SKY VALLEY CHIROPRACTIC

JOB ACCIDENT FORM: Date of Injury: _____ Time of Injury: _____

NAME: _____ DATE: _____

Injury occurred while:

__ Carrying an object and lost balance
__ Driving
__ Lifting an object
__ Repetitive motion
__ Struck by falling objective
__ Other

Please explain: _____
_____
_____
_____
_____
_____

Did you report this injury in writing at work? YES NO
Who did you report the injury to? _____
Date you reported the injury: _____
Have you seen another health care provider for this injury? YES NO

Complete the section **ONLY** if injury occurred while lifting:

The injury occurred lifting:
__ From the floor
__ From a surface over my head
__ From a surface about waist high

While I was lifting, I:
__ Had my back straight
__ Had my waist bent
__ Was twisted to the left side
__ Was twisted to the right side

The object I was lifting was about:
__ 2-5 lbs
__ 5-10 lbs
__ 10-15 lbs
__ 15-20 lbs
__ 20-25 lbs
__ 25-50 lbs
__ More than 50 lbs

The pain I felt immediately after the injury was:
__ A dull ache
__ A grabbing feeling
__ A popping feeling
__ A sharp pain in one spot
__ A sharp pain with radiating symptoms

Complete this section **ONLY** if injury occurred from fall:

I fell:
__ 2-4 ft high
__ 4-6 ft high
__ 6-8 ft high
__ Over 8ft high
__ Onto the surface I was walking on

When I fell I hit my:
__ Back
__ Right elbow
__ Left hand/wrist
__ Head
__ Right knee
__ Left elbow
__ Face
__ Right hand/wrist
__ Left knee
__ Tail bone

The surface I fell on can be described as:
__ Containing an object that caused the fall
__ Slick due to liquid
__ Uneven carpet
__ Icy
__ Wet

I landed on my:
__ Back
__ Knee
__ Rear end
__ Out stretched arms
__ Left side
__ Right side
__ Stomach

How would you describe your health **BEFORE** your injury?

__ Excellent
__ Good
__ Fair
__ Poor

Have you experienced the same or similar symptoms before this injury?

Please explain: _____
_____
_____

Have you done anything to aggravate your work injury?

Please explain: _____
_____
_____

Do you have any other information you feel your doctors should know regarding this injury?

Please explain: _____
_____
_____
_____

PATIENT INTAKE FORM

PATIENT HISTORY Date:_____

Name:_____ Last 4 of SSN#:_____

Address:_____ City:_____ Zip:_____

Phone: (Cell)_____ (Home)_____ Email:_____

Birthdate:_____ Age:_____ Gender:_____M _____F _____# Children

Status: ____Single ____Married ____Separated ____Divorced ____Widowed ____Domestic Partner

EMERGENCY CONTACT

Name:_____ Phone #:_____ Relationship:_____

WORK HISTORY

Are you currently:_____ Employed _____ Retired

Name of Employer:_____ Type of Work: _____

Do you have insurance?: ____ Yes ____ No Name of Insurance Carrier:_____

REASON FOR YOUR VISIT TODAY

Describe the reason for your visit here today (please be more specific than "back pain"): _____

_____

Do you know approximately when this condition started? _____

Do you know what caused the condition? Please describe: _____

_____

Have you received care for this condition from any other health care provider? _____

_____

Have you received chiropractic care in the past? Y N If yes, when? _____

NATURE OF PAIN

_____ Numbness _____ Pins and Needles _____ Burning _____ Aching _____Stabbing

What aggravates the pain? _____

What helps to give relief to the pain? _____

Does this condition: _____ get worse ____ stay the same _____ come and go

Has this condition occurred in the past? _____ Yes _____ No

Who may we thank for referring you to this office? _____

Authorization for Care

I clearly understand and agree that all the services rendered me are charged directly to me and that I am personally responsible for payment I agree that I am responsible for all bills incurred at this office I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable I hereby authorize assignment of my rights and benefits (if applicable) directly to the provider for services rendered

Initial: _____ Date: _____

HEALTH HISTORY FORM

HEALTH HABITS

	No	Yes	
Do you smoke?			_____ packs/day
Do you drink alcohol?			_____ drinks/day
Do you drink caffeine?			_____ cups/day
Do you exercise regularly?			_____ Moderate _____ Daily
Do you wear			_____ Heel Lifts ____ Sole Lifts ___ Inner Soles ____ Arch Supports

HEALTH CONDITIONS

Please mark each of the diseases or conditions that you have with an **N** for **Now** or with a **P** for **Past**. These conditions can sometimes affect the overall diagnosis, care plan, and/or eligibility for chiropractic care.

