All Ways Chiropractic - Dr. Michael D. Eekhoff, B.A., D.C.
3773 Martin Way E, Suite B-106, Olympia, WA 98506 - (360) 352-8896 - Fax: (360) 705-0633 - www.AllWaysChiro.com

About You

Today's Date:_____

Legal Name:_____

Preferred Name:

Sex: Male ❒ Female ❒

Date of Birth: ____/____/____

Social Security Number:_____

Marital Status: Married ❒ Single ❒ Divorced ❒ Separated ❒ Widow(er) ❒

Preferred Contact # ❒ Home ❒ Cell ❒ Work ❒ Other

Home #_____ Cell #_____

Work #_____ Other #_____

Mailing Address_____

City_____ State_____ Zip Code_____

Email _____

Patient's Occupation: _____ Employer: _____

Emergency Contact_____ Relationship_____

Phone #_____ ❒ Home ❒ Cell ❒ Work

INSURANCE INFORMATION

Primary Insurance

Insured Name:_____ Date of Birth_____

Male ❒ Female ❒ Relationship to Patient: _____

Insured Address: _____

Secondary Insurance

Insured Name:_____ Date of Birth_____

Male ❒ Female ❒ Relationship to Patient: _____

Insured Address: _____

ALL WAYS CHIROPRACTIC, PLLC

PATIENT FINANCIAL AGREEMENT

Please ***print your initials on the line*** next to your method of payment. This helps with billing procedures and proper record keeping.

_____ **TIME OF SERVICE (TOS)**: Payment is expected as the services are rendered. We accept cash, checks, Master Card, Visa, American Express, Discover, FSA (Flex Savings Account) cards, and HSA (Health Savings Account) cards.

_____ **HEALTH INSURANCE**: Co-payments and co-insurance payments are due at the time of service. Please provide us with a copy of the front and back of your health insurance card. Any quote of benefits we receive from your insurance company does not guarantee coverage or insurance payment. We are not responsible for any changes made to your insurance policy. It is your responsibility to know your insurance benefits. Your insurance claims will be billed by an outside billing agency. You are ultimately responsible for your account, which could include deductibles, co-pays, co-ins, non-covered services and denied services.

_____ **PERSONAL INJURY**: Please provide us with all the necessary information needed for billing. This will include the name and phone numbers of ALL insurance companies involved. The claim number(s), date of accident, ALL insured party's name (including third party name), and/or the name of your attorney, if represented. Our office does not bill health insurance for personal injury claims. We reserve the right to file a lien at any time. You are ultimately responsible for your account and all charges incurred with our office.

_____ **LABOR & INDUSTRIES**: You need to have filed an accident report with your employer. You are also responsible for filling out the Labor & Industries long claim form or the claim form necessary for self-insured businesses. If you are switching care from another physician, we have the required transfer card available. If your claim is not accepted or services are not covered, you are ultimately responsible for your account and all charges incurred with our office.

_____ **MEDICARE**: Please provide us with a copy of your Medicare card and supplemental health card, if applicable. You are responsible for your annual deductible that begins each January of the New Year. Medicare does not cover x-rays, examinations or maintenance care. Medicare will only pay for services they determine to be medically necessary. You are ultimately responsible for your account with our office.

-Assignment and Release-

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to All Ways Chiropractic, PLLC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Doctor Signature Date

_____ _____

Attorney Signature Date

ALL WAYS CHIROPRACTIC
Informed Consent

The Nature of Chiropractic Treatment:
The Doctor will use his/her hands or a mechanical device to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked". You may also feel movement of the joint. Various ancillary procedures such as ice and heat therapy, electric muscle stimulation, therapeutic exercise and decompression therapy may also be used.

Possible Risks:
As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include but are not limited to fractures, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to the arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of Risks Occurring:
The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications that are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over the counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys and other side effects in a significant number of cases.
- *Medical Care*, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significance number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated:
Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and, make future rehabilitation more difficult.

Unusual Risks:
I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

_____ _____
Patients Signature Date

_____ _____
Authorized All Ways Chiropractic Employee Signature Date

ALL WAYS CHIROPRACTIC, PLLC

Dr. Michael Eekhoff
3773 Martin Way E, Suite B-106, Olympia, WA 98506
Phone: (360) 352-8896 Fax: (360) 705-0633
www.AllWaysChiro.com

Notice of Privacy Practices
Signature Page

This notice describes how All Ways Chiropractic PLLC may use and disclose your medical information, and how you may access this information. Please review this notice carefully. If you have any questions about this notice please contact our privacy officer at 360-352-8896 or email at officemanager@allwayschiro.com.

