Welcome to Kaufman Chiropractic

Name:_____ Preferred Name:_____

Address:_____ Home Phone:_____

City, State, Zip:_____ Cell Phone: _____

Date of Birth:_____ Patient SS#:_____ Work Phone: _____

Email Address:_____ Employer: _____

____Male ____Female Emergency Contact:_____

____Married ____Single ____Other Phone:_____

____Employed ____Student ____Other

Whom may we thank for referring you?_____

If patient is a minor, who is the responsible for this account?_____

Health Insurance Information - A copy of your insurance card is required to be on file.

(1) Primary Insurance:_____ ID Number_____ Group_____

(2) Secondary Insurance:_____ ID Number_____ Group_____

Were you involved in an accident? YES / NO _____ Auto _____ Work _____ Other

Auto accident related, please complete the following

Date of Accident:_____

Your auto insurance company:_____ Your claim/PIP #:_____

Adjuster name:_____ Adjuster phone:_____

Other party's insurance company:_____ Other party's claim #:_____

Have you retained an attorney? Y / N Attorney name:_____ Phone: _____

Work injury related, please complete the following

Employer:_____ Date of Injury:_____ Claim #:_____

I, the undersigned, certify that I (or my dependant) have insurance with the above and I authorize direct payment to Kaufman Chiropractic Clinic for any insurance benefits otherwise payable to me for the services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure benefits. I authorize the use of this signature on all insurance claims.

Signature:_____ Date:_____

Health History

What treatment have you already received for your condition?

Medications____ Surgery____ Physical Therapy____ Chiropractic____ None____ Other_____

Who is your primary care provider? _____

Date of last: Physical exam:_____ Spinal adjustment:_____ Spinal x-ray:_____

Check if Current or Past Problems

Alcoholism		Headaches		Multiple Sclerosis		Tuberculosis	
Aids/HIV		Glaucoma		Numbness		Tumors, Growths	
Allergy Shots		Goiter		Osteoarthritis		Ulcers	
Anemia		Gout		Osteoporosis		Whooping Cough	
Anorexia/Bulimia		Hearing Loss		Pacemaker		Vision Problems	
Appendicitis		Heart Attack		Parkinson's		Fever (prolonged)	
Arthritis		Hemorrhoids		Pinched Nerve		Mumps	
Asthma		Hepatitis		Pneumonia		TMJ (Jaw)	
Bed Wetting		Hernia		Prostate Problem			
Bleeding Disorders		Herniated Disc		Psychiatric Care		**Women Only:**	
Bronchitis		High Blood Pressure		Rheumatic Fever			
Cancer		High Cholesterol		Rheumatoid Arthritis		Hysterectomy	
Chemical Dependency		Infertility		Ringing in Ears		Miscarriage	
Chicken Pox		Joint Replacement		Scarlet Fever		Menopause	
Diabetes		Kidney Disease		Sinus Infections		Premenstrual Syndrome	
Difficulty Breathing		Liver Disease		STD's		Irregular Menses	
Digestive Conditions		Loss of Energy		Stroke		Cramps	
Dizziness		Low Back Pain		Thyroid Problems		Breast Problems	
Emphysema		Measles		Tiredness		Pregnant	
Epilepsy		Migraines		Tremors		Due Date	

Exercise

____ None
____ 1-2 x/week
____ 3-4 x/week
____ 5+ x/week

Stress Level

____ Low
____ Medium
____ High

Causes:_____

Habits

____ Smoking Packs/Day _____
____ Alcohol Drinks/Week _____
____ Coffee/Soda Cups/Week _____

Types of Exercise: _____

Medications: _____

Eating Habits

In the last 24 hours how many servings of fruits/vegetables have you consumed?_____

Is this typical? Y / N How many times a week do you eat fast food?_____

The above information is true and correct to the best of my knowledge. I will accept and acknowledge ultimate responsibility for all charges I incur in this office. All fees are payable at the time x-rays, examination and treatments are received, unless other arrangements are made in advance.

