RAINIER VALLEY CHIROPRACTIC P.S.
David A. Butters, D.C.— Natasha M. Butters, D.C.

4236 36th Avenue S. Seattle, WA 98118
Phone 206-723-2820 Fax 206-722-3664

On The Job Injury Health History Form

** Was your injury caused by an automobile collision while On The Job? If Yes, Please fill out The Automobile Collision History Form instead of this form.*

Full Name______________________________ Date______________

Street Address______________________________ City__________ State______ Zip__________

Date of Birth:______________ Gender__________ Cell#______________ Home#______________

Email______________________ SSN______________ How did you hear about our office______________

Marital Status____________ # of Children? ____ Currently Pregnant? / How Long? ____________

Occupation______________________________ Employer______________________________

Place of Business Address______________________________ Phone______________

Date of On The Job Injury: ___/___/______ Have you reported your injuries to your employer? ☐No ☐Yes

Today's Major Complaints

Please check ✓ ***Please Circle Your Level of Pain.***

Area of Pain and Type of Pain			***0= No Pain through 10=Extreme Pain***
☐Headache	☐Lt ☐Rt	☐Ache ☐Dull ☐Sharp ☐Stabbing	0 1 2 3 4 5 6 7 8 9 10
☐Neck Pain	☐Lt ☐Rt	☐Ache ☐Dull ☐Sharp ☐Stabbing	0 1 2 3 4 5 6 7 8 9 10
☐Shoulder Pain	☐Lt ☐Rt	☐Ache ☐Dull ☐Sharp ☐Stabbing	0 1 2 3 4 5 6 7 8 9 10
☐Arm Pain	☐Lt ☐Rt	☐Ache ☐Dull ☐Sharp ☐Stabbing	0 1 2 3 4 5 6 7 8 9 10
☐Mid Back Pain	☐Lt ☐Rt	☐Ache ☐Dull ☐Sharp ☐Stabbing	0 1 2 3 4 5 6 7 8 9 10
☐Low Back Pain	☐Lt ☐Rt	☐Ache ☐Dull ☐Sharp ☐Stabbing	0 1 2 3 4 5 6 7 8 9 10
☐Hip Pain	☐Lt ☐Rt	☐Ache ☐Dull ☐Sharp ☐Stabbing	0 1 2 3 4 5 6 7 8 9 10
☐Leg Pain	☐Lt ☐Rt	☐Ache ☐Dull ☐Sharp ☐Stabbing	0 1 2 3 4 5 6 7 8 9 10
☐Other ______________			0 1 2 3 4 5 6 7 8 9 10
☐Other ______________			0 1 2 3 4 5 6 7 8 9 10

I feel more pain when doing the following activities:

Check ✓ the activities that cause pain and then Circle minimal, mild, moderate or severe.

☐Sleeping	Minimal	Mild	Moderate	Severe
☐Sitting	Minimal	Mild	Moderate	Severe
☐Walking	Minimal	Mild	Moderate	Severe
☐Standing	Minimal	Mild	Moderate	Severe
☐Lifting	Minimal	Mild	Moderate	Severe
☐Household Chores	Minimal	Mild	Moderate	Severe
☐Routine Personal Care	Minimal	Mild	Moderate	Severe
☐Pushing	Minimal	Mild	Moderate	Severe
☐Squatting	Minimal	Mild	Moderate	Severe
☐Reaching	Minimal	Mild	Moderate	Severe
☐Carrying	Minimal	Mild	Moderate	Severe
☐Pulling	Minimal	Mild	Moderate	Severe
☐Bending	Minimal	Mild	Moderate	Severe
☐Computer Work	Minimal	Mild	Moderate	Severe
☐Typing	Minimal	Mild	Moderate	Severe

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Name____ Date: ____/____/________

What happened to cause your injuries?

____

____

____

Have you had similar injuries or problems **Before**? Please describe ____________________________

____

Please list **other health care providers** you have seen for the condition(s), and **treatment** received.

