DISCOVER CHIROPRACTIC

Name: ________________________ Today's Date: _____________________

Auto Related Injury Reports

Date of Accident: ___________ Time: ____________ □ AM □ PM Location: ______________________________
Did you report the accident? □ Yes □ No If yes, to whom? ____
Describe the accident: ____
____
____

Make and year of your vehicle: ________________ Was your car moving? □ Yes □ No If yes, how fast? ________
Describe the amount of vehicular damage: ____
Cost of the damage? ___________ How many vehicles were involved? ___________
Models and years of the other vehicle(s)? _________________________________
Was the other vehicle moving? □ Yes □ No If yes, how fast? __________
Were you the: □ Driver □ Passenger Position: □ Front Left □ Front Right □ Rear Left □ Rear Right
Was the impact from the: □ Front Left □ Front Right □ Right side □ Left side □ Rear Left □ Rear Right
Did you see the accident coming? □ Yes □ No At the time of impact, were you looking: □ Right □ Left □ Straight
Were your hands on the steering wheel? □ Yes □ No Was your foot on the brake? □ Yes □ No
Did your seat have a headrest? □ Yes □ No How was it positioned relative to your head? □ Above □ Level □ Below
Were you braced at the time of impact? □ Yes □ No The road conditions were: □ Dry □ Wet □ Snow/Ice
Were you wearing a seatbelt? □ Yes □ No If yes was it a □ Lap belt only □ Lap/Shoulder belt combination
Did your airbag deploy? □ Yes □ No Was your vehicle towed from the scene? □ Yes □ No
Did you strike anything in the car? □ Yes □ No If yes, please specify: _______________________________________
□ Head □ Face □ Chest □ Knee □ Shoulder □ Hand □ Foot □ Steering wheel □ Dashboard □ Windshield □ Door
Who else was in the car? ____
How did you feel immediately following the accident? ____
Were you unconscious after the accident □ Yes □ No If yes, how long? _____________________________________
What hurt the following day? ____
What hurt a week later (if applicable), please explain? ____

Did you visit an emergency center after the accident? □ Yes □ No If yes, which one? ________________________
When? ________ By? □ Ambulance □ Drove self □ Friend/Family Who was the attending doctor? _____________
Were X-rays taken? □ Yes □ No Were you given a diagnosis? ____
What treatment was given, if any? ____
Are you on any medications? □ Yes □ No If yes, please list: ________________________ Dosage: _____________
Were you released the same day? □ Yes □ No Were you given home care? □ Yes □ No _____________________
Since the accident have you seen any other doctors for injuries related to the accident? □ Yes □ No
Since the accident, have you had any additional traumas, falls, injuries or aggravations □ Yes □ No
Have you been in an auto accident previously? ____

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CHIROPRACTIC

Name: ________________________ Today's Date: _____________________

Please put a check by any symptoms you have noticed since the accident:

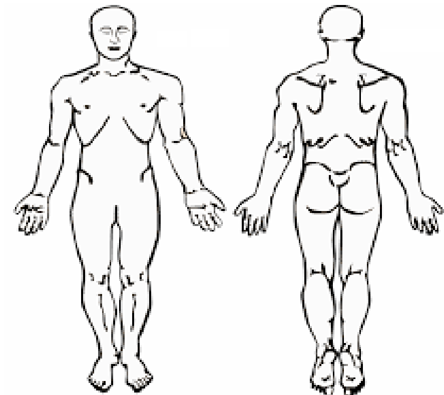
□ Headaches	□ Chest pain	□ Dizziness	□ Fainting	□ Abdominal Cramping
□ Head seems heavy	□ Leg pain/tingling	□ Blurred vision	□ Palpitations	□ Heartburn
□ Neck pain	□ Numbness in toes	□ Vision problems	□ Indigestion	□ Loss of smell/taste
□ Neck stiffness	□ Cold feet	□ Light sensitivity	□ Gas/bloating	□ Difficult urination
□ Pain between	□ Walking problems	□ Loss of concentration	□ Poor appetite	□ Painful urination
shoulder blades	□ Hip pain	□ Depression/confusion	□ Vomiting	□ Excessive thirst
□ Cold hands	□ Leg pain	□ Anxiety/nervousness	□ Diarrhea	□ Discolored urine
□ Numbness in fingers	□ Sleep disturbance	□ Energy loss/fatigue	□ Elbow pain	□ Hemorrhoids
□ Arm pain/tingling	□ Irritability	□ Tired AM/PM	□ Wrist pain	□ Black/bloody stools
□ Mid back pain	□ Allergies	□ Weakness	□ Hand pain	□ Weight trouble
□ Low back pain	□ Stuffed nose/sinus	□ Buzzing/ringing ears	□ Knee pain	□ Menstrual irregularity
□ Short breath	□ Sore throat	□ Ear ache	□ Ankle pain	□ Menstrual cramping
□ Cold sweats	□ Dental Problems	□ Hearing difficulty	□ Foot pain	□ Poor circulation
□ Difficulty chewing	□ Clicking Jaw	□ Constipation	□ Fever	□ Irregular heartbeat
□ Heart problems	□ Blood pressure issues	□ Bladder trouble	□ Liver trouble	□ Gall bladder trouble
□ Varicose veins	□ Ankle swelling	□ Prostate/sexual issue	□ Other	□ Frequent nausea