We are required by law to maintain the privacy of your protected Health Information, to notify you of legal duties and privacy practices with respect to your health information and to notify affected individuals following a breach of unsecured health information. This notice summarizes our duties and your rights concerning your information.

This Notice of Privacy Practices describes All Ways Chiropractic PLLC practices and that of any of our affiliates. All employees, staff and other personnel will follow the terms of this notice. In addition, these entities, sites, and locations may share medical information with each other for treatment, payment or health care operation purposes as described in this Notice.

Changes to this Notice:
We reserve the right to change the terms of out Notice at any time. Any revisions of the Notice will be effective for all Protected Health Information that we maintain at that time. To receive a copy of the revised Notice, you may contact our Privacy Officer and request that a revised copy be sent to you in the mail. Additionally, you may also obtain a copy at the front desk at the time of your next appointment.

All Ways Chiropractic PLLC is commitment to Protecting Medical Information:
We understand and appreciate the personal nature of any information related to you and your health. All Ways Chiropractic PLLC is committed to protecting your medical information, and are required by law to:

- Ensure the privacy of your identifiable medical information
- Provide you with this notice of our legal duties and privacy practices with respect to your medical information
- Follow the terms of the most current Notice.

I have read and understand the Notice of Privacy Practices from All Ways Chiropractic PLLC.

_____ _____
Patient Printed Name Date

_____ _____
Patient Signature AWC Employee Initial

NOTICE OF PRIVACY POLICY:

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purpose that are permitted or required by law. It also describes your rights to access and control your Protected Health Information.

"Protected Health Information" refers to information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related to healthcare services.

1) Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Care Information Based Upon Your Written Consent.

You will be asked by All Ways Chiropractic PLLC to sign a consent form. Once you have consented to use and disclosure of your protected Health Information for treatment, payment and health care operations, by signing the consent form, All Ways Chiropractic PLLC will use or disclose your Protected Health Information as described in this Section. Each category of uses and disclosures will be explained but not every use or disclosure in each category will be listed. However, every permissible use or disclosure will fall under one of the following categories.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your Protected Health Information.

Payment: Your Protected Health Information will be used and disclosed, as needed, to obtain payment for your health care services. Other uses and disclosures may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you. For example Insurance companies that require us to relate to them the services or treatment you are going to receive or have received in this clinic, so they may determine coverage.

Health Care Operations: We may use or disclose, as needed, your Protected All Ways Chiropractic PLLC operations and business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, conducting or arranging for other business activities and compliance with state law.

For example, we may disclose your Protected Health Information to medical students and massage therapists that see patients within our clinic. In addition we may use a sign in sheet at the front desk where you will be asked to sign your name. We may also call you by name in the waiting room when your treating provider is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment. We will share your Protected Health Information with third party "business associates" that perform various activities such as billing services for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your Protected Health Information, we will obtain a written contact that contains terms that will protect the privacy of your Protected Health Information.

We may use or disclose your Protected Health Information , as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose your Protected Health Information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization:

Other uses and disclosures not described in this Notice will be made only with your written authorization. You may revoke your authorization by submitting a written notice to the Privacy Officer. The revocation will not be effective to the extent All Ways Chiropractic PLLC, has already taken action in the reliance on the authorization.

Other permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object: We may use and disclose your Protected Health Information in the following instances. You will be granted the opportunity to agree or object to the use or disclosure of all or part of your Protected Health Information. If you are not present or able to agree or object to the use or disclosure of the Protected Health Information, then in our best professional judgment, All Ways Chiropractic PLLC may determine whether the disclosure is in your best interest. In this case, only the minimum necessary Protected Health Information relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you instruct us otherwise, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that persons involvement in your health care. If you are unable to agree or object to such a disclosure such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose Protected Health Information to notify or assist in notifying a family member, personal

representative or any other person that is responsible for your care of your location or general condition. Finally we may use or disclose your Protected Health Information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your Protected Health Information in an emergency treatment situation. If this happened, All Ways Chiropractic PLLC staff shall attempt to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or any All Ways Chiropractic PLLC staff member is required by law to treat you and has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected Health Information to treat you.

