# CHIROPRACTIC LIFE CENTER
## REGISTRATION & HISTORY

**Mark R. Johansen, D.C., James L. Andrews, D.C.**
12762 SE Stark Street ● Plaza 125 Bldg. D ● Portland, OR 97233
Phone: 503.255.7746 ● Fax: 503.255.0818 clcpdx.com

### PATIENT INFORMATION

Date ____________________

Patient name ____________________

Address ____________________

____________________

Home ____________________ Cell ____________________

Work ____________________

Email ____________________

Sex: ☐ M ☐ F Age______ Birthdate ____________________

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation ____________________

Employer ____________________

Employer's address ____________________

____________________

Spouse's name ____________________

Whom may we thank for referring you? ____________________

IN CASE OF EMERGENCY, CONTACT:
Name ____________________

Relationship ______________ Phone ____________________

### PATIENT CONDITION

Reason for visit ____________________

When did your symptoms appear? ____________________

Type of pain (you may choose more than one): ☐ Swelling
☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Sharp
☐ Burning ☐ Tingling ☐ Cramping ☐ Stiffness ☐ Dull

How often do you have this pain?:
☐ Constant (76-100%) ☐ Frequent (51-75%)
☐ Occasional (26-50%) ☐ Intermittent (25% or less)

Is this pain: ☐ Increasing ☐ Decreasing ☐ Not Changing

Does it interfere with your:
☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

### ☐ INSURANCE or ☐ SELF-PAY

Who is responsible for this account? ____________________

Relationship to patient ____________________

Insurance Co. ____________________

ID # ____________________

Subscriber's name ____________________

Subscriber's DOB ____________________

Relationship to patient ____________________

ASSIGNMENT & RELEASE
*"I understand and agree that health and accident insurance policies are an arrangement between the insurance company and the patient. Although Chiropractic Life Center will help me bill, I acknowledge that ultimate payment is my responsibility. I give consent to the treatment protocol prescribed by my chiropractor according to the information conveyed on potential benefits vs. risks".*

____________________
Responsible Party Signature

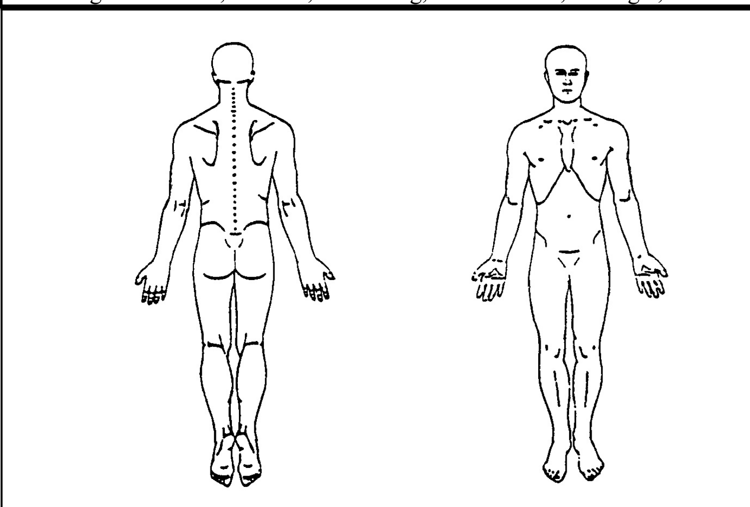
____________________
Relationship Date

### ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date ____________

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

Pain Diagram: X-Pain, A-Ache, B-Burning, N-Numbness, T-Tingle, S-Stab



### Rate your pain from 0 to 10 (10 being the most severe pain)

Neck 0 ____________________ 10
Mid back 0 ____________________ 10
Low back 0 ____________________ 10

## HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other ____________________

Name and address of other doctor(s) who have treated you for your condition ____________________

____________________

If you have ever had a listed symptom/disorder in the past, please check that symptom in the ***Past*** column. If you are presently troubled by a particular symptom/disorder, check that symptom in the ***Present*** column.