Signature:_____ Date:_____

KAUFMAN
CHIROPRACTIC
CLINIC

PAIN LOCATION AND RATING SCALE

NAME: _____ DATE: _____

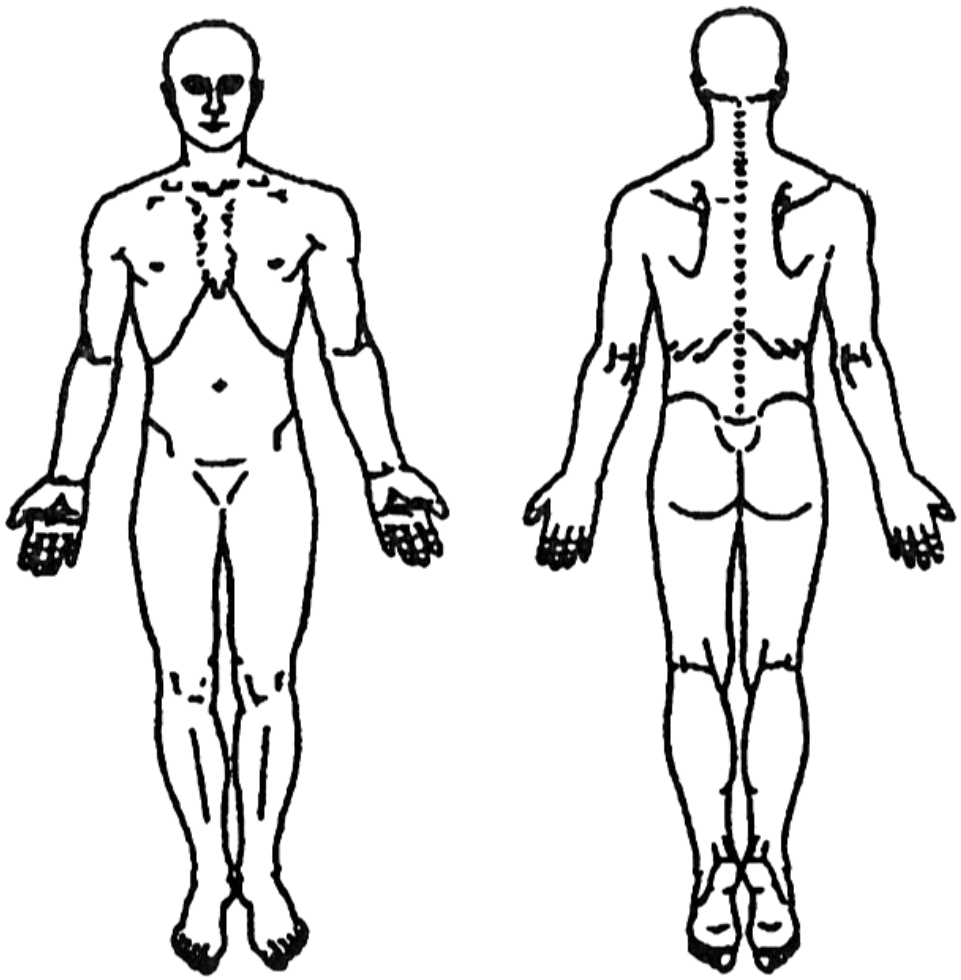
MY CHIEF COMPLAINT IS: _____

2ND COMPLAINT: _____

3RD COMPLAINT: _____

Please draw the location and type of pain on the body outlines:

ACHE:	BURNING:	NUMBNESS:	PINS AND NEEDLES:	STABBING:	OTHER:
MMM	__ __ __	O O O O O O	● ● ● ● ● ● ● ● ● ●	/ / / / / / /	X X X X X



X_____

PATIENT SIGNATURE

IF PATIENT IS A MINOR, PARENT OR LEGAL GUARDIAN SIGNATURE

Name:_____ **DOB:**_____ **Date:** _____

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper/lower limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

THE UPPER EXTREMETY FUNCTIONAL INDEX (Head/Shoulders/Arms)

Today, do you or would you have any difficulty at all with: (Circle one number on each line)

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3	Lifting a bag of groceries at waist level	0	1	2	3	4
4	Lifting a bag of groceries above your head	0	1	2	3	4
5	Grooming your hair	0	1	2	3	4
6	Pushing up on your hands (e.g. from bathtub or chair)	0	1	2	3	4
7	Preparing food (e.g. peeling, cutting)	0	1	2	3	4
8	Driving	0	1	2	3	4
9	Vacuuming, sweeping or raking	0	1	2	3	4
10	Dressing	0	1	2	3	4
11	Doing up buttons	0	1	2	3	4
12	Using tools or appliances	0	1	2	3	4
13	Opening doors	0	1	2	3	4
14	Cleaning	0	1	2	3	4
15	Tying or lacing shoes	0	1	2	3	4
16	Sleeping	0	1	2	3	4
17	Laundering clothes (e.g. washing, ironing, folding)	0	1	2	3	4
18	Opening a jar	0	1	2	3	4
19	Throwing a ball	0	1	2	3	4
20	Carrying a small suitcase with your affected limb	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE:**_____**/ 80 =** _____**% impairment**

FOR OFFICE USE ONLY

THE LOWER EXTREMITY FUNCTIONAL SCALE (Hips/Legs/Feet)

Today, do you or would you have any difficulty at all with: (Circle one number on each line)

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3	Getting into or out of the bath	0	1	2	3	4
4	Walking between rooms	0	1	2	3	4
5	Putting on your socks or shoes	0	1	2	3	4
6	Squatting	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8	Performing light activities around your home	0	1	2	3	4
9	Performing heavy activities around your home	0	1	2	3	4
10	Getting into and out of a car	0	1	2	3	4
11	Walking 2 blocks	0	1	2	3	4
12	Walking a mile	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14	Standing for 1 hour	0	1	2	3	4
15	Sitting for 1 hour	0	1	2	3	4
16	Running on even ground	0	1	2	3	4
17	Running on uneven ground	0	1	2	3	4
18	Making sharp turns while running fast	0	1	2	3	4
19	Hopping	0	1	2	3	4
20	Rolling over in bed	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE:**_____**/ 80 =** _____**% impairment**

