HALEY CHIROPRACTIC CLINIC
1919 NO. PEARL ST. #A4
TACOMA, WA 98406

CONFIDENTIAL PATIENT HISTORY

Name_____ Today's Date: _____

Home #_____ Cell #_____ Cell phone provider:_____

Email Address: _____ Text Message Reminder ☐ OR Email Reminder ☐

Address_____ City_____ State _____ Zip_____

Marital Status: S M W D SSN#_____ Date of Birth _____

Employer_____ Work # _____ Ext: _____

Have you received chiropractic care in the past? ☐ Yes ☐ No

Are you currently under chiropractic care? ☐ Yes ☐ No

The reason for this visit: ☐ PI (automobile accident) ☐ L&I (injury on the job)

☐ Other_____

How did you hear about our office? ☐ Website ☐ Phonebook ☐ Other _____

INSURANCE COVERAGE

We can bill your insurance as a courtesy to you.

Will we be billing insurance for you? ☐ Yes ☐ No

☐ Private Insurance ☐ Medicare Coverage (also provide your supplemental insurance info)

Name of Insurance_____ Phone_____

Policy Number_____ Group # _____

Policy Holders Name_____ Employer_____

SS# of policy holder_____ Date of birth _____

***Secondary Insurance or Supplemental Insurance if applies:**

Name of Insurance_____ Phone_____

Policy Number_____ Group # _____

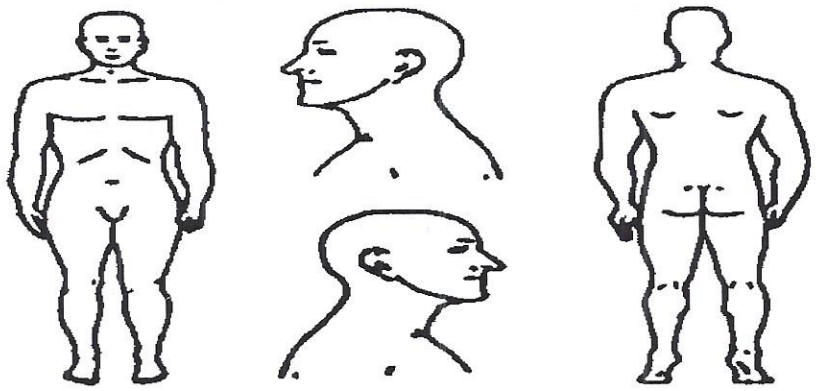
Policy Holders Name_____ Employer_____

SS# of policy holder_____ Date of birth _____

Haley CHIROPRACTIC Clinic

1919 N Pearl St. Suite A4 Tacoma WA 98406 ph: 253-761-0930

PLEASE CIRCLE YOUR AREA(S) OF COMPLAINT



What is your **PRIMARY** complaint? _____ When did your symptoms start? _____

Describe how your symptoms began: _____

_____

How often do you experience your symptoms throughout the day?

☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

What is the severity of your pain? ☐ Mild ☐ Moderate ☐ Severe

What **TYPE** of pain and/or discomfort do you have? (Check all that apply)

☐ Sharp ☐ Dull ☐ Ache ☐ Numb ☐ Tingling ☐ Shooting ☐ Stabbing ☐ Burning

☐ "Tight" ☐ "Stiff" ☐ Pulling ☐ Throbbing ☐ Annoying ☐ Uncomfortable ☐ Other:

Do your symptoms radiate anywhere? ☐ NO ☐ YES If yes, where? _____

Since the onset how are your symptoms changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

How would you rate your pain? (Circle one)

Currently: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

At its worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

What helps relieve your symptoms (ice, heat, massage, etc)? _____

What activities make your symptoms worse (working, exercise, etc)? _____

Have you experienced this type of pain before? ☐ NO ☐ YES If so, what helped relieve pain? _____

How do your symptoms affect your ability to perform activities of daily living (ADL's)? (Check one)

☐ Not at all ☐ Mildly (forgotten with activity) ☐ Moderately (interferes with activity)

☐ Limiting (prevents full activity) ☐ Severe (no activity is possible)

What activities of daily living are **painful and/or difficult** to perform due to symptoms? (Check all that apply)

☐ Sitting for more than 10 minutes	☐ Putting on shoes	☐ Looking over shoulder
☐ Sitting for more than 60 minutes	☐ Changing positions (sit to stand)	☐ Reaching overhead
☐ Standing for more than 10 minutes	☐ Sleeping	☐ Gripping
☐ Standing for more than 60 minutes	☐ Turning over in bed	☐ Pushing
☐ Walking short distances	☐ Lying on stomach	☐ Pulling
☐ Getting in and/or out of the car	☐ Lying on back	☐ Kneeling
☐ Bending over forward	☐ Coughing and/or Sneezing	☐ Balancing
☐ Putting on and/or taking off clothes	☐ Sexual activities	☐ Squatting
☐ Picking something off the floor	☐ Driving	☐ Going up and/or down stairs
☐ Computer work	☐ House/Yard work	☐ Exercise/Running/Biking