Communications Barriers: We may use and disclose your Protected Health Information if we attempt to obtain consent from you but are unable to do so due to substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclose under circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity:

We may use or disclose your Protected Health Information in the following situations without your consent or authorization. These situations include, but are not limited to the following:

Required By Law: We may use or disclose your Protected Health Information to the extent that the use or disclosure us required by law. The use or disclosure will be made in compliance with the law and will be limited to the minimum necessary. You will be notified, as required by law, of any such uses or disclosures. We may use or disclose your information to state agencies for registry purposes as appropriate and required under State of Washington law.

Public Health: We may disclose the minimum necessary amount of your Protected Health Information for public activities to a public health authority that is permitted by law to collect or receive the information. These uses and disclosures may include, but are not limited to the following:

- To prevent disease, injury or disability
- To report child abuse or neglect by making a telephone report to the appropriate authorities, and to follow this report with a written confirmation.
- To report reaction to medication of problems with products required by the Food and Drug Administration
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify the appropriate government authority if we believe a client has been the victim of domestic violence. We will only make this disclosure if you agree, and when consistent, with the requirements or authorizations of applicable Washington State and Federal Law.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your Protected Health Information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety or a person or the public. We may also disclose Protected Health Information if it is necessary for law enforcement authorities to identify or apprehend an individual. Any such disclosures would be limited to the minimum necessary, and would be made to someone included in the prevention of the threat.

Military Activity: When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel 1) for activities deemed necessary by appropriate military command authorities 2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits or 3) to foreign military authority if you are a member of that foreign military services.

Worker's Compensation: We may disclose your Protected Health Information for workers compensation and other similar legally establishes programs, in accordance with state and federal law regarding such disclosures.

National Security: We may disclose your Protected Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Required Uses and Disclosures: By law, we must make minimum necessary disclosures when required to do so by state, federal, or local law.

2. Your Rights Regarding your Protected Health Information

Following is a statement of your rights with respect to your Protected Health Information and a brief description of how you may exercise these rights.

Right to Inspect and Copy: This means you may inspect and obtain a copy of Protected Health Information about you that is contained in a designated record set for as long as we maintain the Protected Health Information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record. To inspect and/or copy your medical information maintained by All Ways Chiropractic PLLC, you must submit your request in writing to the front desk. You may be charged a fee for the administrative costs of retrieving, copying, mailing, and any other activities associated with your request.

Right to Request an Amendment: If you feel any of your medical information maintained by All Ways Chiropractic PLLC is incorrect or inaccurate; you may request an amendment of that information for as long as we maintain this information. In certain cases, we may deny your request for an amendment. To request an amendment, your request must be made in writing and must include the reason for the request. All requests for amendment are to be submitted to the front desk.

All Ways Chiropractic PLLC reserves the right to deny your request for amendment for any of the following reasons:

- The information is complete and accurate;
- We did not create the information;
- The person or entity that created the information is no longer available to make the amendment;
- The information is not part of the medical information kept by our facility; or
- The request pertains to information that you are not permitted to inspect and copy.

You have the right to file a statement of disagreement with us. In turn, we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

Right to an Accounting of Disclosures: This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices for a time frame of up to seven (7) years from the date of the request. It excludes routine disclosures, such as any we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes.

To request an accounting of disclosures, you must submit a written request to the front desk. Your request must state a time period, which may not exceed Seven years. You will not be charged for the first request for accounting within a twelve-month period; however, you may be charged a fee for the administrative costs of retrieving, copying, mailing, and any other activities associated with any additional requests for accounting. You will be notified of the costs involved and will have the option to withdraw your request at that time, before any costs are incurred.

Right to Request Restriction: You have a right to request that All Ways Chiropractic PLLC restrict the use or disclosure of any part of your Protected Health Information for the purposes of treatment, payment or health care operations. You may also request that your Protected Health Information be disclosed to family members or friends for notification purposes on an all or nothing basis. You must decide whether to grant disclosure to all family and friends, or to none. You may request additional restrictions on the use or disclosure of information for treatment, payment or health care operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays in full for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

Right to Request Confidential Communications: You have the right to request to receive confidential communications from All Ways Chiropractic PLLC by alternative means or at an alternative location. For example, you may wish to be contacted only at work or by mail. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. This request must be made in writing to the front desk and must specify how and where you wish to be contacted.

Right to obtain a copy of this Notice: You have the right to obtain a copy of this Notice of Privacy Practices upon request. To receive a copy of this Notice, or any future revisions of the Notice, you may contact our Privacy Officer and request that a revised copy be sent to you in the mail. Additionally, you may also obtain a copy at the front desk at the time of your next appointment.

