OSBORNE
CHIROPRACTIC AND SPORTS INJURY CLINIC

## 1. PERSONAL INFORMATION

Date: _____

Name:_____
Please check all that apply: □ Male □ Female □ Minor □ Single □ Married □ Divorced
Date of Birth:_____
Social Security Number:_____
Address: _____
City_____ State_____ Zip_____
Cell phone: _____ Home phone: _____
Employer: _____

Emergency contact:
Name: _____
Relationship: _____
Contact phone number: _____

## 2. INSURANCE INFORMATION

Primary Insurance:_____ Subscriber # _____
Secondary Insurance: _____ Subscriber # _____

## 3. PREVIOUS DOCTOR

Have you ever been to a Chiropractor before? □ Yes □ No
If yes, which Doctor? _____ Date of last treatment? _____
For this problem or a different problem?_____
Do you have a primary care physician? □ Yes □ No If yes, Doctor's name_____
Have you been treated by a Physician for any health condition in the past 6 months? □ Yes □ No
Please describe:

_____
How were you referred to our clinic?

_____

## 4. CHIEF COMPLAINT

Please describe. _____
How did it occur? _____
Have you lost days of work? □ Yes □ No If so, how many? _____
Have you ever had a similar injury? □ Yes □ No If yes; please explain.

_____
_____

**4. CHIEF COMPLAINT (continued)**

What activities aggravate your condition? _____

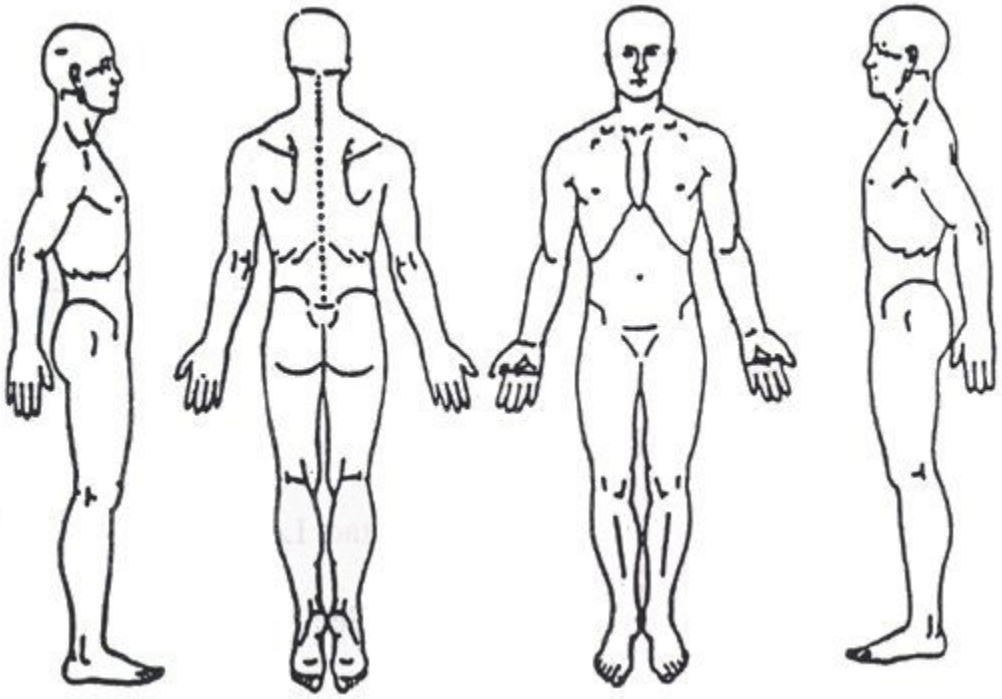
_____

What activities lessen your condition? _____

_____

Is this condition getting: □ Worse □ Better □ Staying the same
Is this condition interfering with: □ Work □ Sleep □ Daily Routine □ Other _____
Are you currently using any "home remedies"? _____
Did you have an X-ray/MRI or any other imaging performed? □ Yes □ No
Date: _____ Location of imaging/X-rays:_____
Have you ever had any of the following? □ Surgery □ Fractures □ Car accident/s
□ On the job injury/s □ Other Trauma
Have you ever had any serious illness or hospitalization?_____
Do you have a family history of: □ Heart disease □ Cancer □ Stroke □ Diabetes □ Arthritis
□ Back problems □ Disc problems □ Other _____
Are you currently taking any medications? Please list: _____
Do you have any allergies? Please list: _____
Are there any activities you have not been able to do that you would like to participate in again?
Please list: _____
Describe your pain: □ Constant □ Comes & goes □ Sharp □ Dull □ Ache □ Burning □ Shooting
Symptoms other than above: _____