Please rate your ability to perform the following activities following the accident on a **scale from 0-10**, *where (0) is the complete inability to perform the activity, and (10) is the ability to perform the same as prior to the accident*.

___ Coughing/sneezing
___ Getting in/out of car
___ Turning over in bed
___ Walking short distance
___ Standing more than 1 hour
___ Sexual activity
___ Lying on side w/ knee bent
___ Lying flat on stomach
___ Bending over forward
___ Sitting at table
___ Other:

___ Pushing
___ Lying on back
___ Kneeling
___ Balancing
___ Dressing self
___ Sleeping
___ Stooping
___ Gripping
___ Pulling
___ Reaching
___ Twisting

Shade any areas of pain or discomfort you have experienced since the accident



Any time from work as a result of injuries from the accident? □ Yes □ No List dates: from ________ to ________
Are work duties restricted due to the accident □ Yes □ No If yes, how: ___________________________________
Insurance companies involved: ____
Name of the driver of the auto you were in: ___________________________ Phone: ______________________
His/her insurance carrier: _____________________ Phone: _________________ Policy #: __________________
Name of the driver of the other vehicle: ___________________________ Address: ________________________
Phone: ________________ His/her insurance carrier: ________________ Address: ________________________
Phone: ______________ Policy #: _______________ Have you contacted the insurance adjustor/representative on this claim? □ Yes □ No If yes, name: ________________ Attorney representation: ______________________

Patients Signature ____ Date ___________________

Discover Chiropractic
155 SW Century Dr., Ste. 111 | Bend, OR 97702 | P 541.797.6224 | F 541.797.6274
www.discoverbendchiro.com

Neck Disability Index

Patient Name: ____ Date: ____________________

This questionnaire will give your provider and insurance company information about how your neck condition affects your everyday life. Please answer every section by marking the ONE statement that best applies to you. If two or more statements in one section apply, please mark ONE that most closely describes your problem.

Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain comes and goes and is moderate
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is worst imaginable at the moment

Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hour sleepless)
- My sleep I mildly disturbed (1-2 hours sleepless)
- My sleep is moderately disturbed (2-3 hours sleepless)
- My sleep is greatly disturbed (3-5 hours sleepless)
- My sleep is completely disturbed (5-7 hours sleepless)

Reading

- I can read as much as I want with no neck pain
- I can read as much as I want with slight neck pain
- I can read as much as I want with moderate neck pain
- I can't read as much as I want because of moderate pain in my neck
- I can hardly read at all because of severe neck pain
- I cannot read at all because of neck pain

Concentration

- I can concentrate fully when I want with no difficulty
- I can concentrate fully when I want with slight difficulty
- I have a fair degree of difficulty concentrating when I want
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty concentrating when I want
- I cannot concentrate at all

Headaches

- I have no headaches at all
- I have slight headaches which come infrequently
- I have moderate headaches which come infrequently
- I have moderate headaches which come frequently
- I have severe headaches which come frequently
- I have headaches almost all of the time

Work

- I can do as much work as I want
- I can only do my usual work but no more
- I can only do most of my usual work but no more
- I cannot do my usual work
- I can hardly do any work at all
- I cannot do any work at all

Personal Care

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

Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it causes extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table)
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything at all

Driving

- I can drive my car without any neck pain
- I can drive my car as long as I want with slight neck pain
- I can drive my car as long as I want with moderate neck pain
- I cannot drive my car as long as I want because of moderate neck pain
- I can hardly drive at all because of severe neck pain
- I cannot drive at all because of neck pain

Recreation

- I am able to engage in all my recreation activities without neck pain
- I am able to engage in my usual recreation activities with some neck pain
- I am able to engage in most, but not all of my usual recreation activities because of neck pain
- I am able to engage in a few of my usual recreation activities because of pain in my neck
- I can hardly do any recreation activities because of neck pain
- I cannot do any recreation activities at all

On a scale from 0-10 with 0= no pain and 10= worst pain you have ever experienced, where are you currently?

