CHIROPRACTIC INTAKE FORM

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SEX _____**M** _____ **F** **PATIENT SS#** _____ **DOB:** _____

_____**SINGLE** _____**MARRIED** _____**DIVORCED** _____**WIDOWED**_____ **SEPARATED**_____

OCCUPATION: _____

EMPLOYER_____

EMPLOYER ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

PERMISSION TO CONTACT PATIENT (CHECK ALL THAT APPLY): MESSAGE & DATA RATES MAY APPLY

_____ HOME/CELL PHONE: _____

_____ WORK PHONE: _____

_____ EMAIL: _____

CONTACT IN CASE OF EMERGENCY: NAME/NUMBER/RELATIONSHIP:

_____

NO SHOW CANCELLATION POLICY:

OXFORD SPINE & SPORTS HAS A 24 HOUR NOTICE APPOINTMENT CANCELLATION POLICY. THERE IS A $40 CHARGE FOR NO SHOW AND/OR FAILURE TO CANCEL YOUR APPOINTMENT

INITIAL_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION (NAME/NUMBER/RELATIONSHIP):

_____

_____

THE PRACTICE'S PRIVACY NOTICE HAS BEEN PROVIDED TO ME PRIOR TO MY SIGNING BELOW. I HAVE HAD A CHANCE TO ASK QUESTIONS AND/OR HAVE CONCERNS ADDRESSED. I UNDERSTAND THAT THIS CONSENT IS VALID FOR 7(SEVEN) YEARS. I FURTHER UNDERSTAND I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME IN THE FUTURE WITH UNDERSTANDING THAT ANY SUCH REVOCATION SHALL NOT APPLY TO ACTIONS TAKEN BY PRACTICE IN RELIANCE ON THIS CONSENT. I UNDERSTAND THAT IF I REVOKE THIS CONSENT, THE PRACTICE HAS THE RIGHT TO REFUSE TO TREAT ME. YOUR PHYSICIAN IS NOT REQUIRED TO AGREE TO A RESTRICTION THAT YOU MAY REQUEST. IF YOUR PHYSICIAN BELIEVES IT IS IN YOUR BEST INTEREST TO PERMIT USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION(PHI), YOUR PHI WILL NOT BE RESTRICTED. IF OUR POLICY IS A CONFLICT FOR YOU, YOU HAVE THE RIGHT TO USE ANOTHER HEALTHCARE PROVIDER.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ **DATE:**_____

PATIENT NAME: _____

CONSENT TO CARE AND INSURANCE ASSIGNMENT

I HEREBY CONSENT TO THE PERFORMANCE OF CHIROPRACTIC TREATMENT AND OTHER CHIROPRACTIC PROCEDURES, INCLUDING BUT NOT LIMITED TO VARIOUS MODES OF PHYSICAL MODALITIES, AND DIAGNOSTIC XRAYS, ON ME (OR ON THE PATIENT NAMED ABOVE, FOR WHOM I AM LEGALLY RESPONSIBLE) BY THE DOCTOR (S)/EMPLOYEES OF OXFORD SPINE & SPORTS,. I UNDERSTAND RESULTS ARE NOT GUARANTEED. I HAVE BEEN INFORMED THAT IN THE PRACTICE OF CHIROPRACTIC THERE ARE SOME RISKS TO TREATMENT INCLUDING BUT NOT LIMITED TO, FRACTURES, DISC INJURIES, STROKES, DISLOCATIONS, AND SPRAINS, AND THESE ARE RARELY ENCOUNTERED. I WISH TO RELY ON THE DOCTOR(S) TO EXERCISE JUDGMENT DURING THE COURSE OF PROCEDURES WHICH THE DOCTOR(S) FEELS AT THE TIME, BASED ON THE FACTS THEN KNOWN, IS IN MY BEST INTEREST. I INTEND THIS CONSENT FORM TO COVER THE ENTIRE COURSE OF TREATMENT FOR MY PRESENT CONDITIONS(S) AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK TREATMENT.