	Neck Pain		Congenital Heart Defect		Shingles
	Headaches		Heart Surgery/Pacemaker		Kidney Problems
	Dizziness		High/Low Blood Pressure		Cancer
	Loss of Sleep		Difficulty Breathing		Chemotherapy
	Allergies		Asthma		Gout
	Arthritis		Scoliosis		Anemia
	Diabetes		Ulcers/Colitis		Multiple Sclerosis
	Hepatitis		Sinus Problems		Heart Murmur
	Pain Between the Shoulders		Alcohol/Drug Abuse		Broken Bones
	Lower Back Pain		Digestive Problems		Osteoporosis
	Arm/Hand Pain		Obesity		HIV/AIDS
	Arm/Hand Numbness/Tingling/Weak		Psychiatric Conditions		Heart Attack/Stroke
	Leg/Foot Pain		Lupus		Tuberculosis
	Leg/Foot Numbness/Tingling/Weak				

WOMEN ONLY

Y	N		Y	N	
		Are you currently pregnant?			Do you experience painful periods?
		Are you currently nursing?			Do you have irregular cycles?
		Are you currently using/taking birth control?			Do you have breast implants?

MEDICATIONS

Medication	***Reason For Medication***	***Medication***	***Reason For Medication***
Stimulants		Blood Thinners	
Pain Killers (incl. aspirin)		Tranquilizers	
Muscle Relaxers		Insulin	
Blood Pressure Medication		Other	