Best _________ Average _________ Worst ________

Neck Pain Score

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Back Disability Index

Patient Name: ____ Date: ____________________

This questionnaire will give your provider and insurance company information about how your back condition affects your everyday life. Please answer every section by marking the ONE statement that best applies to you. If two or more statements in one section apply, please mark ONE that most closely describes your problem.

Pain Intensity

- The pain comes and goes and is very mild
- The pain is mild and does not vary much
- The pain comes and goes and is moderate
- The pain is moderate and does not vary much
- The pain comes and goes and is very severe
- The pain is very severe and does not vary much

Sleeping

- I get no pain while in bed
- I get pain while in bed but it doesn't prevent me from sleeping well
- My pain reduces my normal sleep by less than 25%
- My pain reduces my normal sleep by less than 50%
- My pain reduces my normal sleep by less than 75%
- Pain prevents me from sleeping at all

Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than 1 hour
- Pain prevents me from sitting more than ½ hour
- Pain prevents me from sitting more than 10 minutes
- I avoid sitting because it increases pain immediately

Standing

- I can stand as long as I want without pain
- I have some pain while standing but it does not increase with time
- I can't stand for longer than 1 hour without increasing pain
- I can't stand for longer than ½ hour without increasing pain
- I can't stand for longer than 10 min without increasing pain
- I avoid standing because it increases pain immediately

Walking

- I have no pain while walking
- I have some pain while walking but it doesn't increase with time
- I can't walk for more than 1 mile without increasing pain
- I can't walk for more than ½ mile without increasing pain
- I can't walk for more than ¼ mile without increasing pain
- I can't walk at all without increasing pain

Changing Degree of Pain

- My pain is rapidly getting better
- My pain fluctuates but overall is definitely getting better
- My pain seems to be getting better but improvement is slow
- My pain is neither getting better or worse
- My pain is gradually worsening
- My pain is rapidly worsening

Personal Care

- I don't have to change my way of washing or dressing in order to avoid pain
- I don't normally change my way of washing or dressing even though it causes some pain
- Washing and dressing increases the pain and I manage not to change my way of doing it
- Washing and dressing increases the pain and I find it necessary to change my way of doing it
- Because of the pain I'm unable to do some washing and dressing without help
- Because of the pain I'm unable to wash and dress without help

Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it causes extra pain
- Pain prevents me from lifting heavy weights off the floor
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table)
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights

Traveling

- I get no pain while traveling
- I get some pain while traveling but none of my usual forms of travel make it worse
- I get extra pain while traveling but it doesn't cause me to seek alternate forms of travel
- I get extra pain while traveling which causes me to seek alternate forms of travel
- Pain restricts all forms of travel except that done while lying down
- Pain restricts all forms of travel

Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my energetic interests (e.g., dancing)
- Pain has restricted my social life and I do not go out very often
- Pain has restricted my social life to my home
- I have hardly any social life because of pain

On a scale from 0-10 with 0= no pain and 10= worst pain you have ever experienced, where are you currently?

Best _________ Average _________ Worst ________

Back Pain Score [ ]

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Informed Consent for Chiropractic Care

Dear valued practice member,

All hospitals and most health care physicians now require informed consent forms to be complete to make patients aware of all factors related to treatment. We take the same approach in our office. Every type of health care is associated with some risk of potential problems. This includes chiropractic health care. We wish you to be informed about the possibility of potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic care, like all forms of health care, while offering considerable benefit, may provide some level of risk. The level of risk is very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and in rare instances fractures. One of the rarest complications associated with chiropractic care, occurring at a rate of approximately one instance per 1.5 million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at Discover Chiropractic, a health history and physical examination will be completed. The procedures are performed to assess your specific condition, your overall health, in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examination or studies are deemed necessary. In addition, they will help us determine whether treatment needs to be modified, or if a referral to another health care provider is prudent.

