Springbrook Chiropractic 420 Villa Rd. Newberg, OR 97132

"Life. Realigned!"

Dr. John J. Collins, Chiropractic Physician

PATIENT INTAKE AGREEMENT

Patient Name: _____ Daytime Tel: _____ cell / home / work

Place of Employment: _____ Other Tel: _____ cell / home / work

Mailing Address: _____ City: _____ State: ____ Zip: _____

E-mail: _____ Date of birth: ____/____/_____ Age: ___

Social Security #: _____ Driver's License #: _____ State: _____

Emergency contact: _____ Tel: _____ Relationship to Patient: _____

How did you hear of our clinic? Circle one or more: Friend/family member (Please tell us their name so that we may thank them.):_____, Saw our sign, Yellow Pages, Our web page, Google/internet search, Newspaper, Facebook/social media, Referred by another doctor/practitioner (name)_____, Found us on list provided by employer /insurance company, Other (please tell us):_____.

OUR OFFICE POLICY (updated 12/19): Welcome to our clinic! Thank you for entrusting us to help you with your health. Our goal is to help you restore and maintain your health by providing you with the highest quality chiropractic care available. Please read and sign. By signing below, you acknowledge that:

1) The patient (or legal guardian) is ultimately responsible for payment of all services. The standard fees for our services are at or below 'usual and customary' fees for similar services in this area. A copy of our fee scale is available for you to take, please ask the front desk personnel.
2) If a patient has insurance that provides significant chiropractic coverage at this clinic (i.e. car injury coverage, group health insurance, managed care plan, worker's compensation, etc.), then we will (upon your request) bill the insurer directly (once we have qualified them). This is called "accepting assignment of benefits" and it is a privilege that we extend as a convenience to patients. Regardless of what your insurance company has quoted you, there is no guarantee of insurance until coverage has been verified by our staff. If we bill an insurance company, the patient is still responsible for any and all co-pays, co-insurance and/or outstanding deductible balances. These payments are to be paid on the same date of service unless other arrangements have been made. Please inform the staff or doctor if you are unable to pay on the date of service and we will arrange a payment plan.
3) Although this office makes every reasonable attempt to collect the fees that your insurer is liable for, any charges ultimately denied by the patient's insurance company, for any reason, will be transferred back to the patient and the patient is then responsible for those charges (except in cases where this office has signed managed care contracts to the contrary and/or if fees are limited by law [i.e. Worker's Compensation or Personal Injury, etc.]). It is your responsibility to inform us of any changes to your insurance coverage.
4) All patients owing balances will receive a monthly statement. The amount owed is due, in full, at our office by the 'due date' unless other arrangements are made.
5) Our office reserves the right to charge a fee for appointments missed without prior notification.
6) All missed treatments are to be made up in a timely fashion. Failure by patient to adhere to the agreed-upon treatment plan may be cause for dismissal and/or withdrawal of the 'insurance assignment privilege'.
7) You have received a copy of our ROF/PAR/Informed consent policy.
8) Your privacy is of utmost importance to us. Our office complies with all state and federal laws and requirements regarding the protection of patient information.

_____ Initial here if you have any questions. _____ Initial here when your question is answered.

Patient/Guardian Signature: _____ Date: ____/____/_____

Springbrook Chiropractic - Dr. John J. Collins
420 Villa Rd. (mail: P.O. Box 1022) Newberg, Oregon 97132
(503) 538-0618 fax: (503) 537-2539 www.LifeRealigned.com
"Life, Realigned!"

ROF, PAR & Informed Consent Policy (2/18)

Our office provides "patient-centered care. The IOM (Institute of Medicine) defines **patient-centered care** as: "Providing **care** that is respectful of and responsive to individual **patient** preferences, needs, and values, and ensuring that **patient** values guide all clinical decisions."

ROF (Report of findings) and PAR conversation: After your exam but before receiving any treatment, the doctor will verbally give you a report of findings (ROF) before commencing treatment. The ROF includes summary of the exam findings and includes the doctor's diagnoses, prognosis and treatment plan. The PAR conversation includes procedures, alternatives and risks (PAR) for you to consider. The following is a general summary of the most-common procedures, alternatives and risks.

