Neighborhood Chiropractic and Acupuncture LLC
Registration and History

PATIENT INFORMATION

Last Name:	Date:
First Name	Middle Initial:
Address:	
City:	State: Zip:
Cell Phone Number:	Home Phone Number:
Email:	May we send you e-mail correspondence? ○Yes ○No
Sex: ○M ○F	Pronoun Preference: ○He ○She ○They ○Ze ○
○ Single ○Married ○Domestic Partnership ○Divorced	○Widowed ○Minor
Birthdate:	Age:
Occupation:	
Patient Employer and/or School:	
Work Phone Number:	May we call you at work? ○Yes ○No
Who is responsible for this account? ○Self ○Insurance Company ○Guardian Name:	
Who do we thank for referring you?	

In Case of Emergency, Contact

Name:	Relationship:
Home Phone:	Work Phone:
Primary Care Physician:	Phone Number:

ACCIDENT INFORMATION

Is this condition due to an accident? ○Yes ○No	Date of Accident:
Type of Accident: ○Auto ○Work ○Home ○Other:	
To whom have you made report of your accident? ○Auto Insurance:	
○Employer ○Worker Comp. ○Other:	
Claim # (if applicable):	Attorney Name (if applicable):

PATIENT CONDITION

Reason for your visit
When did your symptoms appear?
Is this condition getting progressively worse? ○Yes ○No ○Don't Know
Mark an X on the picture where you have pain, numbness, or tingling.
Areas of your body that need special attention? ○Yes ○No ○Describe:
Rate the severity of pain from 1 (least pain) to 10 (most pain):
Type of pain: ○Sharp ○Dull ○Throbbing ○Numbness ○Aching ○Shooting ○Burning
○Tingling ○Cramps ○Stiffness ○Swelling ○Other (describe):
Location of numbness or tingling:
How often do you have these symptoms?
Is it constant or does it come and go?
Does it interfere with your: ○Work ○Sleep ○Daily Routine ○Recreation
Activities that are painful: ○Sitting ○Standing ○Walking ○Bending ○Lying Down ○Lovemaking ○Other
Are you experiencing any other symptoms in your body?

HEALTH HISTORY

What treatment have you already had for your condition? ○Medications ○Surgery ○ Physical Therapy ○Chiropractic Services ○None ○Other:

Name of other practitioners who have treated you for this condition:

Have you ever had chiropractic care? ○Yes ○No Massage? ○Yes ○No Acupuncture? ○Yes ○No

Date of Last: Physical Exam: X-ray (Area): Lab Work:

Spinal Exam: MRI, CT-Scan or Bone Scan:

Place a mark in the box to indicate if you have had any of the following:

- ○ AIDS/HIV
- ○ Allergies to oils/ fragrance
- ○ Anemia
- ○ Arm/ Hand Pain
- ○ Arthritis
- ○ Asthma
- ○ Bleeding Disorders
- ○ Blood clots
- ○ Cancer
- ○ Cataracts
- ○ Chemical Dependency
- ○ Chicken Pox
- ○ Communicable disease
- ○ Contacts
- ○ Diabetes
- ○ Dizziness
- ○ Eating Disorder
- ○ Easy Bruising
- ○ Emphysema
- ○ Epilepsy/ seizures
- ○ Fainting
- ○ Fibroids
- ○ Fibromyalgia
- ○ Glaucoma
- ○ Gonorrhea
- ○ Headaches
- ○ Hearing Difficulty
- ○ Heart Disease
- ○ Hepatitis
- ○ Herniated Disc
- ○ Hernia
- ○ High Cholesterol
- ○ Jaw Problems
- ○ Kidney Disease
- ○ Leg/Foot Disease
- ○ Liver Disease
- ○ Low Back Problems
- ○ Low Blood Pressure
- ○ Multiple Sclerosis
- ○ Neck Pain/ Stiffness
- ○ Open cuts or sore
- ○ Osteoporosis
- ○ Pacemaker
- ○ Parkinson's disease
- ○ Pinched Nerve
- ○ Pneumonia
- ○ Polio
- ○ Prosthesis
- ○ Psychiatric Care
- ○ Respiratory Problems
- ○ Rheumatoid Arthritis
- ○ Rheumatic Fever
- ○ Sciatica
- ○ Shoulder Problems
- ○ Skin Disease
- ○ Stroke
- ○ Thyroid Problems
- ○ Transient Ischemic Attack (TIA)
- ○ Tuberculosis
- ○ Tumors/ Growths
- ○ Typhoid
- ○ Ulcers
- ○ Varicose Veins
- ○ Venereal Disease

□Other condition not listed above:

Exercise: ○None ○Moderate ○Daily ○Heavy Describe:

Work Activity: ○Sitting ○Standing ○Light Labor ○Heavy Labor

Habits: ○Smoking: # Cigarettes or Packs/day? ____ How many years? ___ Were you ever a smoker? ○Yes ○No
○Alcohol: # Drinks/week? ____ ○Caffeine Drinks # Cups/Day? ____ ○High Stress Level Reason:

Women: Are you pregnant? ○Yes ○No Due Date: Number of children:

Injuries/ Surgeries (Include a date and a description):

Falls:

Head Injuries:

Broken Bones:

Dislocations:

Surgeries:

Car Accidents:

Family Health History

Has anyone in your immediate family had the following conditions? (including grandparents):
○Heart Disease ○Stroke ○Cancer ○Diabetes ○Other Describe any selected:
○Other Family Diseases:

Medications: For what condition?

Vitamins/Herbs/Supplements:

Allergies:

Is there anything else you would like to share with your doctor?

To the best of my knowledge, this information is complete and correct. I understand it is my responsibility to inform my doctor/Clinic if there are any changes to my health or personal information.

Signature Printed Name Date

Neighborhood Chiropractic and Acupuncture LLC
Motor Vehicle Accident Intake

Last Name:		Date:
First Name:		Middle Initial:
Age:	Occupation:	Date of Accident:
Claim #:	Insurance Co:	Time of Accident: ○ am ○ pm
Agent Name:		Agent's Phone:

Please describe the accident in your own words:	Where were you sitting?
	Or: I was a ○ pedestrian ○ bicyclist ○ motorcyclist
	How many people total, including you were in your vehicle?

YOUR VEHICLE

Year:	Make:	Model:	Where were your hands?
Does your vehicle have air bags? ○ no ○ yes			Left: ○ steering wheel ○ other:
If yes, did they inflate? ○ no ○ yes			Right: ○ steering wheel ○ gear shift ○ other:
If yes, did they inflate properly? ○ no ○ yes			
Were you wearing a seatbelt? ○ no ○ yes			
If yes ○ lap only ○ shoulder only ○ both			Where were your feet?
Did you sustain visible bruising from the seatbelt? ○ no ○ yes			Left: ○ brake ○ clutch ○ floor ○ other:
If yes, was it from ○ lap only ○ shoulder only ○ both			Right: ○ gas ○ clutch ○ floor ○ other:
Is bruising still visible? ○ no ○ yes			
Where is/was the bruising?			
			What direction were you looking? ○ straight ahead ○ left ○ right ○ down ○ up ○ rear view mirror ○ side view mirror ○ *left* ○ *right* ○ behind you to the ○ *left* ○ *right*
Did your seat have a headrest? ○ no ○ yes			
If yes, is it moveable? ○ no ○ yes			
What position was it in in relation to your head? ○ low ○ mid ○ high ○ unsure			Were you ○ surprised by the impact ○ braced for the impact ○ surprised but had time to brace ○ unsure
Did you head strike the headrest? ○ no ○ yes			

Neighborhood Chiropractic and Acupuncture LLC
Motor Vehicle Accident Intake

THE OTHER VEHICLE

Year:	Make:	Model:

What direction was the other vehicle travelling?
○ north ○ south ○ east ○ west

Did the other vehicle's airbags inflate?
○ no ○ yes ○ unsure

REPORTS

Did police come to the scene? ○ no ○ yes

Was a police report filled? ○ no ○ yes

Were you issued a citation? ○ no ○ yes ○ unsure

Was the other driver issued a citation?
○ no ○ yes ○ unsure

THE ACCIDENT

Name of Street:

Name of closest intersection:

Did the accident happen in the intersection?
○ no ○ yes

City:	State:

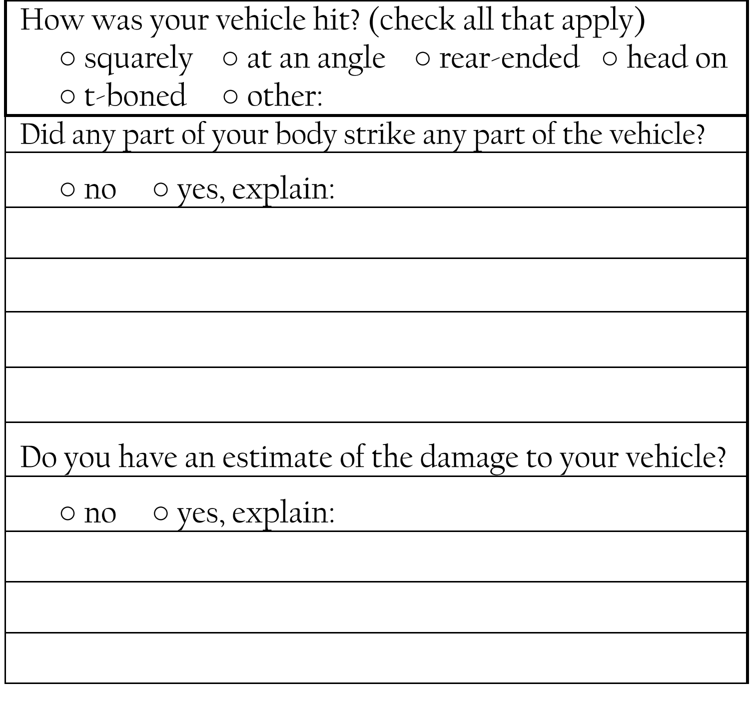
What direction were you travelling?
○ north ○ south ○ east ○ west