Who have you seen for your current symptoms? (Check all that apply)

☐ No one ☐ Chiropractor ☐ Primary Care Physician ☐ Physical Therapist ☐ Massage Therapist

If so, what treatment was given and/or what medication(s) were prescribed to you? _____

What tests/imaging have been performed for your current symptoms? (Check all that apply):

☐ None ☐ X-RAY *date:* _____ ☐ MRI *date:* _____ ☐ CT Scan *date:* _____ Other *date:* _____

Are there any *ADDITIONAL* areas of complaint? ☐ NO ☐ YES If yes where? _____

Describe how symptoms began: _____

When did your symptoms start? _____ What is the severity of your pain? ☐ Mild ☐ Moderate ☐ Severe

How often do you experience your symptoms?

☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

What **TYPE** of pain and/or discomfort do you have? (Check all that apply)

☐ Sharp ☐ Dull ☐ Ache ☐ Numb ☐ Tingling ☐ Shooting ☐ Stabbing ☐ Burning

☐ "Tight" ☐ "Stiff" ☐ Pulling ☐ Throbbing ☐ Annoying ☐ Uncomfortable ☐ Other:

How would you rate your pain? (Circle one)

Currently: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

At its worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

General Patient Health, Social and Past Health History

Height: _____ Weight: _____ Occupation: _____

Do you smoke? ☐ NO ☐ YES If yes, how many cigarettes per day? _____

Do you exercise? ☐ NO ☐ YES If yes, how many times per week? _____

In the space provided please enter **"C"** if you **CURRENTLY** or **"P"** if you have had this problem in the **PAST**.

Musculoskeletal
_____Spinal Surgery
_____Screws, Pins and/or Plates
_____Muscle Spasms/Cramping
_____Scoliosis
_____Arthritis
_____Osteoporosis
_____Slipped/Herniated Disc
_____Spinal/Extremity Fractures
_____TMJ Issues
_____Hip Disorders

Cardiovascular
_____Blood Clots
_____Chest Pain or Tightness
_____Heart Attack
_____Coronary Artery Disease
_____High Blood Pressure
_____Low Blood Pressure
_____Excessive Bruising
_____Swollen Legs or Feet
_____Varicose Veins
_____Leg Pain with Walking

General
_____Unexplained Weight Loss/Gain
_____Anemia
_____Diabetes
_____Gout
_____Cancer
_____Thyroid Disease
_____Migraines with Aura
_____Migraines without Aura
_____Changes in Bowel or Bladder Habits

Neurologic
_____Tremors
_____Dizziness/Vertigo
_____Fainting
_____Epilepsy and/or Seizures
_____Numbness/Tingling/Weakness
_____Partial or Complete Paralysis
_____Stroke
_____Loss of Vision, Taste or Smell

Respiratory
_____Snoring Issues
_____Difficulty Breathing
_____Chronic Cough
_____Emphysema
_____Spitting Blood
_____Wheezing/Asthma
_____Shortness of Breath

Allergies:_____
_____
_____

Eye, Ear Nose & Throat
_____Blurred or Double Vision
_____Eye Pain or Vision Change
_____Chronic Ear Infections
_____Ringing in Ears
_____Sinus Problems
_____Difficulty Swallowing

Gastrointestinal
_____Abdominal Pain
_____Irritable Bowel
_____Food Sensitivities
_____Constipation
_____Hernia
_____Loss of Bowel Control
_____Appendicitis

Women ONLY:
Currently pregnant: ☐ NO ☐ YES
Currently nursing: ☐ NO ☐ YES
Birth Control: ☐ NO ☐ YES
Breast implants: ☐ NO ☐ YES
Hormone Replacement: ☐ NO ☐ YES
Menopause Symptoms: ☐ NO ☐ YES

List all the surgical procedures you have had and the dates they were performed:
_____
_____
_____

List all the prescriptions, over-the counter medications and nutritional supplements you are taking:
_____
_____
_____

Have you been involved in previous auto/work/fall accidents? ☐ NO ☐ YES If yes; explain: _____
_____

Have you been hospitalized for any previous illnesses? ☐ NO ☐ YES If yes; explain: _____

Is there anything else that is causing you concern, worry or stress? ☐ NO ☐ YES If yes; explain: _____
_____

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

Patient Name_____ Date_____

I hereby authorize Haley Chiropractic Clinic to release any information deemed appropriate to my health insurance company and their affiliates, my auto insurance company and their affiliates, or my attorney and/or claims adjuster in order to process any claim for reimbursement of charges incurred.