Procedures: The most common procedure done in our office is hands-on chiropractic manipulative therapy. The second most common treatment is soft tissue massage. Other treatments used are: non-manipulative manual therapy (passive mobilization or stretching procedures), home exercise and diet advice, stress-management advice, mechanical traction, inversion traction, ultrasound, hot packs, electrical stimulation, instrument-assisted chiropractic manipulative therapy, et al.

Alternatives: While there are no other forms of treatment that can duplicate chiropractic care, other treatment options for chiropractic patients may include one or more of the following:

- Do nothing
- Self-treatment, such as with OTC medications (i.e. NSAIDs, Tylenol), herbs, exercise and/or other at-home products.
- Other types of health care providers such as DPTs, MDs, NDs, LAc.s, LMTs, etc.
- Prescription drugs such as anti-inflammatory, muscle relaxants and/or opioid-type pain-killers, etc.
- Hospitalization
- Surgery

Risks: All of the above alternatives involve varying degrees of risk with surgery being the highest risk. For example, one study found that NSAIDs (such as Ibuprofen or Advil) may be responsible for as many as 15 deaths, per 100,000 users. Another study estimated 16,500 deaths per year in the USA from NSAID use alone. Another example is opioids…Opioid-class medications are considered substantially more risky than OTC NSAIDs and are therefore only available with a prescription. At our office, a common treatment used is manual spinal manipulative therapy or manual chiropractic manipulative therapy (CMT). The doctor may use CMT with his hands upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you experience when you "crack" your knuckles. You may feel a sense of movement. Although chiropractic care, in general, is considered one of the safest forms of healthcare in the USA, there are some very small risks associated with CMT. Very rare complications may include muscular-skeletal injuries. In extremely rare cases, some types of manipulation of the neck (especially high-velocity, rotational manipulations to the upper neck) may be associated with injuries to certain arteries in the upper neck leading to, or contributing to serious complications. The Doctor makes every reasonable effort during the detailed consultation and examination to screen for contraindications to CMT or other forms of chiropractic care. Additionally, to further lower the already extremely-small risk, the doctor in this office never uses high-velocity, manual/rotational manipulations to the upper neck. That said, if you have symptoms, medical conditions or other known health risk factors, it is your responsibility to fully inform the Doctor of anything that you know. Vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. Somewhere around 1 per 1,000,000 neck adjustments may be associated with VAD but the rest research on the topic does NOT show a causal relationship. Unfortunately, there is no single, reliable screening procedure to identify patients with neck pain who are at risk of a vertebral artery dissection. If you choose to use one of the above noted "alternatives" options, you may wish to discuss these with your chiropractor or primary medical physician. There are also risks and dangers to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility and/or may result in "central sensitization" and long-term pain.

Informed consent:

You, the patient, are ultimately in charge of your chiropractic care. Only with the patient's permission can treatment commence. The patient may choose to cease care at any time, for any reason. After the ROF and PAR discussion, the doctor will ask the patient for verbal consent to commence treatment. Once consent is given, then care may begin immediately or at the next appointment.

□ I have read and understood this document:

Print Patient Name:_____ Signature:_____ Date: ___/___/___

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Wellness Behaviors Questionnaire: *Select the answer that seems most correct.*

1-I **regularly eat** home-cooked meals with fruit, organic vegetables and meats, poultry or seafood.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

2-I **rarely eat** fast food, processed food, added sugar, desserts, alcohol, caffeine or preservatives.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

3- **Most days**, I walk, jog or run at least 10,000 steps/5 miles per day.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

4- **At least a few times per week**: I move my entire body through its full range of motion and lift, carry, push or pull heavy objects/items/weights in ways that require much of my physical strength.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

5- **Most nights**, I go to bed 'on time' and rarely need an alarm clock to wake me in time to start my day.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

6- I have multiple supportive relationships with family, friends and others. I have one or more supportive social communities/networks (include extended family) and feel a strong sense of belonging.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

7- I **do NOT smoke or use tobacco products**.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

0 1 2 3 4 5 6 7 8 9 10

General Physical Function Questionnaire: Please choose the answer that seems most correct.

"Recently, because of my pain (or other symptoms for which I am seeking treatment) my ability to:

SIT is:
- ❑ Not Limited 0
- ❑ Mildly Limited 1
- ❑ Moderately Limited 2
- ❑ Severely Limited 3

HOLD or CARRY things is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

CARE FOR MYSELF is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

STAND or WALK is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

BEND or REACH is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

SLEEP is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

Print Patient Name:_____ Signature:_____ Date: ___/___/___

This form is 2-sided

Staff use only: WBQ Score ____/70 (0-70, 70=Perfect wellness behavior score)
GPFQ Score ____/18 (0=No functional limitation, 18=Highest possible functional limitation)

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Welcome!

