CONFIDENTIAL HEALTH INFORMATION

Audubon Park Wellness
2909 West Northwest Blvd
Spokane, WA 99205
Office 509-327-4049
audubonparkwellness.com

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Gender
○ Male ○ Female

Your Last Name

Your Social Security Number

Your First Name | Your Middle Name (or Initial) | Birth Date (MM/DD/YYYY) | Age

Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Address

City | State/Province | ZIP/Postal Code | Home Phone | Spouse's Name

Email Address | Cell Phone | Child's Name and Age

Emergency Contact | Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer

May we contact you at work?
○ Yes ○ No

Address

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

City | State/Province | ZIP/Postal Code | Work Phone

Insurance Carrier | Policy Number | Primary Care Provider's Name

Insured's Last Name | Birth Date (MM/DD/YYYY)

Who carries this policy?
○ Self ○ Spouse ○ Parent

First Name | Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ○ An accident or injury
○ Work ○ Auto ○ Other _____
○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other _____

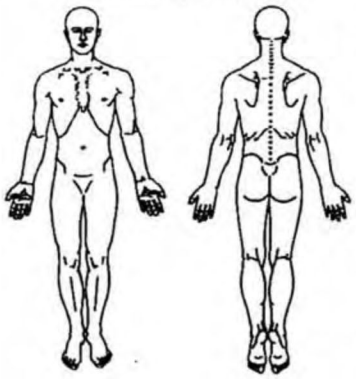
3. Onset (When did you first notice your current symptoms?)
_____

4. Intensity (How extreme are your current symptoms?)
0○○○○○○○○○○10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
○ Constant ○ Comes and goes. How Often? _____
_____

6. Quality of symptoms (What does it feel like?)
○ Numbness
○ Tingling
○ Stiffness
○ Dull
○ Aching
○ Cramps
○ Nagging
○ Sharp
○ Burning
○ Shooting
○ Throbbing
○ Stabbing
○ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)
○ Prescription medication ○ Surgery ○ Ice
○ Over-the-counter drugs ○ Acupuncture ○ Heat
○ Homeopathic remedies ○ Chiropractic Other _____
○ Physical therapy ○ Massage _____

11. What else should Audubon Park Wellness know about your current condition? _____
_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture

NONE ○ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness

NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising

NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea

NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste

NONE ○ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash

NONE ○ Initials ____

Consultation Notes

Patient name _____

Patient Number (office use only) _____

Doctor's Initials _____

Audubon Park Wellness

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	Initials ____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			_____
○	○	Chicken pox			_____
○	○	Diabetes			_____
○	○	Epilepsy			_____
○	○	Glaucoma			_____
○	○	Goiter			_____
○	○	Gout			_____
○	○	Heart disease			_____
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: _____

○ ○ Medications (prescription and over-the-counter): _____

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

FAMILY

18. Family History

Some health issues are hereditary. Tell Audubon Park Wellness about the health of your immediate family members.

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
_____		○	○			○	○

19. Are there any other hereditary health issues that you know about? _____

_____

20. Social History

Tell Audubon Park Wellness about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much? _____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much? _____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much? _____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much? _____			

Hobbies: _____

Patient name _____

Patient Number (office use only) _____

○ All other systems negative

Consultation Notes

Doctor's Initials _____

Audubon Park Wellness

21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? _____ **23. How much sleep do you average per night?** _____ **Hours**

24. What is the type and approximate age of your mattress and pillow? _____ **25. What is your preferred sleeping position?** _____

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

_____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

_____ _____
Signature Date (MM/DD/YYYY)

Consultation Notes

Patient name

Patient Number
(office use only)

Doctor's Initials

Audubon Park Wellness

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment this office uses as Doctors of Chiropractic are spinal manipulative therapy. The doctor will use that procedure to treat you. He/she may use their hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the treatment you are requesting today, you are consenting to the following procedure(s):

___ spinal manipulative therapy
___ range of motion testing
___ muscle strength testing
___ hot/cold therapy
___ radiographic studies
___ palpation
___ orthopedic testing
___ postural analysis
___ EMS
___ vital signs
___ basic neurology

(Patient: initial each procedure you are consenting to)

The material risks inherent in chiropractic adjustment.

As with any health care procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the spinal manipulative treatment to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which is typically checked for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers.
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduced mobility which may set up a pain reaction of further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPIATE BLOCK AND SIGN BELOW.

I have read [ ] o r have had read to me [ ] the above explanation of the adjustment and related treatment. I have discussed it with Audubon Park Chiropractic and have had my questions to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ Dated: _____

_____ _____
Patient's Name Doctors Name

_____ _____
Signature Signature

_____
Signature of Parent or Guardian
(If a minor)

Neck Pain Disability Oswestry Revised 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 CHOICE 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*

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 causes extra pain.
C – Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. 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 sleepless).