____

____

Have you found any activities that make your injuries feel better? (Examples are ice, heat, stretching, other treatment)

____

____

Describe briefly and give approximate dates for any **major injuries, illnesses, surgeries or accidents**:

____

____

____

Does your immediate family have a history of any diseases? (Cancer, Heart Disease, Diabetes, Etc.)

Mother's side ____

Father's side ____

Are you presently on any medications? (please specify)

____

____

Do you drink alcohol?	❑No	❑Yes,	____ Drinks	❑Daily	❑Weekly	❑Monthly
Do you smoke?	❑No	❑Yes,	____ Packs	❑Daily	❑Weekly	❑Monthly
Do you exercise?	❑No	❑Yes,	If yes, then how often?	❑Daily	❑2-3 times a Week	❑Monthly

Height_________ Weight____________

Have you been to a chiropractor before? ❑Yes ❑No

Chiropractor's name/ location: ________________________________ Last seen: ______________

Name of Primary Care Physician________________________ Date of last Physical________________

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period:_____________

Signature: ____ ***Date:*** ____/____/________

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Name____ Date: ____/____/________
Employer at time of injury: ______________________________ Employer's Phone #:______________________
Employer's Address:____
L & I / Self-Insured Co.:______________________________ Self-Ins. Co Phone #: ______________________
Self-Insured Co. Address:____

Since the injury is your condition ❑ Improving ❑ Getting Worse ❑ Same

Have you lost time from work as a result of this injury? ❑No ❑Yes

If Yes, please list
dates:____

Date you returned to work or expect to return to work*:* ____/____/________

Check those activities that are required of you at work

❑Lifting	❑Occasionally	❑Frequently	❑Continuously	Up to _____ lb.
❑Carrying	❑Occasionally	❑Frequently	❑Continuously	Up to _____ lb.
❑Pushing	❑Occasionally	❑Frequently	❑Continuously	Up to _____ lb.
❑Pulling	❑Occasionally	❑Frequently	❑Continuously	Up to _____ lb.
❑Sitting	❑Occasionally	❑Frequently	❑Continuously	
❑Standing	❑Occasionally	❑Frequently	❑Continuously	
❑Walking	❑Occasionally	❑Frequently	❑Continuously	
❑Bending	❑Occasionally	❑Frequently	❑Continuously	
❑Squatting	❑Occasionally	❑Frequently	❑Continuously	
❑Computer work	❑Occasionally	❑Frequently	❑Continuously	
❑Reaching	❑Occasionally	❑Frequently	❑Continuously	
❑Typing	❑Occasionally	❑Frequently	❑Continuously	

Signature (Guardian if under 18):____ ***Date:***____/____/________

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only 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.

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

Neck Index Score

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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.

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.

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.

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.

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.

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.

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.

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.

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.

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 ______

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Name____ Date: ____/____/________

Authorization To Release Medical Records:

PATIENT INFORMATION:

Name (print) ______________________ DOB ____________ SSN ______________

INFORMATION TO BE RELEASED FROM:

1) Name of facility or provider ______________________ Ph#______________ Pt. Initials ________
Address ______________________ Fax#______________ Date Sent ___/___/___

2) Name of facility or provider ______________________ Ph#______________ Pt. Initials ________
Address ______________________ Fax#______________ Date Sent ___/___/___

3) Name of facility or provider ______________________ Ph#______________ Pt. Initials_______
Address ______________________ Fax#______________ Date Sent ___/___/___

INFORMATION TO BE SENT TO:

Rainier Valley Chiropractic, P.S.
4236 36th Avenue S., Seattle, WA 98118
206-723-2820 (fax # 206-722-3664)

INFORMATION TO BE RELEASED: **(check one)**

__X__ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
______ All medical records
______ Specific information (please specify):

PURPOSE FOR WHICH THE DISCOSURE IS BEING MADE: (please check one)

______ Attorney _______Insurance __X__ Doctor ________Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

_____ Drug/Alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease
_____ HIV/AIDS diagnosis/treatment testing _____ Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization ma re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: ______________________________ Date: ______________
(Patient, guardian*, or Authorized representative*)

This authorization will expire 90 days from the date signed