Please mark the illustrations below with circles to indicate the areas of pain, numbness, tingling or aggravation:



**PATIENT HEALTH HISTORY**

(Please complete all sections)

Have you ever (at any time) experienced the following?

| | | | | | |
|---|---|---|---|---|---|
| Difficulty urinating | □ Yes □ No | Blood in Urine | □ Yes □ No | Claustrophobia | □ Yes □ No |
| Loss of bladder control | □ Yes □ No | Breast removal | □ Yes □ No | Common flu/cold | □ Yes □ No |
| Loss of bowel control | □ Yes □ No | Spinal surgery | □ Yes □ No | Carotid Artery Surgery | □ Yes □ No |

Have you ever been diagnosed with or told you have one of the following?

| | | | | | |
|---|---|---|---|---|---|
| Detached retina | □ Yes □ No | Hardening of the arteries | □ Yes □ No | High blood pressure | □ Yes □ No |
| Stroke | □ Yes □ No | Partial or complete paralysis | □ Yes □ No | Blood in Stool | □ Yes □ No |
| Slipped Disc | □ Yes □ No | Rheumatoid Arthritis | □ Yes □ No | Cancer | □ Yes □ No |
| Herniated Disc | □ Yes □ No | Fracture/Broken vertebra | □ Yes □ No | AIDS | □ Yes □ No |
| Osteoporosis | □ Yes □ No | Bleeding Disorder | □ Yes □ No | Prostate Disease | □ Yes □ No |
| TIA's (Mini strokes) | □ Yes □ No | | | | |

Do you currently have, or could you be, any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Pregnant | □ Yes □ No | Tattoos | □ Yes □ No | Neuron-Stimulator | □ Yes □ No |
| Taking birth control | □ Yes □ No | Aortic clips | □ Yes □ No | Dentures | □ Yes □ No |
| Receiving hormone therapy | □ Yes □ No | Brain clips | □ Yes □ No | Pacemaker | □ Yes □ No |
| Male Female | | Artificial heart valve | □ Yes □ No | Hearing Aid | □ Yes □ No |
| Taking blood thinners | □ Yes □ No | Rods, Pins or Screws | □ Yes □ No | Insulin Pump | □ Yes □ No |
| Metal fragments | □ Yes □ No | IUD | □ Yes □ No | Joint replacement | □ Yes □ No |
| Bullets or Shrapnel | □ Yes □ No | Surgical clips or wires | □ Yes □ No | Cochlear Implants (ear) | □ Yes □ No |
| Body piercing | □ Yes □ No | Shunt | □ Yes □ No | | |

Have you experienced any of the following within the past 2 weeks?

| | | | | | |
|---|---|---|---|---|---|
| Nausea | □ Yes □ No | Personality changes | □ Yes □ No | Diarrhea | □ Yes □ No |
| Vomiting | □ Yes □ No | Recurrent headaches | □ Yes □ No | A minor fall | □ Yes □ No |
| Vertigo (Spinning) | □ Yes □ No | Use of a Tanning booth | □ Yes □ No | A major fall | □ Yes □ No |
| Difficulty walking | □ Yes □ No | Skin Rash or infection | □ Yes □ No | An auto accident | □ Yes □ No |
| Lack of Coordination | □ Yes □ No | Speech problems | □ Yes □ No | A work injury | □ Yes □ No |
| Numbness | □ Yes □ No | Tinnitus (ringing in ears) | □ Yes □ No | Loss of Strength | □ Yes □ No |
| Double Vision | □ Yes □ No | Clumsiness | □ Yes □ No | Painful Bowel Movements | □ Yes □ No |
| Blurred Vision | □ Yes □ No | Memory Loss | □ Yes □ No | Head Trauma | □ Yes □ No |
| Extended travel by Auto (period) | □ Yes □ No | Fever | □ Yes □ No | Abnormal Menstruation | □ Yes □ No |

Current Health Habits

| | | |
|---|---|---|
| Exercise | □ None □ Light □ Moderate □ Heavy | _____Times per week |
| Alcohol | □ None □ Light □ Moderate □ Heavy | _____Times per day |
| Coffee | □ None □ Light □ Moderate □ Heavy | _____Times per day |
| Vitamins | □ None □ Light □ Moderate □ Heavy | _____Times per week |
| Water | □ None □ Light □ Moderate □ Heavy | _____Times per day |
| Smoking | □ None □ Light □ Moderate □ Heavy | _____Times per week |

**5. AUTHORIZATION AND RELEASE**

● I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

Initials _____

● I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

Initials _____

● I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of what the insurance company pays.