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:_____

PAIN CHART

ABOUT YOU

Name:_____

What is your current weight:_____lbs., and height:_____ft._____in.

Please describe your condition:_____

_____

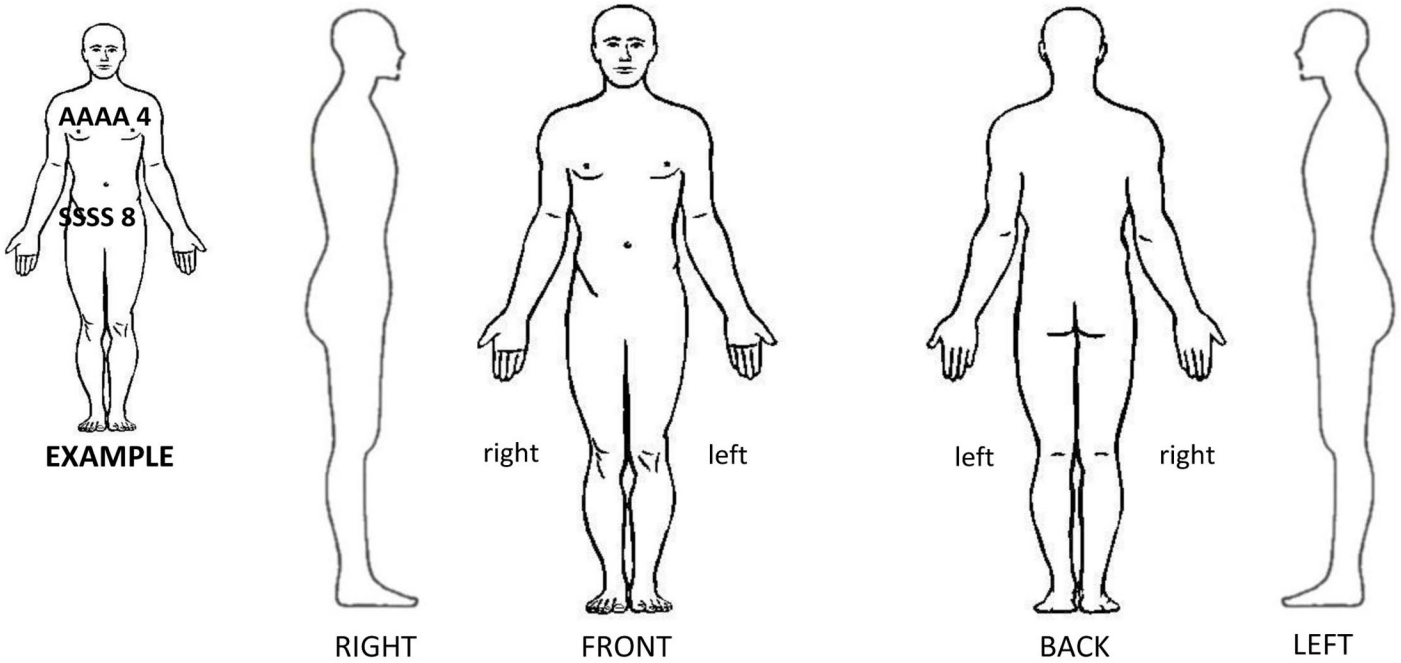
Signature:_____ Date:_____

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain)

Description –	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol –	NNNN	PPPP	BBBB	AAAA	SSSS

Circle any area of pain not represented by a symbol.



Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorized the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of Patient (or parent of minor) Date

Date_____

THE REVISED OSWESTRY PAIN 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 increase the pain, but I manage not to change my way of doing it.
- D Washing and dressing increase 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, e.g. 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.

From: N.Hudson, K.Tome-Nicholson, A.Breen; 1989

REVISED 9/25/91

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 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 less 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, 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:___

chiropractic

Bringing Out The Best In You!

Terms of Acceptance

Patient _____

When we accept you as a patient into our practice, it is important that you understand the objectives of our care.

Chiropractors provide a **unique service** that other healthcare providers do not offer: the location and correction of subluxations (structural and nervous system stress) in your body.

A **subluxation** is a misalignment or distortion of your spinal column or related structures that can affect your brain, nervous system and overall body function. **Subluxations can cause dis-ease** or loss of proper body function.

Chiropractors spend years studying how to locate and correct this destructive condition, first by analyzing your structural system (especially your spine) using various methods. Secondly, we **correct or adjust your subluxations** by using specialized techniques (adjustments). When your structural system, spine and nervous system are free from the deep stress of subluxations **you function more efficiently** and your natural healing ability, **your inner healer**, will better communicate through your body.