3. Complaints

If you believe your privacy rights have been violated, you may file a complaint with All Ways Chiropractic PLLC or with the Secretary of Health and Human Services. You may also contact our Privacy Officer for further information about the complaint process. We will not retaliate against you for filing a complaint.

All Ways Chiropractic

3773 Martin Way E
Suite B-106
Olympia, WA 98506

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

Height: _____ Weight:_____ Blood Pressure:_____ /_____

All Ways Chiropractic, PLLC

Please draw the location of your symptoms on the body diagram below and mark your current level of pain on the line at the bottom of the diagram.

Dull / Ache
^ ^ ^ ^

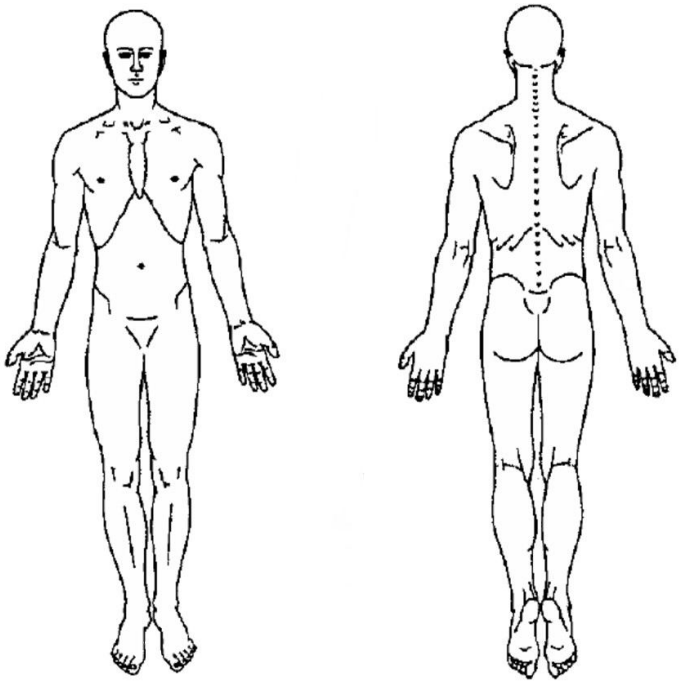
Burning
= = = = =

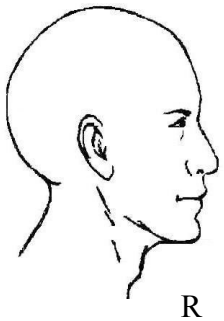
Numbness
o o o o o

Pins & Needles
. . . . . .

Sharp
x x x x x x

Other
/ / / / / /





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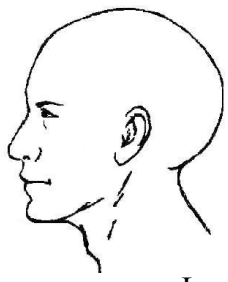

L

No Pain ---------- Worst Pain Possible

Please make a slash through this line as to the level of your pain.

Is the pain getting worse_____ staying the same_____ or improving _____?

Is the pain occasional _____ frequent _____ or constant _____?

What makes the pain better?_____

What makes the pain worse?_____

Patient's Name: _____

Patient's Signature: _____

Date Signed: _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage 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 related to you, but PLEASE ONLY CIRCLE THE ONE. CHOOSE WITH 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 (Washing, Dressing, etc.)

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 was 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 gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights of 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 of 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 neck pain
C I can drive my car as long as I want with moderate neck pain
D I cannot drive my car as long as I want with moderate neck pain
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 acitivities 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 recreation activities at all.

COMMENTS:_____

_____

NAME: _____ DATE: _____ SCORE: _____

All Ways Chiropractic
3773 Martin Way E Suite B-106
360-352-8896

THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

Date _____ Patient Name _____ Date of Birth _____

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

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

Section 2 - Personal Care

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but 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 am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

Section 3 – 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, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk while using a cane or on crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

Section 6 – Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

Section 7 – Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

Section 8 - Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of my pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ 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 the pain.