What were the driving conditions?
○ wet ○ dry ○ icy ○ foggy
○ other:

Were you stopped? ○ no ○ yes

If no, what was your approximate speed?

THE IMPACT



How was your vehicle hit? (check all that apply)
○ squarely ○ at an angle ○ rear-ended ○ head on
○ t-boned ○ other:

Did any part of your body strike any part of the vehicle?
○ no ○ yes, explain:

Do you have an estimate of the damage to your vehicle?
○ no ○ yes, explain:

THE DAMAGE

Mark all the impact areas on your vehicle:	Mark all the impact areas on other vehicle:

Did your vehicle impact anything else?
○ no ○ yes, explain:

Please mark all the areas of the second impact:

AT THE SCENE

Did medical personal (ambulance, fire) come to the scene? ○ no ○ yes

If yes, were you treated at the scene? ○ no ○ yes, please explain:

Neighborhood Chiropractic and Acupuncture LLC
Motor Vehicle Accident Intake

HOSPITAL / EMERGENCY DEPARTMENT

Did you go to the Emergency Room? ○ no ○ yes

If yes, what was the name of the Hospital?

What was your doctor's name (if known)?

Did you go by: ○ ambulance ○ someone drove me ○ I drove myself

When did you go the emergency room? ○ Immediately after the accident ○ The next day ○ Two or more days later ○ ( )# hours after the accident

Were x-rays taken? ○ no ○ yes ○ I had x-rays, but I am not sure what was x-rayed.

If yes, what x-rays were taken? ○ neck ○ upper back ○ mid back ○ low back

LEFT:	○ shoulder	○ upper arm	○ elbow	○ forearm	○ wrist	○ hand	○ fingers
	○ hip	○ thigh	○ knee	○ calf	○ ankle	○ foot	○ toes
RIGHT:	○ shoulder	○ upper arm	○ elbow	○ forearm	○ wrist	○ hand	○ fingers
	○ hip	○ thigh	○ knee	○ calf	○ ankle	○ foot	○ toes

○ Additional x-rays not marked above:

Do you know the results your x-rays? ○ no ○ yes, please explain:

Were any additional tests performed? ○ no ○ yes ○ unsure

If yes, do you know what tests were performed? ○ no ○ yes

If yes, check all that apply: ○ blood ○ CAT/CT scan ○ MRI ○ Other:

Do you know the results of any of these tests? ○ no ○ yes, please explain

Did you receive a diagnosis? ○ no ○ yes, please explain:

Please explain treatment given in the emergency room:

Upon leaving, what treatment plan were you given?

What prescriptions (and dosing) were you given?

AFTER THE ACCIDENT

Have you seen any other doctor since the accident? ○ no ○ yes

If yes, what was the name of the physician?

Was this doctor your primary care physician? ○ no ○ yes

What date(s) did you see this doctor?

If yes, what x-rays were taken? ○ neck ○ upper back ○ mid back ○ low back

LEFT:	○ shoulder	○ upper arm	○ elbow	○ forearm	○ wrist	○ hand	○ fingers
	○ hip	○ thigh	○ knee	○ calf	○ ankle	○ foot	○ toes
RIGHT:	○ shoulder	○ upper arm	○ elbow	○ forearm	○ wrist	○ hand	○ fingers
	○ hip	○ thigh	○ knee	○ calf	○ ankle	○ foot	○ toes

○ Additional x-rays not marked above:

Do you know the results your x-rays? ○ no ○ yes, please explain:

Were any additional tests performed? ○ no ○ yes ○ unsure

If yes, do you know what tests were performed? ○ no ○ yes

If yes, please check all that apply: ○ blood ○ CAT/CT scan ○ MRI ○ Other:

AFTER THE ACCIDENT: continued

Do you know the results of any of these tests? ○ no ○ yes, please explain
Did you receive a diagnosis? ○ no ○ yes, please explain:
Please explain treatment given in the doctor's office:
Upon leaving, what treatment plan were you given?
What prescriptions (and dosing) were you given?