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Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

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

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

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

Neck Index Score _____

FOR OFFICE USE ONLY

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

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

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

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

Back Index Score _____

FOR OFFICE USE ONLY

KAUFMAN CHIROPRACTIC CLINIC

18920 BOTHELL WAY NE, STE 100
BOTHELL, WASHINGTON 98011

14090 FRYELANDS BLVD SE, STE 274
MONROE, WASHINGTON 98272

ALLOWABLE CONTACT BY EMAIL/TEXT

RELEASE FORM

Being a Healthcare Provider, one of our top priorities is to protect you and your Protected Health Information (PHI). If you so choose, your information will be only used for the operation of Kaufman Chiropractic Clinic. **WE WILL NEVER GIVE NOR SELL YOUR INFORMATION TO A THIRD PARTY.**

We are requesting your permission for Kaufman Chiropractic Clinic to communicate with you in the following ways. Please initial <u>ONE</u> of the following options:

1) I authorize Kaufman Chiropractic Clinic to send text messages and/or utilize my email that may contain appointment reminders and/or personal information, including protected health information, as well as, announcements regarding product/service information, education events, seminars, etc.

   _____ **Initial here for consent**

2) I **<u>DO NOT</u>** authorize Kaufman Chiropractic Clinic to send text messages or emails at this time. I am responsible to notify the front desk if I would like text messages or email reminders in the future.

   _____ **Initial here for non-consent**

I have read the information above and authorize the initialed sections.

Signature: _____ Date: _____

Printed Name: _____

Email: _____

Address: _____ City, State, Zip _____

Cell phone: _____

KAUFMAN CHIROPRACTIC CLINIC

Patient Billing Acknowledgement Form
Maintenance/Elective Care**

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract, including care determined to be elective or maintenance.

Maintenance/Elective care is treatment that does not significantly improve a clinical condition.While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also receive maintenance care once maximum benefit from treatment has been reached.

If during the course of Maintenance/Elective care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance/Elective and may then be covered by your health plan. Your provider must submit a request for insurance coverage.
****Not for use in New Jersey**

PROVIDER	*Service to be provided are listed below:* ___ Chiropractic/Manipulative Therapy _____ In-Home Care ___ Modalities/Procedures _____ Other Time Frame from _____ through _____ Schedule/details_____ Provider Signature _____
PATIENT	I _____, agree to pay for non-covered services, including Patient Name- Printed or Typed care determined to be elective or maintenance as well as those services that may be denied by my health plan. Patient *or* Guardian Signature Date _____ _____

KAUFMAN CHIROPRACTIC CLINIC

18920 BOTHELL WAY NE, STE 100
BOTHELL, WASHINGTON 98011

14090 FRYELANDS BLVD SE, STE 274
MONROE, WASHINGTON 98272

Consent to use PHI

Acknowledgement for Consent to Use and Disclose of Protected Health Information

Uses and Disclosures of your Protected Health Information
Your Protected Health Information will be used by Kaufman Chiropractic or may be disclosed to others for the purpose of treatment, obtaining payment, or supporting day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received in this office. **Please initial that you have received a copy of the Notice of Patient Privacy Policy.**

_____ Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Certain treatments may be performed in a common therapy area and/or you may find yourself within public areas within the clinic times. Please note private rooms are always available upon request for discussing your Protected Health Information.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below, I give Kaufman Chiropractic Clinic permission to use and disclose my health information for the purposes of treatment, obtaining payment and supporting day-to-day health care operations of this office.

_____ _____

Patient or legally Authorized Individual Signature **Date**

_____

Printed Patient's Full Name

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments, computerized range of motion, examination procedures, including diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by any licensed doctor of chiropractic who treats me at Kaufman Chiropractic Clinic. I am responsible for informing the doctor if I am pregnant or may be pregnant **PRIOR** to having x-rays.

I will have an opportunity to discuss with my doctor at Kaufman Chiropractic Clinic and/or other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that patients experience an audible “pop” during a manual adjustment and this is a normal part of treatment. Kaufman Chiropractic doctors perform full spine adjustments, which may include areas other than my chief complaint, in an effort to correct the biomechanics of my spine as a whole.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interest. According to research, the probability of serious injury is 1:1,000,000 or about the same risk as being struck by lightning. I understand that 40% of non-symptomatic patients have disc herniations, which may exist in my spine and become symptomatic whether or not I have treatment.

I have read, or have had read to me, the above consent and I understand. I will also have an opportunity to ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) and for which I seek treatment.

To Be Completed By Patient

Patient Name: _____ **Signature:** _____

Date Signed: _____/_____/_____

If Patient is a Minor, Physically or Legally Incapacitated
To Be Completed by Patient’s Representative

Patient Name: _____ Name of Representative: _____

Date Signed: _____/_____/_____ Signature of Representative: _____

Relationship or Authority of Patient’s Representative: _____