Reason for visit (check one or more):

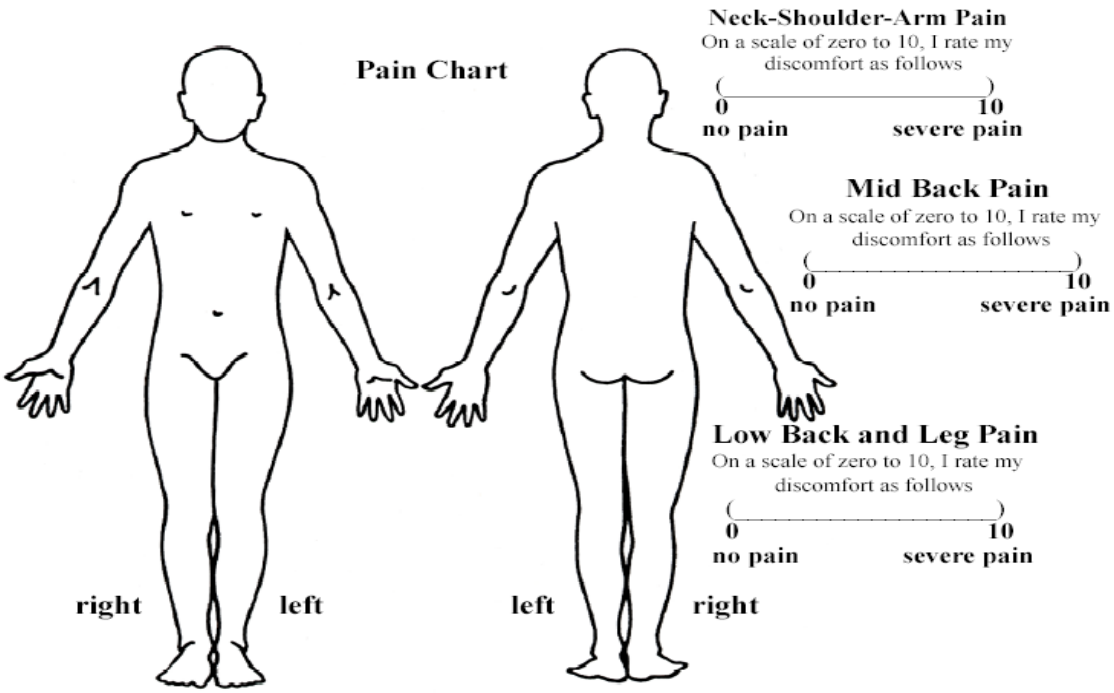
1- __ I am a new patient.
2- __ I am a former patient returning with a new problem (or reoccurrence of an old problem).
3- __ I am a current patient and this is a scheduled re-evaluation.

If you checked #1 or #2 briefly describe your reason for this visit: _____
_____

If you checked #3, has your condition improved since your last exam? __Yes; __No; __ Don't know

Please mark, draw or fill in areas on the body picture (below) **where** you feel any PAIN OR OTHER SYMPTOMS. Mark areas of shooting pain too. Include headaches and any other symptoms that you might have. You can also write words and use arrows to describe your symptoms.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	OOOOO	xxxxx	*****	/ / / / /
- - - - -	OOOOO	xxxxx	*****	/ / / / /
- - - - -	OOOOO	xxxxx	*****	/ / / / /



Are you taking medications (prescription or non-prescription) to alleviate your symptoms? No. Yes.

If yes, what are you taking and how much? _____.

In general, your MAIN symptoms are (circle one): Infrequent Occasional Frequent Constant

Print Patient Name: _____ Signature: _____ Date: ___/___/___

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Revised Oswestry Pain Disability Questionnaire

Patient Name: _____ Date of birth: ___/___/_____ Date: ___/___/_____

Please Read:
This questionnaire has been designed to give your doctor/therapist 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 best describes your condition today.

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition.

Section 1 – Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad but I manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me moderate relief from pain.
- ☐ Pain medication provides me little relief from pain.
- ☐ Pain medication has no effect on the pain.