Have you been able to work since the injury? ○ yes ○ no, how many days have you missed?
Prior to the injury, were you able to work on an equal basis with others your age? ○ yes ○ no
If no, what has changed?

Have you had any of the following symptoms since your injury? (Check all that apply.)

○ arm / shoulder pain	○ ear ringing	○ irritability	○ neck stiffness
○ back pain	○ fatigue	○ jaw problems	○ shortness of breath
○ back stiffness	○ feet / toe numbness	○ leg pain	○ sleep difficulty
○ chest pain	○ hand / finger numbness or stiffness	○ memory loss	○ stomach upset
○ dizziness		○ nausea	○ tension
○ ear buzzing	○ headaches	○ neck pain	○ vision blurred

Is the condition getting progressively worse? ○ no ○ yes ○ unsure

Movements that are painful: ○ sitting ○ standing ○ walking ○ bending ○ lying down

Rate the severity of your pain from 1 (least pain) to 10 (severe pain):

Type of pain (check all that apply): ○ sharp ○ dull ○ throbbing ○ numbness ○ aching ○ shooting ○ burning ○tingling ○ cramps ○ stiffness ○ swelling ○ other:

How often do you get this pain? Is the pain: ○ constant ○ come and go

Does it interfere with your: ○ work ○ sleep ○ daily routine ○ recreation

Place an X on the picture here you have continued pain, numbness, tingling.

Is there anything else you would like us to know?

Neighborhood Chiropractic and Acupuncture LLC
Motor Vehicle Accident Intake

Have you received any additional treatment other than what is listed above? ○ no ○ yes If yes, please fill in the information. Use the bottom and back side of this form if more space is needed.			
Dates	Name of Practitioner	Type of Practitioner	Treatment
		○ MD ○ ND ○ LAc ○ LMT ○ PT ○ DC ○ DO ○ other:	
		○ MD ○ ND ○ LAc ○ LMT ○ PT ○ DC ○ DO ○ other:	

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I or my minor child have any changes to my health.

____ ____________________

Signature of patient (or parent/ guardian or personal representative of patient) **Date**

Relationship to patient: ○ self ○ parent ○ guardian ○ representative

Back Index

Form BI100

rev 3/27/2003

Patient Name ______________________ **Date** ____________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

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 very severe.
⑤ The pain is very severe and does not vary much.

Personal Care

⓪ I do 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 increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases 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.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes 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 from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Sitting

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

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while 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 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect 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.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall 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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Neck Index

Form N1-100

rev 3/27/2003

Patient Name ______________________________ ***Date*** ______________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

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).

Reading

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

Concentration

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

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only 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.

Personal Care

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 and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

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.

Neck Index Score

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

6040 SE Belmont Street Suite 1230 Portland, Oregon 97215
(P) 503.236.8701 (F) 503.236.8710

HIPAA Policy – Acknowledge of Receipt of Notice of Privacy Practices

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practice of Neighborhood Chiropractic and Acupuncture which describes the Practice policies and procedures regarding the use and disclosure of any of my Protected Health information created, received, or maintain by the Practice.

Missed/Cancellation Policy

When you make an appointment, you're paying for the practitioner's time. Appointments require a 24-hour business day cancellation notice. For Saturday, Sunday, and Monday appointments, cancellation must occur prior to Friday at noon. **If we do not receive 24-hour business day notice, you will be charged a $25 appointment cancellation fee.** We are unable to bill insurance companies for missed appointments. Thank you for your understanding of this matter.

Communication Consent

We are adding different communication options to provide you with more personalized and integrative ways to inform you about your care. In order to communicate information regarding your care, account, appointments, and the clinic, we need permission to do so. We will never sell any of your information, nor use it for unsolicited marketing purposes.

By signing this, you authorize Neighborhood Chiropractic and/or our automated third-party reminder service to contact you and/or named authorized person(s) and to convey Personal Health Information by the following methods and assume responsibility to notify Neighborhood Chiropractic whenever this information changes.

Text Message: ___Yes Text: ________________________________
___No, provider may not contact me by text message.

Detailed Voicemail: ___Yes Phone: ________________________________
___No, Provider may only leave a name and phone number.

Detailed Email: ___Yes Email: ________________________________
___No, provider may not contact me by email.

Please list names & relationships of other people authorized to receive information about your care:

____

I hereby attest the above information is correct, and that I have read and understood the above policies.

Print Name: ____ Date: ____________________________

Signature: ____