Patient Confidential Information

Date: ____________________

Patient Name: ______________________________________ Date of Birth: __________

Home Address: ____

City: ________ State: _____ Zip: __________ SSN: ___________________

Home Phone: ____________ Work Phone: ___________ Cell Phone: ____________

E-mail Address: ________________________________

Employer: _______________________ Occupation: ____________________

Address: ______________________ City: __________ State: ______ Zip: _________

Marital Status: __________________ Spouse's Name: ___________________

SSN: _______________ Date of Birth: _______ Spouse's Employer: _______________

Address: ______________________ City: ___________ State: ______ Zip: _________

Emergency Contact: _________________ Home Phone: __________ Cell: ___________

How did you hear about Marshall Chiropractic & Wellness Center: ______________

Purpose of Appointment: ____

When did present condition start: _______________ Where were you? _____________

How did accident happen: At work_____ Automobile_____ Other__________________

Explain: ____

Please briefly describe your condition: ______________________________

____

____

Have you seen another Doctor for this condition: Yes___ No___ Doctor Name: ___________

Have you seen a doctor for any other health condition in the past year? Yes___ No___

If yes, please describe: ____

Have you been to a chiropractor before? Yes___ No___ Are you pregnant? Yes___ No___

Insurance Information

Due to the fact that health and accident insurance policies are an agreement between the insurance carrier and myself, I clearly understand and agree that all services rendered to me are charged directly to me and that I am solely responsible for payment. I am also aware that Marshall Chiropractic & Wellness Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Marshall Chiropractic & Wellness Center will be credited to my account. I also understand that when it is time or if I choose to suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Consent of Chiropractic Services & Release of Information

I hereby authorize and release Dr. Ryan Marshall and his employees of Marshall Chiropractic & Wellness Center to administer, at Dr. Marshall's discretion, treatment, physical examination, x-ray studies, chiropractic care or any services that he deems necessary in my case. I acknowledge I received a copy of this medical practice's notice of privacy practices.

Patient Signature (Parent/Guardian): ______________________________

Marshall Chiropractic
6703 E 81st Street, Suite E
Tulsa, OK 74133

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

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 / Other / 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:______________

For office use only

Height: ________ Weight:___________ Blood Pressure:_____ /______

Patient Case History

Name: ______________________ Age: ________ Date: ______________

Current Symptoms: ____

____

Please mark other current symptoms that you are now experiencing:

Musculo-Skeletal System

__Neck Pain
__Pain between shoulders
__Mid back Pain
__Low back Pain
__Arm pain
__Leg pain
__Swollen joints
__Painful joints
__Stiff joints
__Sore muscles
__Weak muscles
__Walking problems
__Broken Bones
__Shoulder Pain

Nervous System

__Numbness
__Paralysis
__Dizziness
__Headaches
__Fainting
__Convulsions
__Depression
__Insomnia
__Confusion
__Muscle Spasms
__Loss of feeling
__Vertigo

Eye, Ear, Nose & Throat

__Visual Disturbance
__Eye strain
__Ear Pain
__Ear Noises
__Ear discharge
__Hearing loss
__Nose discharge
__Nose Bleeding
__Nose pain
__Dental Problems
__Sore throat
__Sinus pain
__jaw pain
__Allergy

Gastro-intestinal System

__Poor appetite
__Excessive hunger
__Difficult chewing
__Difficult swallowing
__Excessive Thirst
__Nausea
__Abdominal Pain
__Diarrhea
__Constipation
__Black Stool
__Bloody stool
__Hemorrhoids
__Liver trouble
__Gall bladder trouble
__Excessive weight gain/loss

Cardio-Vascular Respiratory

__Chest Pain
__Rapid Heart beat
__Blood pressure problems
__Heart problems
__Lung problems

Genito-Urinary System

__Bladder Trouble
__Excessive urination
__Painful urination
__Discolored urine
__Scanty urination

Patient Surgeries	Date

Please Mark the Intensity of Your Pain Today.