OFFICE POLICY ON INSURANCE ASSIGNMENT

I CERTIFY THAT I(OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH

_____

AND ASSIGN DIRECTLY TO OXFORD SPINE & SPORTS ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I HEREBY AUTHORIZE THE DOCTOR(S) TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. THIS OFFICE DOES NOT GUARANTEE MY INSURANCE COMPANY WILL PAY FOR MY CARE. I UNDERSTAND I AM FULLY FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE AND REGARDLESS OF SATISFACTION OF CARE. DISCONTINUANCE OF CARE DOES NOT RELIEVE ME OF MY RESPONSIBILITY TO PAY FOR SERVICES ALREADY RENDERED. OUR OFFICE WILL NOT ENTER INTO A DISPUTE WITH MY INSURANCE COMPANY OVER A CLAIM. THIS IS MY RESPONSIBILITY AND OBLIGATION. IF PAYMENT FROM INSURANCE COMPANY IS NOT RECEIVED WITHIN 60 DAYS OF SERVICE, I (THE PATIENT) WILL RECEIVE A BILLING STATEMENT AND I AM EXPECTED TO PAY FOR SERVICES IN FULL WITHIN 7 BUSINESS DAYS OF THE STATEMENT DATE OR A FINANCE CHARGE WILL BE ADDED TO MY ACCOUNT. IF THIS ACCOUNT IS PLACED WITH AN ATTORNEY OR COLLECTION AGENCY FOR COLLECTION, I HAVE BEEN ADVISED THAT ADDITIONAL FEES MAY BE ADDED. IF LITIGATION PURSUES, I ALSO UNDERSTAND I WILL BE RESPONSIBLE FOR ADDITIONAL COURT COST OR ATTORNEY FEES.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ DATE:_____

PATIENT NAME: _____

PATIENT CONDITION

REASON FOR VISIT: _____

I ACKNOWLEDGE THAT I AM **NOT** REPORTING TO OXFORD SPINE & SPORTS FOR CARE DUE TO INJURIES RELATED TO AN AUTOMOBILE OR WORK COMP RELATED ACCIDENT/INJURY. I UNDERSTAND THIS SIGNED STATEMENT WILL BE PART OF MY PERMANENT HEALTH RECORD AND WILL BE INCLUDED WITH ANY RECORD REQUEST.

_____INITIAL

WHEN DID YOUR SYMPTOMS START: _____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE: _____YES _____ NO _____ UNKNOWN

RATE PAIN SEVERITY ON 0 (NO PAIN) - 10 (SEVERE PAINT) SCALE: _____

1) TYPE OF PAIN

___SHARP ___DULL ___THROBBING ___NUMBNESS ___ACHING ___SHOOTING

2) HOW OFTEN DO YOU HAVE THIS PROBLEM?

___1X DAILY ___ 2X OR MORE DAILY ___1XWEEKLY ___2X OR MORE WEEKLY ___OTHER

3) IS IT ___ CONSTANT ___COME AND GO ___ OTHER

ACTIVITIES OF DAILY LIVING

1) DOES IT INTERFERE WITH YOUR ___WORK ___SLEEP ___DAILY ROUTINE ___RECREATION

2) ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM:

___SITTING ___STANDING ___WALKING ___BENDING ___LYING DOWN

PREVIOUS TREATMENT FOR CONDITION:

___NONE ___CHIROPRACTIC ___PHYSICAL THERAPY ___SURGERY ___EMERGENCY ROOM

___PRIMARY CARE/URGENT CARE ___OTHER _____

MEDICAL HISTORY:

LIST ALL MEDICATIONS (RECENTLY GIVEN AND DAILY): _____

_____

_____

ALL PREVIOUS SURGERIES/DATES PERFORMED: _____

_____

_____

ALL FALL/BROKEN BONES/HEADS INJURIES/DATES OF INJURIES: _____

_____

PAST XRAY/MRI/CT/BONE SCAN WITH DATES PERFORMED: _____

_____

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ **DATE:**_____

PATIENT NAME: _____

THE NECK/BACK BOURNEMOUTH QUESTIONNAIRE

THE FOLLOWING SCALES HAVE BEEN DESIGNED TO FIND OUT ABOUT YOUR NECK AND BACK PAIN AND HOW IT IS AFFECTING YOU. PLEASE ANSWER ALL THE SCALES BY CIRCLING ONE NUMBER ON EACH SCALE THAT BEST DESCRIBES HOW YOU FEEL:

1. OVER THE PAST WEEK, ON AVERAGE, HOW WOULD YOU RATE YOUR NECK/BACK PAIN

NO PAIN — WORST PAIN POSSIBLE

0 1 2 3 4 5 6 7 8 9 10

2. OVER THE PAST WEEK, HOW MUCH HAS YOUR NECK/LOW BACK/PAINT INTERFERED WITH YOUR DAILY ACTIVITIES (HOUSEWORK, WASHING, DRESSING, WALKING, CLIMBING STAIRS, GETTING IN/OUT OF BED/CHAIR):

NO INTERFERENCE — UNABLE TO PERFORM ACTIVITY

0 1 2 3 4 5 6 7 8 9 10

3. OVER THE PAST WEEK, HOW MUCH HAS YOUR NECK/LOW BACK PAIN INTERFERED WITH YOUR ABILITY TO TAKE PART IN RECREATIONAL, SOCIAL, AND FAMILY ACTIVITIES?

NO INTERFERENCE — UNABLE TO PERFORM ACTIVITY

0 1 2 3 4 5 6 7 8 9 10

4. OVER THE PAST WEEK, HOW ANXIOUS (TENSE, UPTIGHT, IRRITABLE, DIFFICULTY IN CONCENTRATING/RELAXING) HAVE YOU BEEN FEELING?