We do not medically diagnose or treat any disease, symptom or condition. No matter what condition(s) you may have been diagnosed with and no matter what symptom(s) your body is expressing, **you always need a body free from subluxations**.

If, during the course of our chiropractic examination, we encounter unusual findings, **we will let you know**. You may then decide whether you wish to investigate further and discuss your healthcare options with other healthcare professionals. **We will cooperate with you and with them in your goals.**

To summarize: the purpose of chiropractic care is not to treat diseases or conditions, nor to suppress symptoms, nor to perform surgery, but rather to make your body function better by **removing structural nerve stress (subluxations)**. Therefore we do not prescribe surgery or medications. If you wish to decrease or stop medications you should discuss that with your MD.

Our objective is to **eliminate a major interference to the expression of your physical/emotional health and healing**—subluxations—so that your natural healing ability and **your inner healer may function without this severe form of stress.**

I, _____, have read and fully understand the above statements.

Date _____

CHIROPRACTIC
Bringing Out The Best In You

Patient _____
Doctor _____
Date _____ Case # _____

Statement of Non-pregnancy & X-ray Consent

X-rays are one way of looking inside a person's body. Chiropractors use X-ray analysis as one of the tools that help tell if your body is properly balanced and if your vertebrae and other skeletal structures are in proper alignment. This helps us determine your structural integrity.

Long-standing spinal nerve stress (vertebral subluxations) may cause a condition of inflammation of the bone and related structures and premature aging called spinal degeneration. An X-ray can tell us if you have this condition.

X-rays are a form of electromagnetic radiation and may have adverse effects on body tissue, especially rapidly dividing cells. For that reason it is best to avoid X-rays when pregnant. Please sign below so we may be able to proceed.

I, _____, in signing this form, state to the best of my knowledge, there is no pregnancy, confirmed or suspected at this time.

Patient's signature _____ Date _____

Doctor's signature _____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICES
SUMMARY AND DISCLOSURE
Audubon Park Chiropractic

Effective Date: _____

Our HIPAA Notice of Privacy Practices describes the privacy practices of Audubon Park Chiropractic. We respect our legal obligation to keep health information that identifies you private, and by law, we are obligated to provide you a notice of our privacy practices. We are required by law to maintain the privacy of your health information, to follow the terms of our Notice that are currently in effect, and if you request, to provide you a copy of our Notice regarding our privacy practices and legal duties in respect of you and the information we collect and maintain regarding your health information. Our Notice also describes your rights regarding your health information and certain obligations that mandate how we use and disclose your health information.

Your Rights You may...
- -Request to inspect any copy of your records.
- -Request to amend incomplete or inaccurate information in your records.
- -Receive an accounting of certain disclosures of your health information.
- -Ask for additional privacy protections (although your request may be declined).
- -Ask for confidential communications in a particular manner.
- -Receive a paper copy of this Notice.
- -File a complaint without penalty.

Use and Disclosures We will not use or disclose your information unless you tell us to do so or unless the law allows or requires us to do so. We use and disclose your information:
- -For treatment, payment, and health care operations.
- -Through patient scheduling; to notify family or a close friend you have entrusted with your care; or for notification after benefits and services.
- -As permitted or required by the law.
- -For certain activities when the law requires it, such as: public health, reporting of abuse, neglect, or domestic violence; health oversight; lawsuits and disputes; law enforcement activities; coroner; medical examiner, or funeral director purposes; organ donation; avoidance of a serious threat to health or safety; workers' compensation; and national security.
- -With your authorization.

Changes to this Notice We reserve the right to change this Notice at any time as allowed by law. Updated Notices will be in our office and paper copies will be available upon request.

Complaints If you believe that we have not properly respected the privacy of your health information, you may file a complaint with our clinic by contacting an Office Manager by calling (509) 327-4049, sending a letter to our office address, or by e-mailing twochiros@comcast.net

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Please indicate below if we may discuss your health information, appointment scheduling and/or billing with someone else you trust:

❑ Spouse: _____ ❑ Parent/s or Guardian/s: _____

❑ Relative/Friend/Other: _____ Indicate Relationship: _____

❑ Please do not release my information to anyone unless required to do so by law.

Acknowledgement of Receipt of this Notice As a patient of Audubon Park Chiropractic, I acknowledge that I have received and seen this notice and understand that I may request a copy of the full HIPAA Notice Privacy Practices for additional information. I understand that Audubon Park Chiropractic respects their legal obligation to keep health information private unless required by law. My signature below indicates that I agree to these conditions.

Printed Patient Name: _____

Signature of Patient _____ Date _____
(Parent or Guardian Signature if Patient is a Minor)