Wildflowers CHIROPRACTIC

Lake Oswego:
Dr. Sabrina J. Marcus, DC
15110 SW Boones Ferry Road
Suite# 380
Lake Oswego, OR 97035

Portland:
Dr. Sabrina J. Marcus, DC
2262 N. Albina Avenue
Suite# 129
Portland, OR 97227

Auto Accident Report

Please fill out the following as completely as possible. It is essential for proper processing and submission of claims to your insurance company.

Name ______________________________________ Date of Birth ______________ Age ______
Address ____
Marital Status: Single Married Divorced Widowed **Gender**: M / F **Occupation** ___________
Date of Accident ___________________________ Time of Accident _______________ AM PM
Location of Accident ____
Did you have automobile insurance at the time of this accident? ( )Yes ( )No
Have you reported this accident to your insurance carrier? ( )Yes ( )No
Your Insurance Company _______________________________ Claim # __________________
Address of Your Insurance Carrier ____
Adjuster's Name _______________________________ Phone Number ___________________
Name and phone number of your attorney (if applicable):
____

Were the police notified? ( )Yes ( )No
Did they file a report? ( )Yes ( )No
Were you the driver? ( )Yes ( )No
Which seat were you in? ( )Front( )Back
Did you hit your head? ( )Yes ( )No

Did you lose consciousness?( )Yes ( )No
Were you taken to a hospital?( )Yes( )No
Did you drive yourself there? ( )Yes ( )No
Pain medication prescribed? ( )Yes( )No
Muscle relaxers prescribed? ( )Yes ( )No

Please list what diagnoses and treatment you received at the hospital: ____________________
____
Did you have x-rays taken? ( )Yes ( )No What areas? _________________________
Have you sought other medical care pertaining to this accident? ( )Yes ( )No
If yes, please describe: ____

Your Vehicle: ( )Car ( )Motorcycle ( )Other
Vehicle's year/make/model ____________________
Were there others in your vehicle? ( )Yes ( )No
Were you wearing a seatbelt?( )Yes ( )No
Were airbags deployed? ( )Yes ( )No
Which direction were you heading? N S E W

Other Involved Vehicle: (if multiple vehicles were involved, please list on back of page)
Other Vehicle: ( )Car ( )Motorcycle ( )Other
Vehicle's year/make/model ____________________Which direction were they heading? N S E W
Please list any other pertinent information pertaining to the other person/people involved including their insurance information: ____
____

____________________________________ ____________________
Signature / Signature of Guardian Date

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Please describe the accident: ____

____

____

____

What direction was your head facing? ____

Were you struck from: ( )Behind ( )Front ( )Left Side ( )Right Side

Were you bracing for impact or were you surprised by the impact? ______________________

Where was the headrest in relation to the back of your head?

( )Above head ( )Below head ( )Even with the base of your head

Did any part of your body hit something? If so, please indicate what part of your body was hit and what happened ____

____

Please describe the condition of your car after the accident: ______________________

____

Please describe how you felt:

During the accident: ____

Immediately after the accident: ____

Later that day/night ____

The following one or two days: ____

What are your present symptoms? ____

____

Please list all medications you are currently taking: ______________________________

____

If you did not see a doctor within the first month of injury, please indicate why not?

Please check all that apply:

( )No pain was noticed

( )No transportation available

( )Thought the pain would go away

( )Had no insurance or money

( )Work / home schedule conflicts

( )Thought pain meds would be enough

Are you pregnant? ( )Yes ( )No Nursing? ( )Yes ( )No

Have you ever been involved in an accident before? If so, please indicate the nature of that trauma and in what year it occurred: ____

Have you ever suffered from any of your current symptoms before? If so, which symptoms?

____

Have those symptoms gotten worse since the accident? ( )Yes ( )No

Have you missed work since this accident? ( ) Yes ( )No

If yes, please list those dates or times: ____

Who referred you to this office? ____

______________________________ ____________________

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The Neck Disability Index

Patient name: ______________________ File#__________ Date:__________

Please read instructions:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing, Dressing, etc.)

- ☐ 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 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.

SECTION 3-LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, 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 lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4-READING

- ☐ I can read as much as I want to, with no pain in my neck.
- ☐ I can read as much as I want to, with slight pain in my neck.
- ☐ I can read as much as I want to, with moderate pain in my neck.
- ☐ 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 pain in my neck.
- ☐ I cannot read at all.

SECTION 5-HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6-CONCENTRATION

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

SECTION 7-WORK

- ☐ I can do as much work as I want to.
- ☐ I can do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8-DRIVING

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want, with slight pain in my neck.
- ☐ I can drive my car as long as I want, with moderate pain in my neck.
- ☐ I can't drive my car as long as I want, because of moderate pain in my neck.
- ☐ I can hardly drive at all, because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9-SLEEPING

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

SECTION 10-RECREATION

- ☐ I am able to engage in all my recreation activities, with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some neck pain at all.
- ☐ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- ☐ I am able to engage in few of my recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of pain in my neck.
- ☐ I can't do any recreation activities at all.