In the event my insurance company or attorney does not pay Haley Chiropractic Clinic for services and/or product I receive. I understand that I am personally responsible to pay my account balance in full. I also understand that Haley Chiropractic Clinic will make all efforts in my favor to settle or resolve any said claim as we see fit.

In addition to the above, I waive the statute of limitations on collection in the state of WA. I agree that this authorization is irrevocable and ongoing until all monies owed are paid in full. This authorization will be in effect until revoked by both parties.

Our office is required by federal law to maintain the privacy of you Private Health Information (PHI). We will not share your PHI with other healthcare providers or persons unless you have granted us permission to do so.
I hereby give permission for Haley Chiropractic Clinic to share my PHI to the following health care providers and/or persons:

_____

_____

For a complete description of our practice's privacy notice, please ask at the reception desk. By signing below, I acknowledge I have read and understand the above terms.

SIGNATURE_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We keep a record of the care we give you. The record also contains other health information about you. We will not discuss your health information to others unless we have your permission to do so, or unless the law allows or requires us to do so. If you have questions about your health information or want to ask about your rights, contact:

Haley Chiropractic Clinic
1919 N. Pearl Street, Suite A4
Tacoma, WA 98406
(253)761-0930

By signing this form, you are letting everyone know that you received a copy of the Notice of Privacy Practices that explain your rights.

SIGNATURE_____ DATE_____

IF MINOR, PARENT/GUARDIAN_____ RELATIONSHIP_____

HALEY CHIROPRACTIC CLINIC PAYMENT POLICY

PATIENTS WITHOUT INSURANCE OR INSURANCE THAT DOES NOT COVER CHIROPRACTIC CARE:
Patients are expected to pay for services in full at the time services are rendered. If any questions regarding these fees have not been answered please let us know and we will be happy to go over these fees with you. If payment arrangements need to be made please consult with the office manager before making an appointment. A $10.00 Service Fee may be applied to your account if your estimated portion due is not received at the time of service.

PATIENTS WITH INSURANCE COVERAGE FOR CHIROPRACTIC CARE: If your private insurance policy provides chiropractic benefits we will be happy to submit a claim to them for you. In accordance with our contracts with all insurance companies you are responsible for paying you portion at the time of service. Your estimated portion will be calculated by the benefit deductibles, co-pays, and/or a specific percentage your insurance company has established for your individual policy. A billing fee may be charged to your account if payment is not received at the time services are rendered. Please discuss any need for payment arrangements with our office manager before scheduling an appointment. Please let us know if you have new insurance since your last visit. A $10.00 Service Fee will apply if not informed at the time of service of your current insurance, and a claim needs to be reprocessed due to incorrect billing information.

********IT IS THE PATIENTS RESPONSIBILITY TO KNOW THEIR OWN BENEFITS. WE MAY LOOK UP YOUR BENEFITS AS A COURTESY. THIS IS NOT A GUARANTEE OF BENEFITS AND/OR PAYMENT DUE. THIS IS SUBJECT TO ONLY THE INFORMATION AVAILABLE TO US THROUGH THE WEBSITE. THE AMOUNT YOU WILL BE CHARGE FOR SERVICES RENDERED IS BASED ON THE CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.

BILLING SCHEDULE: Statements will be mailed every other month to patients with balances due by them after all Explanation of Benefits are received from your insurance company(s). If patient payments are not received after the first notice is sent to you a billing fee may be charged to your account for every 60 days your account is past due (I.E. 90 days, 120 days). If payment from you is not made within 120 days of your first notice from our office your account may be turned over to a collections agency.

WORKERS COMPENSATION AND MOTOR VEHICLE COLLISION INJURIES: Please notify us if you have been injured on the job or in a motor vehicle accident. Worker's compensation does cover necessary chiropractic treatments if your claim has been approved and is currently open. A new claim will require necessary forms to be completed by the patient and the doctor before it will be considered by the worker's compensation department. If your injury claim is not allowed it is your responsibility to pay any outstanding balances. Your auto insurance company will pay for any necessary chiropractic treatment if you had "PIP" coverage (Personal Injury Protection) included in your auto insurance policy at the time of the injury. You must file a claim with your auto insurance company and complete and return a "PIP" application to them before they will issue any payment towards your account. Workers compensation/Auto insurance policies will not cover any cost incurred by retail charges (i.e. braces, ice packs, etc).

I have read the above policies of Haley Chiropractic Clinic and fully understand that I am responsible for the payment of my account. If a minor, a parent or guardian must sign this form and be responsible for payment.