Section 2 – Personal Care (Washing, Dressing, etc.)
- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights 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 lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking
- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using crutches or a cane.
- ☐ 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 sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing
- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but it increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for 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 pain medication.
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Even when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life
- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex. sports, dancing, etc.)
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Section 9 – Traveling
- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ Pain restricts travel over 2 hours.
- ☐ Pain restricts travel over 1 hour.
- ☐ Pain restricts my travel to short necessary journeys under ½ hour.
- ☐ Pain prevents all travel except for visits to the doctor/therapist or hospital.

Section 10 – Employment/Homemaking
- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job/homemaking chores.

Score (filled out by doctor/clinician): _____%

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REVIEW OF SYSTEMS & Past, Family, Social History & PATIENT-CENTERED QUESTIONNAIRE: Patient or guardian is to fill form out completely. Please do not leave questions unanswered. (Takes 10 minutes) (Revised 4/18)

Print Patient Name: _____ Signature: _____ Date: ___/___/___

PATIENT-CENTERED QUESTIONNAIRE: To be filled out by patient. Circle "A" or "B"

A: I have no particular health problem, condition or injury. I am here for a routine chiropractic check-up. (If you circle 'A', do not proceed below.)

B: I have one or more health symptoms, conditions or injuries that I would like Dr. Collins to focus on. (If you circle 'B', then proceed below.)

1) WHAT IS YOUR MAIN HEALTH PROBLEM/ CONDITION/ INJURY?

2) WHAT CAUSED IT AND WHEN DID IT BEGIN?

3) WHAT DO THINK IS CAUSING YOUR SYMPTOMS?

4) HOW SEVERE IS IT? (mild, moderate or severe)

5) HOW LONG DO YOU BELIEVE IT WILL LAST?

6) WHAT TREATMENT HAVE YOU DONE SO FAR?

7) WHAT KIND OF TREATMENT DO YOU THINK MIGHT HELP YOU?

8) WHAT RESULTS DO YOU EXPECT FROM TREATMENT?

9) WHAT ARE THE MAIN EFFECTS THIS PROBLEM/CONDITION/INJURY HAS ON YOUR LIFE?

10) WHAT DO YOU FEAR MOST ABOUT THIS PROBLEM/CONDITION/INJURY, IF ANYTHING?

11) WHICH TYPE OF CHIROPRACTIC CARE WOULD YOU LIKE TO RECEIVE? (CIRCLE A, B, or C)

A) RELIEF CARE (GET PROPER DIAGNOSIS AND FOCUS MAINLY ON RELIEF OF SYMPTOMS)

B) RELIEF AND CORRECTIVE CARE (CORRECT & MINIMIZE THE UNDERLYING CAUSES)

C) RELIEF and CORRECTIVE and MAINTENANCE (MAINTENANCE AND PREVENTION CARE TOO)

PLEASE LIST ANY/ALL MEDICATIONS (NOT INCLUDING HERBS/VITAMINS) THAT YOU TAKE:

Do you **currently** experience, or have you **regularly experienced in the past** any of the following?

Eye/ Vision Problems: NO / YES
Ear/ Hearing problems: n / y
Sinus/Nose Problems: n / y
Heart Problems: n / y
High Blood Pressure: n / y
High Cholesterol: n / y
Lung/ Breathing Problems: n / y
Digestion Problems: n / y
Problems w/ Bowels: n / y
Problems w/ Urination: n / y
Dizziness: n / y
Blood Sugar Problems: n / y
Allergies: n / y
Fatigue/ Tiredness: n / y
Anxiety or Depression: n / y
(Men) Erection Difficulty: n / y
Weakness n / y
Headache: n / y
Joint Problems: n / y
Skin/Hair/Nail Problems: n / y
Tingling or Numbness: n / y
(Women) Menstrual Problems: n / y
(Women) Ovary/ Uterine Problems: n / y
Sleep Problems: n/y

List Any and All Significant Past Illnesses: _____

_____

_____

_____

List All Hospitalizations & Surgeries:_____

_____

_____

List Any and All Past Major Injuries: _____

_____

_____

_____

Your Work or Daily Activity Is (circle one from each):

1- **Sedentary, Somewhat Physical, Moderately Physical, Very Physical**
2- **Not stressful, Mildly Stressful, Moderately Stressful, Very Stressful**

Describe Your Living Situation (i.e. married, 2 kids):

_____

_____

_____