Section 9 - Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling, which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

Section 10 – 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 at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Score _____ [50] **Benchmark -5 = _____**

All Ways Chiropractic - ***Health History***

Patient Name:_____ Date:_____

Primary Care Physician:_____ Date Last Seen:_____

Are you pregnant?❒Yes ❒NoDue Date:_____ # of Children:_____# of Pregnancies:_____

Smoking Status:❒ Every day ❒ Occasional ❒ Former Smoker ❒ Never smoked

How often do you consume alcohol? ❒Never ❒1-2 times per week ❒3-4 times per week ❒5+ times per week

How often do you consume caffeine?❒Never ❒1-2 times per week ❒3-4 times per week ❒5+ times per week

How often do you exercise? ❒Never ❒1-2 times per week ❒3-4 times per week ❒5+times per week

Health History: - CIRCLE ALL that APPLY. CHECK NONE if NONE APPLY

SURGICAL HISTORY❒ NONE	***MEDICATIONS ❒NONE*** *OTC = Over the Counter* *RX = Prescription*	***PERSONAL & FAMILY HEALTH HISTORY❒ NONE*** ***❒ OTHER***
Spinal Fusion	Muscle Relaxer❒ OTC ❒ RX	CancerSelf Family
Discectomy	NSAID/Ibuprofen ❒OTC ❒ RX	AIDS/HIVSelf Family
Laminectomy	Tylenol❒ OTC ❒ RX	AlcoholismSelf Family
Abdominal Aortic Aneurysm Repair	Pain Reliever/Pain Killer❒ OTC ❒ RX	Alzheimer'sSelf Family
Appendectomy	Antacid❒ OTC ❒RX	AnemiaSelf Family
Breast Augmentation	Anti-Depressant❒OTC ❒RX	Arthritis Self Family
Bunionectomy - Left Side	Anti-Viral❒OTC ❒RX	AsthmaSelf Family
Bunionectomy – Right Side	Aspirin❒OTC ❒RX	Bleeding DisordersSelf Family
Cardiac Bypass	Birth Control❒OTC ❒RX	Bronchitis Self Family
Cardiac Valve Replacement	Blood Pressure❒OTC ❒RX	Chemical DependencySelf Family
Cataract	Chemotherapy❒OTC ❒RX	DepressionSelf Family
C-Section	Codeine❒OTC ❒RX	DiabetesSelf Family
Cosmetic	Hallucinogenic❒OTC ❒RX	Eating DisorderSelf Family
Carpal Tunnel Syndrome – Left Hand	Marijuana❒OTC ❒RX	EmphysemaSelf Family
Carpal Tunnel Syndrome – Right Hand	Mood Elevator❒OTC ❒RX	EpilepsySelf Family
Ear Tubes	Sleeping Pill❒OTC ❒RX	FracturesSelf Family
Gall Bladder Removed	Stimulant❒OTC ❒RX	Heart DiseaseSelf Family
Ganglion Cyst	Tranquilizer❒OTC ❒RX	HepatitisSelf Family
Gastric Bypass	Other ❒	HerniaSelf Family
Hysterectomy Complete	***ACCIDENT(S) HISTORY❒ NONE***	Herniated Disc Self Family
Hysterectomy Partial	Single Auto Accident	High Blood Pressure Self Family
Left Knee	Multiple Auto Accidents	High Cholesterol Self Family
Right Knee	Slip & Fall	Kidney Disease Self Family
Lasik	Single Motorcycle Accident	Liver Disease Self Family
Left Shoulder	Multiple Motorcycle Accidents	Migraine Headaches Self Family
Right Shoulder	Single Boating Accident	Multiple Sclerosis Self Family
Thyroidectomy	Multiple Boating Accidents	Osteoarthritis Self Family
Tonsils	***RESULT OF ACCIDENT(S)❒ NONE***	Pacemaker Self Family
Tonsils & Adenoids	Fracture(s)	Parkinson's Disease Self Family
Transplant	Permanent injury or disability	Pneumonia Self Family
Wisdom Teeth	Hospitalization(s)	Polio Self Family
WORK STATUS	No significant injury or loss	Prostate Problems Self Family
Full Time Part Time Home Maker Retired Student Unemployed	I am no longer receiving treatment for the above injuries	Psychiatric Care Self Family
Hours per week: 0 – 20 20 – 40		Rheumatoid Arthritis Self Family
40 – 50 50 – 60 60 – 70 70+		Seizure Self Family
At work I mostly: Sit Stand		Stroke Self Family
Labor Intensity: Light Moderate Heavy Sedentary		Suicide Attempts Self Family
I consider my work to be: Difficult Enjoyable Relaxed Stressful	***CHIROPRACTIC HISTORY***	Thyroid Problems Self Family
	Have you been adjusted by a *chiropractor* before? ❒ YES ❒ No If so, when? _____	Tumor Self Family
		Ulcers Self Family
		Vaginal Infection Self Family
		Venereal Disease Self Family