1980) The Oswestry low back pain disability questionnaire. Phyysiother 66:271-273

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 every 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 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, wash with difficulty, and stay in bed.

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 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 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 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 7 – Work

A I can do as much work as I want to.
B I can 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 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 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 sleepless).

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: ______________

WC

PI

CLAIM INFORMATION

TODAY'S DATE ______________________________

NAME OF PATIENT ______________________________

DATE OF INJURY ______________________________

WHAT STATE THE ACCIDENT HAPPENED IN ______________

EMPLOYMENT RELATED ______________________________

EMPLOYER ______________________________

YOUR AUTO INSURANCE CO. ______________________

MANAGED CARE ______________________________

MEDICAL ADJUSTER'S NAME ______________________

& PHONE NO. ______________________________

CLAIM NO. ______________________________

ADDRESS OF WHERE TO SEND THE MEDICAL BILLS

____

____

____

____

3716 SE International Way
Milwaukie, OR 97222

MILWAUKIE CHIROPRACTIC CENTER

Keith D. Johns, D.C, P.C. •

Office 503-659-0073
Fax 503-659-7471

AUTOMOBILE ACCIDENT FORM

Name: ______________________ Date: __________

Please complete this form carefully, checking or writing in your answers as needed.

Date of Accident __________ Time of Accident __________ ❑ AM ❑ PM

Where did the accident occur: City __________ Street __________

Road conditions were: ❑ Wet ❑ Dry ❑ Icy ❑ Other: __________ Police came to the scene? ❑ Yes ❑ No

Please describe to the best of your ability, what happened during this accident: __________

____

____

____

____

____

The following questions pertain to you, the patient, and the vehicle you were traveling in:

Year ______ Make __________ Model __________ of car you were in?

Were you driving? ❑ Yes ❑ No If no, where were you in the car? __________

Were you aware of the approaching collision? ❑ Yes ❑ No
Did you lose consciousness (black out) upon impact? ❑ Yes ❑ No

How far was the top of the headrest or seatback from the top of your head? __________

Were you wearing your seatbelt? ❑ Yes ❑ No If yes, was there a shoulder strap? ❑ Yes ❑ No

Was your car stopped at the time of impact? ❑ Yes ❑ No

If yes, was the driver's foot on the brake? ❑ Yes ❑ No

If the car was moving, how fast were you going: ______ mph.

Were you moving at a: ❑ Steady speed ❑ Gaining speed ❑ Slowing down

What was your body position at the time of impact?

❑ Head turned right ❑ Head straight ❑ Looking back(❑ Left ❑ Right), body twisted
❑ Head turned left ❑ Body in straight sitting position ❑ Other: __________

On what part of the car did the following body parts hit (if any):

Head hit: __________ Left/Right hip hit: __________

Chest hit: __________ Left/Right leg hit: __________

Left/Right shoulder hit: __________ Left/Right knee hit: __________

Left/Right arm hit: __________ Other: __________

What bleeding cuts did you get during this accident? __________

What bruises did you get during this accident? __________

Were you taken to a hospital? ☐ Yes ☐ No If yes, how did you get there? ____________________

To which hospital (name & location): ____________________

Were X-rays taken? ☐ Yes ☐ No If yes, what areas were X-rayed? ____________________

Check symptoms you have noticed ***since*** the accident:

☐ Headaches	☐ Dizziness	☐ Fever
☐ Neck pain	☐ Head feels heavy	☐ Fatigue
☐ Neck stiff	☐ Pins & needles in arms	☐ Loss of memory
☐ Sleeping problems	☐ Pins & needles in legs	☐ Ears ring
☐ Mid back pain	☐ Numbness in fingers	☐ Face flushed
☐ Low back pain	☐ Numbness in toes	☐ Depression
☐ Nervousness	☐ Shortness of breath	☐ Diarrhea
☐ Tension	☐ Light bothers eyes	☐ Fainting
☐ Irritability	☐ Buzzing in ears	☐ Loss of smell
☐ Chest pain	☐ Loss of balance	☐ Loss of taste
☐ Cold sweats	☐ Constipation	☐ Hands cold
☐ Stomach upset	☐ Jaw pain	☐ Feet cold

Please list any of the above symptoms that you had before the accident, (if any): ____________________

Have you been under a doctor's care as a result of this accident? ☐ Yes ☐ No

If yes, what is the doctor's name, address and phone #: ____________________

Have you lost any days from work? ☐ Yes ☐ No If yes, dates absent from work: from ______ to ______

List any dates of limited work activities: ____________________ Date returned to normal work: ____________________

Please check any of the following vehicle parts broken during the accident:

☐ Windshield ☐ Front seat back ☐ Steering wheel ☐ Left side window ☐ Right side window

☐ Other: ____________________

What was the cost of damage to the vehicle you were in? ____________________

The following questions pertain to the other vehicle involved in the accident:

Year ______ Make ____________________ Model ____________________ of the other car?