| Past | Present | | Past | Present | | Past | Present | | Past | Present | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Abdominal Pain | ☐ | ☐ | Constipation | ☐ | ☐ | Hernia | ☐ | ☐ | Osteo Arthritis |
| ☐ | ☐ | Abnormal Weight | ☐ | ☐ | Convulsions | ☐ | ☐ | Herniated Disk | ☐ | ☐ | Osteoporosis |
| | | ☐ Gain | ☐ | ☐ | Depression | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Pacemakeer |
| | | ☐ Loss | ☐ | ☐ | Dermatitis/Eczema/Rash | ☐ | ☐ | High Cholesterol | ☐ | ☐ | Pinched Nerve |
| ☐ | ☐ | AIDS/HIV | ☐ | ☐ | Diabetes | ☐ | ☐ | Hip/Upper Leg Pain | ☐ | ☐ | PMS |
| ☐ | ☐ | Ankle/Foot Pain | ☐ | ☐ | Difficulty Swallowing | ☐ | ☐ | Irregular Menstrual Flow | ☐ | ☐ | Prostate Problems |
| ☐ | ☐ | Allergies | ☐ | ☐ | Dizziness | ☐ | ☐ | Irritable Colon | ☐ | ☐ | Rapid Heart Beat |
| ☐ | ☐ | Anemia | ☐ | ☐ | Eating Disorder | ☐ | ☐ | Jaw Pain | ☐ | ☐ | Rheumatoid Arthritis |
| ☐ | ☐ | Asthma | ☐ | ☐ | Emphysema | ☐ | ☐ | Kidney Stones | ☐ | ☐ | Shoulder Pain |
| ☐ | ☐ | Angina | ☐ | ☐ | Epilepsy | ☐ | ☐ | Knee/Lower Leg Pain | ☐ | ☐ | Sleeping Problems |
| ☐ | ☐ | Aortic Aneurysm | ☐ | ☐ | Excessive Thirst | ☐ | ☐ | Liver Disease | ☐ | ☐ | Stroke |
| ☐ | ☐ | Appendicitis | ☐ | ☐ | Fainting | ☐ | ☐ | Loss of Appetite | ☐ | ☐ | Swelling/Stiffness of Joints |
| ☐ | ☐ | Bladder Infection | ☐ | ☐ | Fractures | ☐ | ☐ | Loss of Bladder Control | ☐ | ☐ | Thyroid Problems |
| ☐ | ☐ | Bleeding Disorder | ☐ | ☐ | Frequent Urination | ☐ | ☐ | Low Back Pain | ☐ | ☐ | Tinnitus (Ear Noises) |
| ☐ | ☐ | Breast Lump | ☐ | ☐ | General Fatigue | ☐ | ☐ | Mid Back Pain | ☐ | ☐ | Tumors/Growths |
| ☐ | ☐ | Bronchitis | ☐ | ☐ | Gout | ☐ | ☐ | Migraine Headaches | ☐ | ☐ | Ulcers |
| ☐ | ☐ | Cancer | ☐ | ☐ | Hand Pain | ☐ | ☐ | Miscarriage | ☐ | ☐ | Upper Arm/Elbow Pain |
| ☐ | ☐ | Chemical Dependency | ☐ | ☐ | Headache | ☐ | ☐ | Multiple Sclerosis | ☐ | ☐ | Upper Back Pain |
| ☐ | ☐ | Chronic Cough | ☐ | ☐ | Heart Disease | ☐ | ☐ | Muscular Incoordination | ☐ | ☐ | Other__________ |
| ☐ | ☐ | Chronic Sinusitis | ☐ | ☐ | Heartburn/Indigestion | ☐ | ☐ | Neck Pain | ☐ | ☐ | Other__________ |

| EXERCISE | WORK ACTIVITY | HABITS |
|---|---|---|
| ☐ None | ☐ Sitting | ☐ Smoking (Packs/Day) ______ |
| ☐ Moderate | ☐ Standing | ☐ Alcohol (Drinks/Week) ______ |
| ☐ Daily | ☐ Light Labor | ☐ Coffee/Caffeine Drinks (Cups/Day) ______ |
| ☐ Heavy | ☐ Heavy Labor | ☐ High Stress Level Reason ____________________ |

### GENERAL HEALTH ISSUES

When did you last have a physical examination? Date __________ ☐ Never
When did you last have a cholesterol test? Date __________ ☐ Never
When did you last have a blood pressure test? Date __________ ☐ Never
Do you have a permanent disability rating? ☐ Yes ☐ No
Describe ____________________ Date received __________ Rating percentage __________
Surgical procedures (please list) ____________________
Medications (please list) ____________________
____________________
Allergies (please list) ____________________
____________________
Present: Weight ________ pounds Height ________ feet ________ inches

### WOMEN'S HEALTH ISSUES

Do you do breast self-examinations? ☐ Yes How Often? ________ ☐ No
When did you last have a Pap smear? Date __________ ☐ Never
When did you last have a Mammogram? Date __________ ☐ Never
Birth control pills used ☐ Yes ☐ No
Are you pregnant at this time? ☐ Yes Due Date __________ ☐ No ☐ Unsure

### MEN'S HEALTH ISSUES

When did you last have a prostate exam? Date __________ ☐ Never

Patient's Signature: ______________________________ Date: ____________________

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## HIPAA Compliance Patient Consent Form

The following is our Notice of Privacy Practices and provides information about how we may use or disclose protected health information.