______________________________ ______________

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The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient name: ______________________ File #__________ Date:__________

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

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 very 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, but I manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ 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

- ☐ I have no pain on walking.
- ☐ I have some pain on walking, but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5-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 one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more 10 minutes.
- ☐ I avoid sitting because it increases pain right 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 right away.

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 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-TRAVELLING

- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling, but none of my usual forms of travel makes it any worse.
- ☐ I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling, 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 is definitively 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.

______________________________ ______________

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Patient Information

Date_____________________

Name____
Last First M.I. Preferred Name

Street____

City_______________ State_____ Zip_________ Email________________________

Best Phone Number (_____) _____ - _______ Please circle one: cell home work

Date of Birth________________ Gender________ Occupation____________________

Employer's Name and Address____

Preferred time/method of contact____

How did you hear about our center?____

Is your visit due to a Motor Vehicle Accident or Worker's Comp claim? Yes / No

If yes, please list the name and phone number of your claim representative below:

____

In Case of Emergency:

Contact______________________ Relationship_____________________________

Phone (______) _______ - _______ Alternate Phone (______) ______-_______

Address____

____ __________________
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Patient Intake

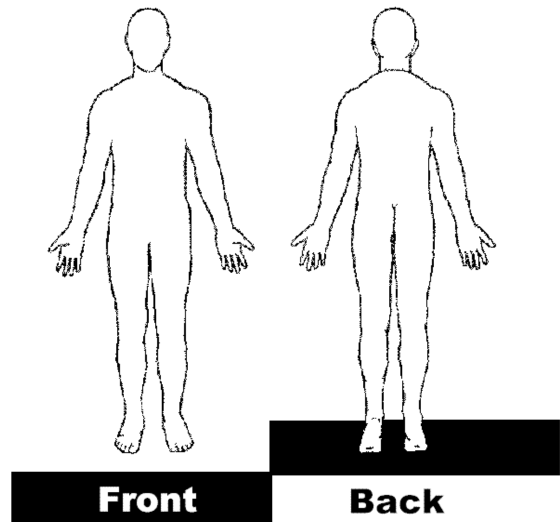
Name__________________________________ Age______ Date of visit_____________________

What is the reason for your visit?____

____.

Please indicate where you are experiencing symptoms by **circling** and **labeling** the diagram below with the appropriate letter abbreviation to correspond with the area.

D=dull pain
S=stiffness/soreness
P=sharp or shooting pain
B=burning pain
N=numbness
T=tingling
W=weakness



For areas where pain is experienced, please provide additional information below:

Area Affected	Please rate **level of pain** with **0-10** where **0=NO pain** and **10=the worst pain you can imagine**	How often? (Hourly, daily, weekly, monthly, etc.)	How long does it last?

Do your symptoms affect your ability to perform daily activities? Yes / No

Activity Affected	Please rate **level of functioning** with **0-10** where **0=zero functioning** and **10=the best functioning of your life** PSFS

____ ____________________
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Financial Policy

Wildflowers Chiropractic is included in many, though not all insurance networks. As such, we may be considered an Out of Network Provider for your care. **Please provide us with a copy of your health insurance card and driver's license** so that we may assist you in determining your benefits and the reimbursements available for the care we provide. Quotes relating to your benefits will be rendered as they are communicated to us by your insurance company and do not guarantee their reimbursement. Ultimately, you are responsible for knowing your benefits and for payment to us for the care you receive.

Auto Injuries / Personal Injuries / Worker's Compensation Injuries:
If your injuries are connected with an auto accident, personal injury case, or injury sustained while on the job, Wildflowers Chiropractic will help you to determine whether your insurance will reimburse Wildflowers Chiropractic for the work performed here on your behalf. **Please provide us with a copy of your personal health insurance card and driver's license** so that we may assist you, as well as with the name and phone number of your claims representative.

I have read this financial policy. I understand that all charges billed to me from Wildflowers Chiropractic are my responsibility to pay in full. Efforts will be made to obtain financial reimbursement from all applicable insurance companies or third party agencies, but ultimately it is my responsibility to pay for all services rendered me.

If I am a patient who does not have chiropractic and/or physical therapy benefits through insurance, there are discounts available for services if paid at the time of service. A delay of payment may forfeit the time of service discount. It is my responsibility to pay for all services rendered me.

I understand that I may be assessed a $75.00 charge for any appointment missed or not cancelled more than 24 hours in advance of appointment time. If I miss or do not cancel 3 appointments more than 24 hours in advanced notice within the course of my treatment, my service provider will have the right to refuse additional appointments with me and the doctor/ patient relationship may be terminated.

I understand that any check returned for insufficient funds will be assessed a $75.00 fee and it is at the service provider's discretion whether to accept checks from me in the future.