1 - NO PAIN
10 - MOST INTENSE EVER FELT

Example ______ Neck ______
1 2 3 (4) 5 6 7 8 9 10

1. ______________________
1 2 3 4 5 6 7 8 9 10

2. ______________________
1 2 3 4 5 6 7 8 9 10

3. ______________________
1 2 3 4 5 6 7 8 9 10

DOCTORS' USE ONLY

____
____
____
____
____

Please Mark Area & Type of Pain on the Drawings Using the Code Listed Below.

N - Numbness
T - Tingling
S - Soreness
P - Pain
A - Ache
ST - Stiffness

Right Left
Left Right

Patient Name:______________________ Date of Birth:______________

Social Security #:______________________ Date:______________

Patient Informed Consent

Congratulations on choosing chiropractic health care. This clinic believes it is the safest, most natural health care delivery system in the world today. Chiropractic adjustments (chiropractic manipulative therapy; C.M.T.) and other care procedures are safe and cost effective.

All health care professionals (anesthesiologists, chiropractors, dentists, medical doctors, osteopaths, pharmacists, surgeons, etc.) are regulated by laws and board. These health care professionals are required to give you, the patient, advanced notice of any care risks, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risks and/or complications. Informed consent information regarding any risks such as: paraplegia, quadriplegia, brain damage, stroke, disc injury, breaks, fractures, dislocations, drug reactions, death or loss of function of any organ or limb, or disfiguring scars associated with physical care, drugs, surgery and/or treatment is an undesirable result, but it does not necessarily indicate an error in clinical judgment. No guarantee of cure or results has been made to you, the patient in this clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions.

For your information the following is furnished to all patients who request and/or accept chiropractic care in this clinic. Again, chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions. This clinic is staffed with graduate chiropractors who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

Chiropractic is the science that concerns itself with the relationship between the brain, central nervous system, spine, and the function of the body. Any alteration of this relationship can cause the biomechanical and neurophysiologic dynamics of the contiguous spinal and paraspinal structures to be disrupted. This can cause neuronal disturbances in the form of the vertebral subluxation complex (V.S.C.) with its physical and chemical components, which can then interrupt the body's inherent recuperative powers.

The practice of chiropractic can include exams and diagnostic testing. In some cases, this includes the utilization of specialized instrumentation, lab tests, radiological exams, nutritional and/or physical therapy, and rehabilitation procedures, etc. There is a special procedure unique to chiropractic: the chiropractic adjustment (chiropractic manipulative therapy- C.M.T.). Adjustments are made by chiropractors to correct and/or reduce and/or stabilize vertebral or extremity subluxation complexes. The goal of chiropractic health care is to reduce and/or stabilize the nerve interference caused by the VSC and its component parts. There are over 200 different adjusting techniques, some using specialized equipment. Adjustments are usually performed by hand, but may be performed by hand-guided instruments. A C.M.T. is the application of a specific force, applied to a segmental contact point, usually on a vertebra, to reduce or stabilize the V.S.C. and its component parts.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care.

All health care procedures have some risks. With C.M.T.'S these risks may include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's Syndrome, Vertebral Artery Syndrome (V.A.S.), stroke, etc. The chances of this occurring have been estimated by experts to be approximately only 1 per 400,000 treatments, to 1 per 1,000,000 treatments.

Appropriate tests will be performed to identify if you may be susceptible to these risks, and you will be notified, in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care, based on the facts then known. I have also had opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure has been made to me concerning results, care and treatment.

______________________ ______________________

Patient Name Printed — Patient Signature — Date

______________________ ______________________

Patient/Guardian Signature (if minor) — Staff/Witness Signature — Date

Marshall Chiropractic
6703 E. 81st St., Suite E
Tulsa, OK 74133-4157

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, ________________________________, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

____
Patient

____
Signature

____
Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** ____

____

____
Staff signature **Date**

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Form may only be copied and/or customized by the owner of this book for use in his/her own office.

Patient's Name____ Number____________ Date____________________

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

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

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

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, 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 – 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 one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or 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 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 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = ____________ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

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

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

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 the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient's Name____ Number____________ Date________________

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which 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, 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 with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

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

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = ____________ %ADL______

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 only 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 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 my car 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 moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 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 pain in my neck.
☐ 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 a few of my usual 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.

Comments____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15