The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

To confirm your appointments, please circle preference: Text Email Phone

Cell Phone #: ______________________ Cell Phone Provider: ___________________________________

Email: __________________________________________________________

May we leave a message on your answering machine at home or on your cell phone? ___YES ___NO

May we discuss your medical condition with any member of your family? ___YES ___NO

If YES, please list the members: ______________________________________________________________

__________________________________________________________________________________________

Patient/Legal Guardian Name (print name, please): ______________________________________________

Patient/Legal Guardian Signature: _____________________________________ Date: _________________

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## MASSAGE THERAPY POLICY

Due to problems associated with clients not showing for their massage therapy sessions, we have had to enact rules to ensure compliance with scheduling.

Massage Therapy is an integral part of your treatment plan and healing process. In order to ensure that all of our patients are able to receive the therapy they need our office requires:

- At least **4 hours advance notice** if you are unable to keep your therapy appointment
- If the advanced notice is not adhered to you will be charged a **"NO SHOW" fee** *(this fee will not be covered by your insurance company)*:
  - $30 for 30 min
  - $45 for 45 min
  - $60 for 60 min

I have read and accept this Massage Therapy Policy,

Patient Signature          Date

Print name

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## The Neck Disability Index

Patient name:_________________________________ File #:___________________ Date:_____________________

Please read instructions:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY
0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
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.

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 and 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; 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 extra pain.
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 off the floor, 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't 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.

SECTION 5-HEADACHES
0. I have no headaches at all.
1. I have slight headaches that come infrequently.
2. I have moderate headaches that come infrequently.
3. I have moderate headaches that come frequently.
4. I have severe headaches that 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 do my usual work, but no more.
2. I cannot do my usual work.
3. I can hardly do any work at all.
4. I can't 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.
2. I can drive my car as long as I want, with moderate pain in my neck.
3. I can't 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 can't drive my car at all.

SECTION 9-SLEEPING
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hr sleepless).
2. My sleep is mildly disturbed (1-2 hrs sleepless).
3. My sleep is moderately disturbed (2-3 hrs sleepless).
4. My sleep is greatly disturbed (3-5 hrs sleepless).
5. My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION
0. I am able to engage in all my recreation activities, with no neck pain at all.
1. I am able to engage in all my recreation activities, with some neck pain.
2. I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
3. I am able to engage in few of my recreation activities, because of pain in my neck.
4. I can hardly do any recreation activities, because of pain in my neck.
5. I can't do any recreation activities at all because of my neck.

Instructions:
1. The NDI is scored in the same way as the Oswestry Disability Index. Add scored numbers and times by 2 to get %.
2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

Score:_________________________

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## The Low Back Oswestry Index

Patient name:_________________________________ File #:___________________ Date:_____________________

Please read instructions:
This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE that applies to you.

SECTION 1-PAIN INTENSITY
0. I have no pain at the moment
1. The pain is very mild at the moment
2. The pain is moderate at the moment
3. The pain is fairly severe at the moment but varies
4. The pain is very severe at the moment
5. 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 and 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, 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 extra pain
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. 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 only lift very light weight
5. I cannot lift or carry anything at all

SECTION 4-WALKING
0. Pain does not prevent me walking any distance
1. Pain prevents me from walking more than 1 mile
2. Pain prevents me from walking more than ½ mile
3. Pain prevents me from walking more than 100 yards
4. I can only walk using a stick or crutches
5. I avoid walking altogether, because of the pain

SECTION 5-SITTING
0. I can sit in any chair as long as I like
1. I can only sit in my favourite chair as long as I like
2. Pain prevents me sitting more than one hour
3. Pain prevents me from sitting more than 30 minutes
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 extra pain
1. I can stand as long as I want but it gives me extra pain
2. Pain prevents me from standing for more than 1 hour
3. Pain prevents me from standing for more than 30 minutes
4. Pain prevents me from standing for more than 10 minutes
5. Pain prevents me from standing at all

SECTION 7-SLEEPING
0. My sleep is never disturbed by pain
1. My sleep is occasionally disturbed by pain
2. Because of pain I have less than 6 hours sleep
3. Because of pain I have less than 4 hours sleep
4. Because of pain I have less than 2 hours sleep
5. Pain prevents me from sleeping at all

SECTION 8-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 effect on my social life apart from limiting my more energetic interests eg, sport
3. Pain has restricted my social life and I do not go out as often
4. Pain has restricted my social life to my home
5. I have no social life because of pain

SECTION 9-TRAVEL
0. I can travel anywhere without pain
1. I can travel anywhere but it gives me extra pain
2. Pain is bad but I manage journeys over two hours
3. Pain restricts me to journeys of less than one hour
4. Pain restricts me to short necessary journeys under 30 minutes
5. Pain prevents me from travelling except to receive treatment

SECTION 10-RECREATION
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.

Instructions:
1. The LBO is scored in the same way as the Neck Disability Index. Add scored numbers and times by 2 to get %.
2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

Score:_________________________