_______________________________ _______________

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Past Health History

Name: ______________________________________

Are you experiencing any major illness at this time?____________________________________

Have you had any major surgeries or hospitalizations within your lifetime? When and for what?______________________________________
____

Have you had any accidents (car, falls, sports-related, other)?________________________________
____
____

Have you ever broken any bones? If any, which ones and how?________________________________
____
____

What is your occupation/job?___________________
____

Is your work physically demanding? How?
____

Do you smoke or have you ever?________________
____

How much alcohol do you drink within a week?
____

Do you take any drugs, whether prescribed or not? Please list them below. ________________________
____

Do you take any Over the Counter medications?
____

Do you take any supplements?
____

Do you exercise on a regular basis? What does exercise mean to you?__________________________
____

Do you participate in any hobbies that can put a strain on your body (such as gardening, knitting, a high degree of video game play, etc.)?
____

In your diet, what types of food do you eat the most?____

In your diet, what types of food do you eat the least?____

How many hours per night do you sleep?_________

Do you wake up well-rested? YES / NO

Are you currently in a relationship which makes you feel scared or threatened? YES / NO

Are you currently experiencing a lot of stress in your life or within the past year? YES / NO

Women only:

When was the first day of your last menstrual period?_______________________________________

Are you pregnant? YES / NO

Are you taking oral contraception? YES / NO

Right to Privacy

Protecting the privacy of your protected health information is important to us. Protected health information includes both medical and individually identifiable information. We will not disclose this information without your authorization, except as required by law.

Our Notice of Privacy Practices provides information about how your protected health information may be used or disclosed. You have the right to request that we restrict how protected health information about how it is used or disclosed. Upon request, we will give you a copy of your Notice of Privacy Practices for you to review and/or make a copy for your records.

By signing this form, you consent to our use and disclosure of your protected health information as indicated in the Notice of Privacy Practices. Please note that your personal informant is not shared with third parties, such as financial, credit, or marketing companies. Use is restricted to procedures that are relevant to your care.

____________________________________ ____________________

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Please indicate if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fracture
- ☐ Gout
- ☐ Hypertension
- ☐ Multiple Sclerosis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Ankylosing Spondylitis
- ☐ Other Rheumatic Disease
- ☐ Other Major Illness/Surgery

Please indicate if you have experienced any of the following within the past 6 months:

General**:**
- ☐ Headache
- ☐ Fever
- ☐ Loss of Sleep
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Thyroid Issues
- ☐ Allergies
- ☐ Excessive Urination
- ☐ Painful Urination
- ☐ Discolored Urine

Musculoskeletal**:**
- ☐ Neck Pain
- ☐ Pain between shoulders
- ☐ Low back Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Teeth Grinding
- ☐ Other Jaw Issues
- ☐ Foot Pain
- ☐ Walking Issues
- ☐ Spinal Curvature

Nervous System:
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Sharp/Burning Pain
- ☐ Twitching
- ☐ Seizures
- ☐ Stroke
- ☐ Stress
- ☐ Anxiety
- ☐ Depression

Gastrointestinal:
- ☐ Excessive Thirst
- ☐ Constipation
- ☐ Diarrhea
- ☐ Sexual Dysfunction
- ☐ Nausea
- ☐ Vomiting
- ☐ Poor or Excessive Appetite
- ☐ Abdominal Pain/Cramping
- ☐ Excessive Gas
- ☐ Heartburn
- ☐ Black or Bloody Stools
- ☐ Liver or Gall Bladder Issues
- ☐ Ulcers

Cardiovascular and Respiratory:
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Heart Attack
- ☐ Aneurysm
- ☐ Asthma
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Varicose Veins
- ☐ Ankle Swelling

EENT:
Any problems with:
- ☐ Ears/Hearing
- ☐ Eyes/Vision
- ☐ Nose
- ☐ Throat
- ☐ Sinuses

***Please indicate if any members of your immediate family (parents, grandparents, siblings, children) have a history of the same condition or symptom as yours.**

***Please indicate if you have ever had any prior adverse reactions to any forms of body work including chiropractic care.**

***Please list any other relevant details below:**

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Consent to Treatment

Chiropractic examination and therapeutic procedures are considered safe and effective methods of care. These include spinal adjustments, extremity adjustments, applications of ice or heat, manual muscle therapy, and therapeutic and preventative rehabilitation exercises. Occasionally, however, complications may arise. While the chances of experiencing complications are small, it is the practice of Wildflowers Chiropractic to inform our patients about possible complications. These may include, but are not limited to; soreness, inflammation, soft tissue injury or bruising, dizziness, burns, or temporary worsening of symptoms. More serious complications are extremely rare, and their association with spinal adjustments are debated. These complications include injury to arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries of the spinal discs, and bone fractures. Additional information on side effects and complications are available upon request.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me by Wildflowers Chiropractic. I have read and understand the above statements regarding possible treatment side effects, and I also understand that there is no guarantee for a specific cure or result that is implied or to be inferred pertaining to the course of treatment I receive at Wildflowers Chiropractic. I intend for this consent form to cover the entire course of treatment performed by Wildflowers Chiropractic for my present condition(s) and for any future condition(s).

____
Print Name / Name of Guardian

______________________________________ __________________
Signature / Signature of Guardian Date