Chiropractic care consists of the detection and correction of spinal misalignments and as such, is orientated to improvement of spinal function relative to (but not limited to) range of motion, muscular and neurologic aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use their hands or a mechanical device upon my body to adjust a joint, which may cause an audible sound. It is my intention to rely on the doctor to exercise professional judgement during the course of any procedures, which they determine to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during a history and examination, and the doctor’s interpretation thereof. As well as the doctor’s professional judgement and expertise in working with like cases.

I have read, or have had read to me the Informed Consent for Chiropractic Care. I have also had an opportunity to ask questions and receive answers. I fully understand and am comfortable with the information provided. I provide consent to chiropractic treatment and management on that basis. I understand and accept that there are risks associated with chiropractic care and give my consent to examinations the doctor deems necessary, and to chiropractic care including spinal adjustments, as reported following my assessment.

Patient/Guardian Signature: ____ Date: _________________________
Patient/Guardian Print Name: _________________________________ Relation to Patient: ______________________
Witness Signature (office staff) ____ Date: _________________________

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Financial Policy

1. All payments are expected at the time that services are rendered
2. Co-pays are to be paid at the time of service
3. No patient balance may ever exceed $300 at any given time
4. In the event that you discontinue care prior to the Doctor's consent, you are responsible to pay in full any and all outstanding balances within 10 days. Insurance assignment patients are required to pay all outstanding claims in full

Appointment Policy:
The frequency of your care plan is paramount importance to your results, so we ask that each patient assume full responsibility of strict adherence to the appointment program as it is designed by your Doctor for optimum results.

______ Initials
1. Regardless of how many appointments are scheduled for you each week, please note that it is the FREQUENCY of visits that is most important, not the days on which you receive care.
2. Our recommendation is that you make multiple appointments, for your convenience and ours. This will ensure that you get the appointment time and date that works best for you.

______ Initials
3. If you are unable to keep an appointment for any reason, we require you to provide us with at least 24 hours notice (if the office is closed a voicemail is sufficient). Emergencies are an exception.
4. It is of utmost importance to make-up a missed appointment within 7 days of any cancellation or missed appointment. Again, it is the frequency of appointments throughout the week that has the greatest effect on your healing process, not the specific days.
5. When entering our office, it is our requirement that you sign in at the front desk. We strive to honor all appointments at the scheduled time, therefor please arrive on time. If you are late or early, you may have to wait for the next available appointment.

______ Initials
6. We reserve the right to charge $35 for missed appointments **without 24 hours prior notice.**

Heath Care Classes:
Discover Chiropractic offers interactive educational classes each month. You will find class schedules posted at the front desk, Facebook and our website www.discoverbendchiro.com. Our classes are complementary to our practice members and guests, unless otherwise noted. We encourage you to bring family and friends, this is a terrific opportunity to improve their health as well. Please ask the front desk staff to reserve a place for you and your guest(s). It is our observation that patients who take a more proactive role in their healthcare save time, money and typically respond better to care.

We request that you sign this form as verification that you have read, understand and agree with the above mentioned policies.

Patient/Guardian Signature: ____ Date: _________________________
Patient/Guardian Print Name: ____

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Notice of Privacy Practices

I understand that Discover Chiropractic and Staff (referred below as "The Practice") will use and disclose health information about me.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a *Privacy Notice To Patients* and describes the use and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the *Privacy Notice To Patients* may be revised from time to time, and that I am entitled to receive a copy of any revised *Privacy Notice To Patients*. I also understand that a copy or summary of the most current version to This Practice's Privacy *Notice To Patients* in effect will be posted in the waiting/ reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the *Privacy Notice To Patients*, and I understand that This Practice is not required by law to agree to such request.

Clinic Protocol

- **Appointment Reminders** may be called to the Patient's home phone or texted to a cell phone prior to the appointment date. If a message is left, no confidential information will be given.
- **Test Results**
  - The clinic doctors reserve the right to discuss patient results and issues with family members if deemed necessary
  - If the clinic staff is unable to contact the patient by phone, results may be mailed to the patient's home

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of *the Privacy Notice To Patients.*

Patient/Guardian Signature: ____ Date: ________________________
Patient/Guardian Print Name: ____

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