

# INITIAL HEALTH STATUS

*Milwaukee Chiropractic Center*

*Keith D. Johns, D.C., P.C. • Steve L. Sebers, D.C., F.A.C.O. • Theresa White, D.C. • Erica Staehle, D.C., M.S. • Joe Brignac, III, D.C.*

**Patient Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Sex:** M / F

**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

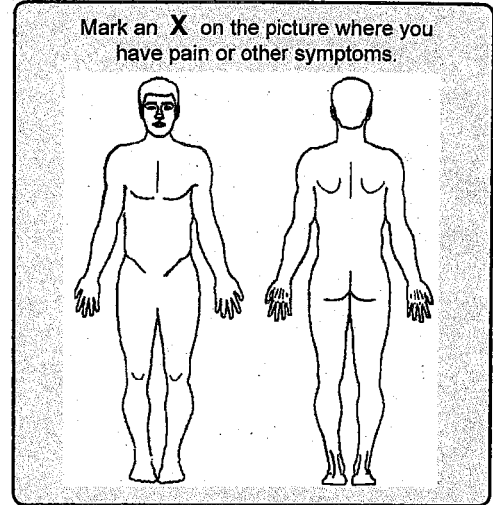
\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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 )



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                  |  |
|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks  | <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances  |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection | <input type="checkbox"/> | <input type="checkbox"/> | Low/Mid Back Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure         | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination   |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteriod Use          | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems  |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting          | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures  |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention           | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills         | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm             | <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor                | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis  |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis                | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                    | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight: <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                    | <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications (please list):   |
| <input type="checkbox"/> | <input type="checkbox"/> | Trauma                      |                          |                          | _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever                       |                          |                          | _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | 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
CITY			STATE	ZIP CODE	EMAIL ADDRESS
HOME PHONE (Include Area Code)			WORK PHONE (Include Area Code)	CELL PHONE (Include Area Code)	BY WHOM WERE YOU REFERRED?
PREVIOUS ADDRESS			CITY		STATE
EMPLOYER'S NAME OR SCHOOL'S NAME			EMPLOYER'S ADDRESS OR SCHOOL'S ADDRESS		
			<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME		
			OCCUPATION		
			ZIP CODE		

**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)
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PATIENT'S SIGNATURE <b>X</b>	DATE
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THE ABOVE SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE POLICIES ABOVE AND AGREE TO ABIDE BY THE SAME.

GUARDIAN'S SIGNATURE <b>X</b>	DATE
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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 <b>X</b>	DATE
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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

\_\_\_\_\_  
Sign here

Date: \_\_\_\_\_

# 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 to 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 information 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 or 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**

**MESSAGE 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.

## OSWESTRY DISABILITY INDEX (FOR BACK PAIN)

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

*Please Read:* This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just circle the one choice which closely describes your problem right now.**

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

*For provider use:*  
 DISABILITY INDEX SCORE: \_\_\_\_\_ %



## 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.**

<p><b>SECTION 1 - Pain Intensity</b></p> <p>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.</p>	<p><b>SECTION 6 - Concentration</b></p> <p>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.</p>
<p><b>SECTION 2 - Personal Care (washing, dressing, etc.)</b></p> <p>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.</p>	<p><b>SECTION 7 - Work</b></p> <p>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.</p>
<p><b>SECTION 3 - Lifting</b></p> <p>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.</p>	<p><b>SECTION 8 - Driving</b></p> <p>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.</p>
<p><b>SECTION 4 - Reading</b></p> <p>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.</p>	<p><b>SECTION 9 - Sleeping</b></p> <p>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).</p>
<p><b>SECTION 5 - Headaches</b></p> <p>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.</p>	<p><b>SECTION 10 - Recreation</b></p> <p>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.</p>

COMMENTS: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ SCORE: \_\_\_\_\_



# Milwaukie Chiropractic Center

## Authorization for Release of Information to Family Members

Patient Name _____	Date of Birth _____
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Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below. I authorize Milwaukie Chiropractic Center to release my medical and/or billing information to the following individual(s):

1. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Contact Number: \_\_\_\_\_

2. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Contact Number: \_\_\_\_\_

3. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Contact Number: \_\_\_\_\_

<p><b>Patient Information:</b></p> <p>I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.</p>
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Signature: _____	Date: _____
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