PLEASE GIVE 24 HOURS NOTICE IF YOU ARE UNABLE TO MAKE YOU SCHEDULED APPOINTMENT. NO SHOW APPOINTMENTS WILL BE SUBJECT TO A $40.00 NO SHOW FEE. PLEASE NOTIFY US OF ANY CHANGES TO INSURANCE, ADDRESS, OR PHONE NUMBERS PROMPTLY.

SIGNATURE_____ DATE _____

PATIENT'S NAME_____

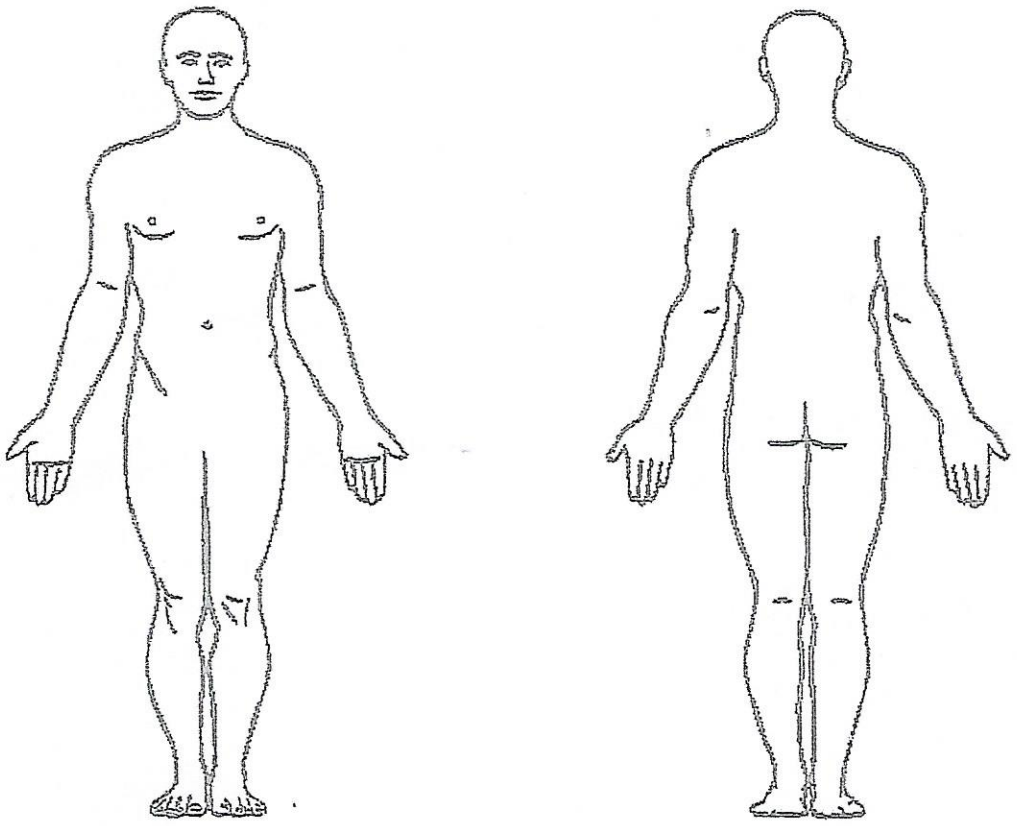
IF MINOR, PARENT / GUARDIAN_____

HALEY CHIROPRACTIC CLINIC
1919 N Pearl. St., #A-4
Tacoma, WA 98406
(253) 761-0930

Review of Symptoms

Indicate on the drawing where you are having symptoms of:

B- Burning
S- Stabbing
A-Aching
N- Numbness
P- Pins & Needles sensation
X-Pain



Name_____Date_____

Your weight_____ Height_____

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 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. CHOOSE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 -Personal Care (Washing, Dressing, etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self-care.
F I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 - Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 - Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 - Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours)

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

COMMENTS: _____

_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ*: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your 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 MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

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 moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 - Personal Care

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 increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a 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.

SECTION 4 - Walking

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 more than 1/2 mile.
D Pain prevents me from walking more than 1/4 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.

SECTION 5 - Sitting

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 ten minutes.
F Pain prevents me from sitting at all.

SECTION 6 - Standing

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 1/2 hour without increasing pain.
E I cannot stand for longer than ten minute without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7 - Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one 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.

SECTION 8 - Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, 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 hardly any social life because of the pain.

SECTION 9 - Traveling

A I get no pain while 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.

SECTION 10 - Changing Degree of Pain

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.

COMMENTS: _____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____

Fairbank J, Davies J, et al. The Oswestry Low Back Pain Disability Questionnaire. Physiother 1980; 66(18): 271-273.