NOT AT ALL ANXIOUS — EXTREMELY ANXIOUS

0 1 2 3 4 5 6 7 8 9 10

5. OVER THE PAST WEEK, HOW DEPRESSED (DOWN-IN-THE-DUMPS, SAD, IN LOW SPIRITS, PESSIMISTIC, UNHAPPY HAVE YOU BEEN FEELING?

NOT AT ALL DEPRESSED — EXTREMELY DEPRESSED

0 1 2 3 4 5 6 7 8 9 10

6. OVER THE PAST WEEK, HOW HAVE YOU FELT YOUR WORK (BOTH INSIDE AND OUTSIDE THE HOME) HAS AFFECTED (OR WOULD AFFECT) YOUR NECK/LOW BACK PAIN?)

HAVE MADE IT NO WORSE — HAVE MADE IT MUCH WORSE

0 1 2 3 4 5 6 7 8 9 10

7. OVER THE PAST WEEK, HOW MUCH HAVE YOU BEEN ABLE TO CONTROL (REDUCE/HELP) YOUR NECK/LOW BACK PAIN ON YOUR OWN?

COMPLETELY CONTROL IT — NO CONTROL WHATSOEVER

0 1 2 3 4 5 6 7 8 9 10

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ DATE:_____

FORM 11 (21)
BOURNEMOUTH BACK QUESTIONNAIRE REPRINTED WITH PERMISSION FOR BOLTON JE, BREEN AC. THE BOURNEMOUTH QUESTIONNAIRE: A SHORT-FORM COMPREHENSIVE OUTCOME MEASURE. I. PSYCHOMETRIC PROPERTIES IN BACK PATIENTS. J MANIPULA PHYSIOL THER 1999;22:503-510

FORM 12(22)
BOURNEMOUTH NECK QUESTIONNAIRE REPRINTED WITH PERMISSION FROM BOLTON JE,HUMPHREYS BK. THE BOURNEMOUTH QUESTIONNAIRE: A SHORT-FORM COMPREHENSIVE OUTCOME MEASURE. II. PSYCHOMETRIC PROPERTIES IN NECK PAIN PATIENTS. J MANIPULA PHYSIOL THER 2022;25:141-148

PATIENT NAME: _____

REVIEW OF SYSTEMS

CHECK THE FOLLOWING CONDITIONS THAT APPLY TO YOUR HEALTH:

1) CONSTITUTIONAL
- ___CHILLS
- ___FATIGUE
- ___FEVER
- ___WEIGHT GAIN
- ___WEIGHT LOSS

2) HEENT
- ___HEARING LOSS
- ___SINUS PRESSURE
- ___VISUAL CHANGES

3) RESPIRATORY
- ___COUGH
- ___SHORTNESS OF BREATH
- ___WHEEZING

4) CARDIOVASCULAR
- ___CHEST PAIN
- ___PAIN WHILE WALKING(CLAUDICATION)
- ___EDEMA
- ___PALPITATIONS

5) GASTROINTESTINAL
- ___ABDOMINAL PAIN
- ___BLOOD IN STOOL
- ___CONSTIPATION
- ___DIARRHEA
- ___HEARTBURN
- ___LOSS OF APPETITE
- ___NAUSEA
- ___VOMITING

6) GENITOURINARY
- ___PAINFUL URINATION (DYSURIA)
- ___EXCESSIVE AMOUNT OF URINE(POLYURIA)
- ___URINARY FREQUENCY

7) METABOLIC/ENDOCRINE
- ___COLD INTORLERANCE
- ___HEAT INTOLERANCE
- ___EXCESSIVE THIRST (POLYDIPSIA)
- ___EXCESSIVE HUNGAR (POLYPHAGIA)

8) NEUROLOGICAL
- ___DIZZINESS
- ___EXTREME NUMBNESS
- ___EXTREMITY WEAKNESS
- ___HEADACHES
- ___SEIZURES
- ___TREMORS

9) PSYCHIATRIC
- ___ANXIETY
- ___DEPRESSION

10) INTEGUMENTARY
- ___BREAST DISCHARGE
- ___BREAST LUMP
- ___HIVES
- ___MOLE CHANGES
- ___RASH
- ___SKIN LESION

11) MUSCULOSKELETAL
- ___BACK PAIN
- ___JOINT PAIN
- ___JOINT SWELLING
- ___NECK PAIN

12) HEMATOLOGIC
- ___EASILY BLEEDS
- ___EASILY BRUISES
- ___LYMPHEDEMA
- ___ISSUES WITH BLOOD CLOTS

13) IMMUNOLOGIC
- ___FOOD ALLERGIES
- ___SEASONAL ALLERGIES

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ DATE:_____