Your Signature: ____________________ Date: ____________________

IRREVOCABLE ASSIGNMENT AND CONSENT TO DISBURSEMENT

I DO HEREBY IRREVOCABLY ASSIGN TO Keith D. Johns, D.C., P.C., and/or Robert Johns, D.C., d.b.a. Milwaukie Chiropractic Center, 3716 SE International Way, Milwaukie, Oregon 97222; (hereafter "MCC") that portion of any settlement, claim, judgement, award, verdict, loan and/or advance arising out of ______________________________ that occurred on the _____ Day of ________________, _______, (the "claim") all funds necessary to satisfy in full the outstanding medical bills at the time of said settlement, claim, judgement, award, verdict, loan and/or advance. I hereby irrevocably direct my insurance carrier and or attorney to make payment directly to MCC of all sums necessary to fully and completely satisfy the outstanding balance due to MCC by reason of their periodic billing, without contest as to the reasonableness of the billing. In the event I later dispute the reasonableness of charges, my dispute shall have no effect on my irrevocable instructions for payment of this bill, provided however, that I reserve the right to contest the reasonableness of charges subsequent to payment as provided herein.

I understand that, regardless of the recovery obtained in the claim I have made for injury to me, I am directly and fully responsible to MCC for all billings issued and for services rendered to me unless my case is accepted under Workers Compensation law in the State of Oregon. This agreement is made solely for MCC's additional protection and in consideration of MCC's agreement to extend credit to me for services performed. My obligation to MCC is not contingent upon any settlement, claim, judgement, award, verdict, loan and/or advance on which I may eventually recover a fee. This assignment and consent to disbursement cannot be revoked, canceled, or terminated by me.

PATIENT

SIGNATURE:	DATE:
PRINT NAME	

INSURANCE INFORMATION

Patient's Insurance Company	Other Party's Insurance Company
TO:	TO:
ADDRESS:	ADDRESS:

ATTORNEY

BY:	ADDRESS
ATTORNEY REPRESENTING PATIENT	

Enclosed is a copy of the above referenced "Irrevocable Assignment and Consent to Disbursement." MCC will be pleased to provide you with updated billings and respond to your inquiries regarding our patient and your client.

Our records will reflect that you have received this "Irrevocable Assignment and Consent to Disbursement." In the event you receive and/or distribute proceeds from settlement, claim, judgement, award, verdict, loan and/or advance for the above-referenced patient who is your client we will expect you to honor the irrevocable instructions of the patient as set forth above and pay the balance due on the patient's account. No payment may be made without consent of MCC unless we are paid in full at the time of settlement and said payment is received. Please provide us with written notification in the event that your involvement with this patient has been terminated. Your cooperation is appreciated.

DATE:

Keith D. Johns, D.C., P.C.
CHIROPRACTIC PHYSICIAN

Rev. 01/31/05
Assignment, Disbursement2.doc

Keith D. Johns, D.C., P.C.
Chiropractic Physician

Steve L. Sebers, D.C., F.A.C.O.
Chiropractic Physician

Theresa White, D.C.
Chiropractic Physician

Joseph Brignac, D.C.
Chiropractic Physician

Erica Staehle, M.S., D.C.
Chiropractic Physician

Milwaukie Chiropractic Center
3716 SE International Way • Milwaukie, OR 97222
503-659-0073

"PAIN RELIEF TODAY...HEALTH FOR A LIFETIME"

MOTOR VEHICLE INSURANCE CLAIMS/ RESPONSIBILITY DISCLAIMER

I, ______________________________, understand that my Auto Insurance carrier may be billed for payment of my treatment as a result of my motor vehicle accident or personal injury.

This does not waive my responsibility for payment of my account with Milwaukie Chiropractic Center, for services rendered in connection with my accident to and including the level authorized by law.

If I make a claim for medical bills and receive a recovery for medical services from my injury, I authorize payment for the unpaid balance or a satisfactory settlement with this office.

DIRECT PAYMENT AUTHORIZATION

I hereby direct and authorize my attorney to pay all unpaid bills or agreed-upon (in writing) discounted amounts owing Milwaukie Chiropractic Center, presented to my attorney before the distribution of any settlement or judgment proceeds to me out of any sums received by myself or by my attorney to which I may be entitled if I make a claim for medical treatment in the amount charged by this office to the general public.

PATIENT NAME: ____

PATIENT SIGNATURE: ______________________________ **DATE:** ______________

Keith D. Johns, D.C., P.C.
Chiropractic Physician

Steve L. Sebers, D.C., F.A.C.O.
Chiropractic Physician

Theresa White, D.C.
Chiropractic Physician

Erica Staehle, M.S., D.C.
Chiropractic Physician

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"PAIN RELIEF TODAY...HEALTH FOR A LIFETIME"

DIRECT PAYMENT AUTHORIZATION

Patient: ______________________ DOB: ______________

Claim #: ______________________ DOI: ______________

Enclosed is a Direct Payment Authorization signed by your above-named client, who is also our patient, for treatment of injuries received in a motor vehicle accident on the date indicated.

If there is a PIP claim filed, we will bill the PIP carrier. If the PIP has expired or is exhausted, we will wait for settlement to be made. Of course, we will be happy to send copies of any information you request in writing.

If you disagree with this request, we would appreciate a call from your office to explain your position.

Thank you for your prompt assistance.

Yours truly,

Milwaukie Chiropractic Center