Initials _____

**6. LATE CHARGES**

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowable by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account.

Initials _____

**7. OTHER FEES**

We realize emergencies come up, but if you need to cancel an appointment for any reason, we request that you make every attempt to give us 24 hours notice. By giving adequate notice of cancellation you allow us to help others more quickly. If you do not contact our office prior to your appointment you will be billed a missed appointment fee of $50.00. For any returned checks you will be charged a $35.00 returned check fee.

Initials _____

SIGNATURE: _____

□ Patient □ Parent / Guardian

Osborne Chiropractic and Sports Injury Clinic
Patient Record of Disclosures - **HIPPA**

In general, the **HIPPA** privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected information. The individual is also provided the right to request confidential communications of protected information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. If you wish to have a copy of the HIPPA laws please ask.

I would like to be contacted in the following manner:

Contact phone number: _____ □ home □ cell □ work
□ It is okay to leave a message with detailed information
□ Leave call back number only

Alternative phone number (optional): _____ □ home □ cell □ work
□ It is okay to leave a message with detailed information
□ Leave call back number only

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AUTHORIZED ACCOUNT USERS

□ I give my permission for the staff and doctors of Osborne Chiropractic and Sports Injury Clinic to discuss my patient care and billing account with the following person/s:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

□ Patient □ Parent / Guardian

# Osborne Chiropractic and Sports Injury Clinic
# Disclosure and Consent
# Chiropractic Adjustments and Care

*TO THE PATIENT AND/OR GUARDIAN OF A MINOR: You have a right to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or harm you; It is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I hereby request and consent to the performance of the chiropractic adjustments and other chiropractic procedure, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Daniel Osborne or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a back-up for Dr. Osborne.

I have had the opportunity to discuss with Dr. Osborne my diagnosis, the nature and the purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, and increased symptoms and pain or not improvements of symptoms of pain. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions and all of my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan, I intend this consent form to cover the entire course of treatment for my present condition and for any future condition/s for which I seek treatment.

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_____ _____

Print patient's name Date

_____

Patient Signature (or Guardian Signature)

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*This section to be completed by Doctor:*

_____ _____

Witness to Patient's signature Date

_____ _____

Translated By: Date

# Appointment Reminders

How would you like to be contacted:

□ Text message - Cell phone number:_____
Name of cell phone provider: _____
□ Email - please provide email address: _____

Signature: _____ Date: _____

Thank you for choosing Osborne Chiropractic and Sports Injury Clinic.

# Functional Rating Index

For use with Neck and/or Back Problems

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

1. **Pain Intensity**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |

2. **Sleeping**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Perfect sleep | Mildly disturbed sleep | Moderately disturbed sleep | Greatly disturbed sleep | Totally disturbed sleep |

3. **Personal Care (washing, dressing, etc.)**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain; no restrictions | Mild pain; no restrictions | Moderate pain; need to go slowly | Moderate pain; need some assistance | Severe pain; need 100% assistance |

4. **Travel (driving, etc.)**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain on long trips | Mild pain on long trips | Moderate pain on long trips | Moderate pain on short trips | Severe pain on short trips |

5. **Work**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do usual work plus unlimited extra work | Can do usual work no extra work | Can do 50% of usual work | Can do 25% of usual work | Cannot work |

6. **Recreation**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do all activities | Can do most activities | Can do some activities | Can do a few activities | Cannot do any activities |

7. **Frequency of pain**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain | Occasional pain; 25% of the day | Intermittent pain; 50% of the day | Frequent pain; 75% of the day | Constant pain; 100% of the day |

8. **Lifting**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain with heavy weight | Increased pain with heavy weight | Increased pain with moderate weight | Increased pain with light weight | Increased pain with any weight |

9. **Walking**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain; any distance | Increased pain after 1 mile | Increased pain after ½ mile | Increased pain after ¼ mile | Increased pain with all walking |

10. **Standing**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain after several hours | Increased pain after several hours | Increased pain after 1 hour | Increased pain after ½ hour | Increased pain with any standing |

**Print patient's name:** _____

**Signature:** _____ **Date:** _____ **Total Score:** _____