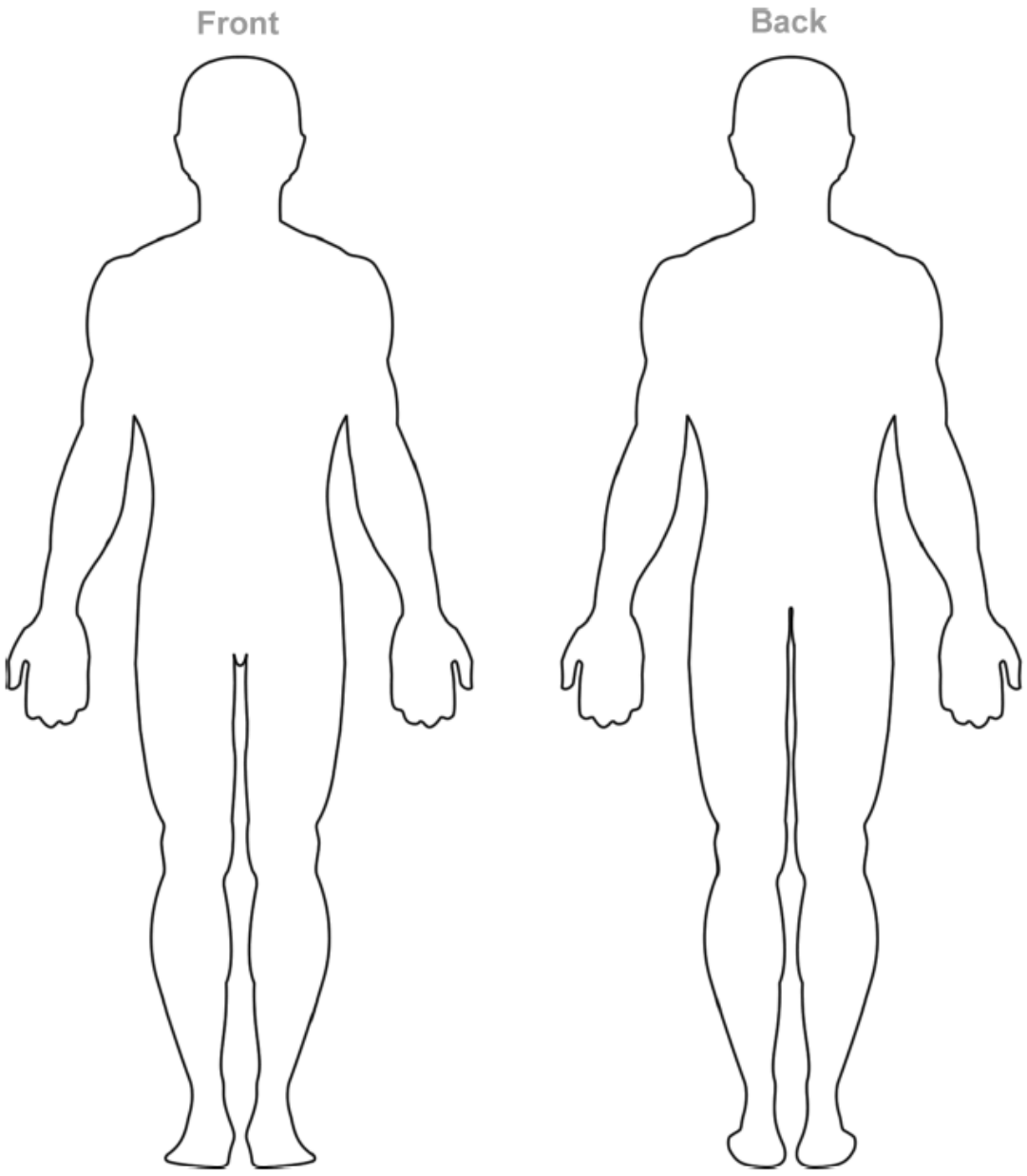
Signature of Patient: _____ Date: _____

Name of Patient (Printed): _____

DRAW-ON BODY DIAGRAM

Please mark the areas on this body diagram where you feel the described sensations. Include all affected areas.

Numbness	Pins and Needles	Burning	Aching	Stabbing
----------	000000000000000	XXXXXXX	********	//////////



Patient Name_____ **Patient Signature**_____ **Date**_____

Cosgrove Chiropractic, P.S. 1129 West Main Street, Suite 128, Monroe, WA 98272 Ph: 360-794-7600

Revised Oswestry Low Back Pain and Disability Index

Patient Name _____ Date _____

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 ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you but please mark the box which most closely describes your problem. Thank you.

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 very severe.
- ☐ F. The pain is severe and does not vary much.

Section 2 - Personal Care

- ☐ 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 can 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 weight without extra pain.
- ☐ B. I can lift heavy weight, but it gives extra pain.
- ☐ C. Pain prevents me from lifting heavy weights off the floor.
- ☐ D. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- ☐ E. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned
- ☐ F. I can only lift very light weights at the most.

Section 4 - Walking

- ☐ A. I have no pain walking.
- ☐ B. I cannot walk more than one mile without increasing pain.
- ☐ C. I cannot walk more than ½ mile without increasing pain.
- ☐ D. I cannot walk more than ¼ mile without increasing pain.
- ☐ E. I can walk with crutches.
- ☐ F. Bedridden and must crawl to the toilet.

Section 5 - Sitting

- ☐ A. I can sit in any chair as long as I like.
- ☐ 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 a half hour.
- ☐ E. Pain prevents me from sitting more than 10 minutes.
- ☐ F. I avoid sitting because it increases the pain straight away.

Section 6 - Standing

- ☐ A. I can stand as long as I want without pain.
- ☐ B. I have some pain on 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 ½ hour without increasing pain.
- ☐ E. I cannot stand for longer than 10 minutes 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 < 1/4.
- ☐ D. Because of pain my normal night's sleep is reduced by < 1/2.
- ☐ E. Because of pain my normal night's sleep is reduced by < 3/4.
- ☐ F. Pain prevents me from sleeping at all.

Section 8 - Driving

- ☐ A. I get no pain while driving.
- ☐ B. I get some pain while driving but none of my usual forms of travel make it any worse.
- ☐ C. I get extra pain while driving but it does not compel me to seek alternative forms of travel.
- ☐ D. I get extra pain while driving 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 9 - Social Life

- ☐ 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 limits my more energetic interests, 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 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.
- ☐ D. My pain is neither getting better nor worse.
- ☐ E. My pain is gradually worsening.
- ☐ F. My pain is rapidly worsening.

