GAITLINK
chiropractic center

YOUR INFORMATION

Today's Date: ____/____/_____

Patient Name:_____
LAST FIRST MI

What You Prefer To Be Called: _____

□ Male □ Female

Date of Birth: ____/____/_____ Age: _____

Social Security #: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

E-Mail Address: _____

Referred By: _____

Employer: _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: □ Minor □ Single □ Married
□ Divorced □ Separated □ Widowed

Spouse's Name: _____

Do you have children? □ Yes □ No How Many? _____

INSURANCE

Co. Name: _____

Phone #:

_____

ID #: _____

Group #: _____

Insured's Name:

_____

Relation:

_____

Date of Birth: _____/____/_____

Insured's Employer:

_____

Please inform front desk if you have a secondary insurance. We will take a copy of your insurance card(s) so please bring with you.

EMERGENCY CONTACT

Who should we contact?

_____

Relation:

_____

Phone #:

_____

Who is your Medical Doctor?

_____

Doctor's Phone #:

_____

ACCOUNT

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SSN #: _____

Phone #: _____

PO Box 267
Pt. Gamble, WA 98364

Phone (360)297-4544
Fax (360)297-7657

Patient Name: _____

REASON FOR VISIT

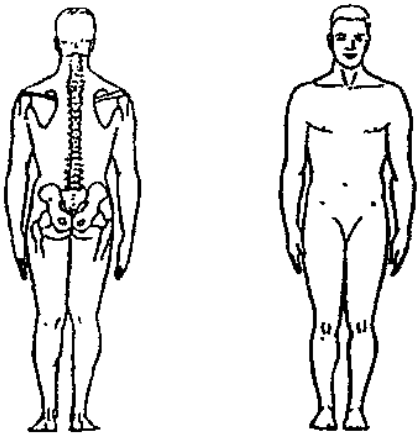
The reason for this visit is a result of (Please circle): work, sports, auto, trauma or chronic.

(Explain what happened): _____
_____
_____
_____
_____
_____

When did condition begin? _____/_____/_____
Is this condition getting worse? □ Yes □ No □ Constant □ Comes and goes
If this condition interfering with your (Please Circle): work, sleep, or daily routine.
Have you had this or similar conditions in the past? □ Yes □ No
If "Yes", please explain: _____
Have you been treated by a Medical Physician for this condition? □ Yes □ No
If "Yes", where? _____
Have you ever been treated by a Chiropractor before? □ Yes □ No
If "Yes", whom? _____Phone #:_____

Please list your symptoms below:

	Less									More
1. _____	0	1	2	3	4	5	6	7	8	9 10
2. _____	0	1	2	3	4	5	6	7	8	9 10
3. _____	0	1	2	3	4	5	6	7	8	9 10
4. _____	0	1	2	3	4	5	6	7	8	9 10
5. _____	0	1	2	3	4	5	6	7	8	9 10
6. _____	0	1	2	3	4	5	6	7	8	9 10



Please draw where your pain is on the diagram.

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HEALTH HISTORY

Are you taking any of the following medications?

□ Nerve pill □ Pain Killers (including aspirin) □ Muscle Relaxers □ Stimulants
□ Blood Thinners □ Tranquilizers □ Insulin □ Other(s) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+ / Aids	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema / Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes / Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Low Back Problems	**Y N** Artificial Bones / Joints	**Y N** Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

_____

Please list anything that you may be allergic to: _____

_____

Please list previous surgical/treatments with dates:

_____

_____

List any **past** serious accidents with dates: _____

_____

Family Health History: _____

Do you: Take Supplements or Vitamins? □ Yes □ No Exercise? □ Yes □ No

Do you smoke? □ No □ Yes / How Much? _____ How Long? _____

Are you wearing: □ Heel Lifts □ Sole Lifts □ Inner Soles □ Arch supports

For woman: Are you taking Birth Control? □ Yes □ No Are you Pregnant? □ Yes □ No

How Far Along? _____ Nursing ? □ Yes □ No

- We invite you to discuss with us any questions regarding our services. The best health services are base on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not pain with in 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to this information I have provided.

Printed Name_____

Signature _____ Date ____/____/_____

□ Adult patient □ Parent or Guardian □Spouse

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HIPPA 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. PLESASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health services.

1. **Uses and Disclosures of Protected Health Information**

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health and any related services. This includes the coordination or management of your health care with a third party, for example, we would disclose your protected health information, as necessary, to home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room where your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact your and remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law.

Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Director, and Organ Donation: Research: Criminal Activity: Military Activity and Nation Security: Worker's Compensation: Inmates: Required uses and Disclosure. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Your Rights: Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at ant time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Following is a statement of your rights with respect to your respected health information.

Your Have the right to request a restriction of your protected health information. Under the federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosures or your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive a confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend you r protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. Your then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to use or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You many file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected heath information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____ Date:_____

PO Box 267
Pt. Gamble, WA 98364

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Fax (360)297-7657

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chiropractic center

Oswestry Low Back Pain Scale

Name: _____ Date: _____

PLEASE READ THE INSTRUCTIONS:
This questionnaire has been designed to give the doctor information as to how your Low Back Pain has affected your ability to manage in everyday life. 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 Section

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but I have extra pain.
2. Pain prevents me from lifting heavy weights off the floor.
3. Pain prevents me from 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.

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Oswestry Low Back Pain Scale cont.

Name:_____ Date: _____

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

Section 5 – Sitting Section

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 have no pain in bed.
1. I have pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal night's sleep is reduced by less than one-quarter.
3. Because of pain my normal night's sleep is reduced by less than one-half.
4. Because of pain my normal night's sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

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

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.

Score: _____

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NECK PAIN AND DISABILITY INDEX (Vernon-Mior)

Patient Name: _____ Date: _____

PLEASE READ THE INSTRUCTIONS:
This questionnaire has been designed to give the doctor information as to how your Neck Pain has affected your ability to manage in everyday life. Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – PAIN INTENSITY

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

Section 2 – PERSONAL CARE (washing, dressing etc.)

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

Section 3 – LIFTING

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives me extra pain.

LIFTING cont.

2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

Section 4 – READING

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

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NECK PAIN AND DISABILITY INDEX (Vernon-Mior) cont.

Patient Name: _____ Date: _____

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

Section 5 – HEADACHES

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

Section 6 – CONCENTRATION

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

Section 7 – WORK

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

Section 8 – DRIVING

0. I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight pain in my neck.

Driving cont.

2. I can drive my car as long as I want with moderate pain in my neck.
3. I can not drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive at all because of severe pain in my neck.
5. I cannot drive my car at all.

Section 9 – SLEEPING

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

Section 10 – RECREATION

0. I am able to engage in all my recreational activities with no neck pain at all.
1. I am able to engage in all my recreational activities with some pain in my neck.
2. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
3. I am able to engage in few of my usual recreational activities because of pain in my neck.
4. I can hardly do any recreational activities because of pain in my neck.
5. I cannot do any recreational activities at all.

Score:_____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____ by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here Dr. Andrew Swanson and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Andrew Swanson and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, joint injuries, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:
To be completed by the patient's representative, if necessary,
(eg: if the patient is a minor or is physically or mentally incapacitated)

_____
Print Patient's Name

_____
Print Name of Representative

_____
Signature of Patient Signature or Representative

This form should be maintained in the patient's health record.

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