Neck Pain and Disability Index (Vernon-Mior)

Patient Name _____ Date _____

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 ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you but please mark the box which most closely describes your problem. Thank you.

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

- ☐ 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 can 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 weight without extra pain.
- ☐ B. I can lift heavy weight, 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.
- ☐ 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 with moderate pain in my neck.
- ☐ D. I can't read as much as I want because of moderate pain in my neck.
- ☐ E. I can read at all because of severe pain in my neck.
- ☐ F. I cannot read at all due to pain in my neck.

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 concentrating when I want to.
- ☐ D. I have a lot of difficulty concentrating when I want to.
- ☐ E. I have a great deal of difficulty 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 can't do any work at all.

Section 8 - Driving

- ☐ A. I can drive my car without any neck pain.
- ☐ B. I can drive as long as I want with slight pain in my neck.
- ☐ C. I can drive as long as I want with moderate pain in my neck.
- ☐ D. I can't drive 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 can't drive my car at all.

Section 9 - Sleeping

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

Section 10 - Recreation

- ☐ A. I am able to engage in all my recreation activities with no neck pain at all.
- ☐ B. I am able to engage in all my recreation activities with some pain in my neck.
- ☐ C. I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- ☐ D. I am able to engage in few of my usual activities due to neck pain.
- ☐ E. I can hardly do any recreation activities because of pain.
- ☐ F. I can't do any recreation activities at all.

COSGROVE CHIROPRACTIC, P.S., dba SKY VALLEY CHIROPRACTIC

1129 West Main Street, Suite 128, Monroe, WA 98272
Phone: 360-794-7600 Fax 360-794-9377

NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my Protected Health Information ("PHI"). I understand that this information can and may be used to:

*Conduct, plan, and direct my treatment and follow-up among all health care providers who may be directly or indirectly involved in my treatment.
* Obtain payment from third-party payers.
*Conduct normal health care operations such as quality assessments and physician certifications.
*Deliver appointment reminders by phone, text, or email.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices at any time and that I may contact this organization at the address above to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, that you are bound to abide by such restrictions.

NON-COVERED SERVICES/INFORMED CONSENT

Non-Covered Services: I clearly understand and agree that all services rendered to me are charged directly to me and/or my insurance carrier, and that, ultimately, I am personally responsible for payment. There will be a missed appointment/cancellation fee for any appointment missed or cancelled without 24 business hours' notice by phone or in person. Regarding scheduled examinations, I understand that if I have been charged an appointment reservation fee, this fee is non-refundable if I cancel without 24 business hours' notice, or if I cancel a Monday appointment over the weekend. If I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless specific arrangements are approved in writing by the doctor.

Informed Consent: I have been informed and understand that in the practice of chiropractic there are some extremely rare risks to treatment including, but not limited to, muscle strains, joint sprains, and disc injuries. I do not expect the doctor to be able to anticipate and explain all risks and complications. I authorize Cosgrove Chiropractic, P.S., dba Sky Valley Chiropractic to examine and utilize any means necessary to diagnose my condition in accordance with the state statues for the care and management of my condition. I am giving my consent to Cosgrove Chiropractic, P.S., dba Sky Valley Chiropractic to cover the entire course of treatment for my present and any future condition for which I seek treatment.

Patient/Guardian Signature _____ Date_____

Patient Name (Printed) _____

Relationship to Patient _____

NOTICE OF PRIVACY PRACTICES

THE 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 Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- *Treatment means providing, coordination or managing health care and related services by one or more health care providers. An example of this would include a physical examination.*
- *Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.*
- *Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.*

We may also create and distribute DE-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- *The right to request restriction on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.*
- *The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.*
- *The right to inspect and copy your protected health information.*
- *The right to amend your protected health information.*
- *The right to receive an accounting of disclosures of protected health information.*
- *The right to obtain a paper copy of this notice from us upon request.*

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information about HIPPA or to file a complaint.

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, D.C. 20201
Toll Free: 877-696-6775

Cosgrove Chiropractic, P.S., dba Sky Valley Chiropractic
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Monroe, WA 98272
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