



Welcome to Our Clinic
Initial Visit Form
 GENERAL INFORMATION (all clients fill out)

Patient Information:

Last Name	First Name	MI	Today's Date
Street address (No PO Box)			How did you hear about us?
City	State	Zip	Social Security # Driver's License #
Home Phone		Sex	Marital Status Date of Birth
Work/Cell Phone:		M <input type="checkbox"/> F <input type="checkbox"/> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Div. <input type="checkbox"/> Wid.	
E-mail Address		Emergency Contact Name & # Phone:	

Insurance Information:

Name of Insured	Date of Birth	Date injury occurred (date of accident)
Your Relationship with Insured		Policy # Claim # / ID #
Insurance Company Name		Accident/Injury type (choose one) <input type="checkbox"/> work <input type="checkbox"/> motor vehicle accident <input type="checkbox"/> other (please explain):
Insurance Claims/Billing Address		
City	State Zip	

CURRENT & PAST MEDICAL INFORMATION

Date of last Physical Exam: _____ Name of Doctor: _____ <input type="checkbox"/> Do not recall when I had my last physical exam	Any current diagnosis being monitored by another Doctor? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Please explain:
Have you had any previous accidents/traumas/falls? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Do not recall Date: _____ Is the injury resolved? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, skip next question) If No, do you have the same or similar conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Do not recall If yes, explain any differences in intensity/frequency/duration of the pain you feel currently:	Have you had any previous work-related injuries? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> Do not recall Is the injury resolved? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, skip to next section) If No, do you have the same or similar conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Do not recall If yes, explain any differences in intensity/frequency/duration of the pain you feel currently:
Explain any previous hospitalizations: <input type="checkbox"/> Do not recall any previous hospitalizations	Have you had any surgeries? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Do not recall What type(s) and date(s)?
List any medications you are currently taking and explain any side-effects: <input type="checkbox"/> N/A <input type="checkbox"/> Insulin <input type="checkbox"/> Cortisone <input type="checkbox"/> Nerve Pills <input type="checkbox"/> Antidepressants <input type="checkbox"/> Shoe lifts /Orthotics <input type="checkbox"/> Blood pressure medication <input type="checkbox"/> Vitamins/supplements <input type="checkbox"/> Pain killer/muscle relaxants <input type="checkbox"/> Aspirin-how often? _____ Any other medications: _____ List any known side effects: _____	Please list any allergies: <input type="checkbox"/> dairy products <input type="checkbox"/> soy <input type="checkbox"/> eggs <input type="checkbox"/> mold <input type="checkbox"/> peanuts <input type="checkbox"/> perfume <input type="checkbox"/> shell fish <input type="checkbox"/> wheat <input type="checkbox"/> pet dander <input type="checkbox"/> poison ivy <input type="checkbox"/> pollen <input type="checkbox"/> smoke <input type="checkbox"/> strawberries <input type="checkbox"/> other <input type="checkbox"/> none Please explain:

FOR AUTO RELATED ACCIDENTS ONLY: (MVA clients only) Not Applicable - Skip to next section

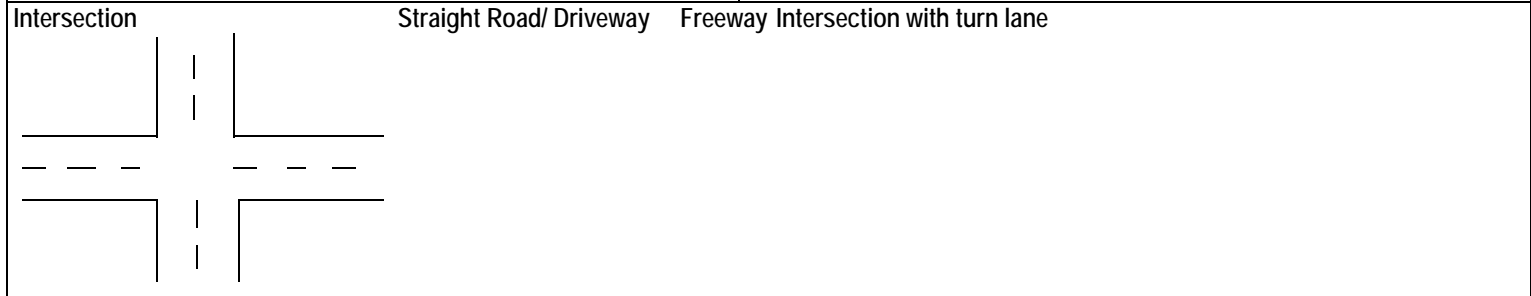
Date of injury: _____ Please describe the incident: _____

How many vehicles were involved in the accident: _____
 Auto: Year _____ Make: _____ Model: _____
 Damage: minor major totaled approx. \$ _____ worth

Was it a: intersection light/stop sign (circle one) not intersection If at a light, was it: green red yellow turn arrow
 Street surface: dry wet slick icy gravel other:

I was: <input type="checkbox"/> Owner of the vehicle <input type="checkbox"/> Pedestrian <input type="checkbox"/> Wearing a seat/lap belt <input type="checkbox"/> In a two-car accident <input type="checkbox"/> Driver <input type="checkbox"/> In the front seat <input type="checkbox"/> Wearing a shoulder harness <input type="checkbox"/> Passenger <input type="checkbox"/> In a single car accident <input type="checkbox"/> Passenger in the back seat <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> motorcycle driver/passenger <input type="checkbox"/> Involved with an uninsured driver/vehicle	My body was positioned: <input type="checkbox"/> looking downward doing something else <input type="checkbox"/> looking at the accident coming <input type="checkbox"/> looking at passenger <input type="checkbox"/> looking straight ahead <input type="checkbox"/> turned to the left/right (please circle) <input type="checkbox"/> looking at oncoming traffic <input type="checkbox"/> looking in the rear view mirror <input type="checkbox"/> looking at the driver <input type="checkbox"/> other-please specify:
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What area(s) on your car were hit? <input type="checkbox"/> front driver side corner <input type="checkbox"/> rear driver side corner <input type="checkbox"/> driver side <input type="checkbox"/> front passenger corner <input type="checkbox"/> rear passenger corner <input type="checkbox"/> passenger side <input type="checkbox"/> front bumper <input type="checkbox"/> rear bumper <input type="checkbox"/> rear trailer <input type="checkbox"/> head on collision <input type="checkbox"/> Totaled <input type="checkbox"/> other:	Was there a secondary impact? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, where was the impact on your car?
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My body hit the: <input type="checkbox"/> steering wheel <input type="checkbox"/> head rest <input type="checkbox"/> side panel <input type="checkbox"/> console <input type="checkbox"/> seat with my chest/abdomen/head/face <input type="checkbox"/> dashboard <input type="checkbox"/> door <input type="checkbox"/> back of driver's seat <input type="checkbox"/> pavement <input type="checkbox"/> other-please explain:	The following parts of my body hit: <input type="checkbox"/> face <input type="checkbox"/> forehead <input type="checkbox"/> nose <input type="checkbox"/> neck <input type="checkbox"/> shoulder <input type="checkbox"/> arm <input type="checkbox"/> hand <input type="checkbox"/> wrist <input type="checkbox"/> fingers <input type="checkbox"/> chest <input type="checkbox"/> abdomen <input type="checkbox"/> hip <input type="checkbox"/> thigh <input type="checkbox"/> knee <input type="checkbox"/> shin <input type="checkbox"/> other-please explain:
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Did you brace before impact? <input type="checkbox"/> No <input type="checkbox"/> Yes	Did you have any warning before the impact? <input type="checkbox"/> No <input type="checkbox"/> Yes
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Did the airbag deploy? <input type="checkbox"/> No <input type="checkbox"/> Yes	Does your car have headrests? <input type="checkbox"/> No <input type="checkbox"/> Yes
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ACCIDENT & INJURY INFORMATION ONLY Not Applicable - Skip to next section

As a result of the accident, were you: Rendered unconscious Shaken but could function Vague about what happened Dazed
 Able to get up/out of car and walk unassisted Unable to move certain body parts (list parts and why) Bruised or bleeding (describe injuries)
 Bruised or bleeding (describe injuries)

Were you seen by Emergency Medical Staff at the scene? <input type="checkbox"/> No <input type="checkbox"/> Yes	Did you visit a hospital ER? <input type="checkbox"/> No <input type="checkbox"/> Yes (Hospital name?) What areas were checked / treated?
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Do you recall hitting your head? <input type="checkbox"/> Do not recall if I did or did not hit my head <input type="checkbox"/> Yes, I recall hitting my head <input type="checkbox"/> No, I did not hit my head	Have you made any follow-up visits for your injuries? <input type="checkbox"/> No <input type="checkbox"/> Yes (with whom?)
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Did the pain occur more than 2 weeks ago? <input type="checkbox"/> No <input type="checkbox"/> Yes	Have x-rays been taken? <input type="checkbox"/> No <input type="checkbox"/> Yes (by who?/which body parts?)
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Did you report this incident to your insurance company or appropriate personnel? No Yes

Have you retained an attorney to represent you for this accident <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes please provide the following for our records: Attorney Name: _____ Attorney Address: _____ Phone Number: _____
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SYSTEMS REVIEW - Please review the following lists of conditions. If you have had a condition in the past, check the "Past" box. If you currently have a condition, check the "Now" box.

Past Now GENERAL		Past Now GASTRO-INTESTINAL		Past Now EYE EAR NOSE THROAT	
<input type="checkbox"/>	Headaches 784.0	<input type="checkbox"/>	Poor Appetite 783	<input type="checkbox"/>	Poor vision 368.9
<input type="checkbox"/>	Fever 780.6	<input type="checkbox"/>	Poor Digestion 536.8	<input type="checkbox"/>	Crossed Eyes 378.9
<input type="checkbox"/>	Chills 780.9	<input type="checkbox"/>	Excessive Hunger 994.2	<input type="checkbox"/>	Pain in Eyes 379.91
<input type="checkbox"/>	Night Sweats 780.8	<input type="checkbox"/>	Belching or Gas 787.3	<input type="checkbox"/>	Deafness 389.9
<input type="checkbox"/>	Fainting 780.2	<input type="checkbox"/>	Nausea 787	<input type="checkbox"/>	Earache 388.7
<input type="checkbox"/>	Dizziness 780.4	<input type="checkbox"/>	Vomiting 78	<input type="checkbox"/>	Ear Noises 388.3
<input type="checkbox"/>	Convulsions 780.3	<input type="checkbox"/>	Vomiting Blood 578	<input type="checkbox"/>	Ear Discharges 388.6
<input type="checkbox"/>	Loss of Sleep 780.52	<input type="checkbox"/>	Pain over Stomach 536.8	<input type="checkbox"/>	Nasal Obstruction 478.1
<input type="checkbox"/>	Fatigue 780.7	<input type="checkbox"/>	Constipation 564	<input type="checkbox"/>	Nose Bleeds 784.7
<input type="checkbox"/>	Nervousness 799.2	<input type="checkbox"/>	Diarrhea 558.9	<input type="checkbox"/>	Sore Throat 462
<input type="checkbox"/>	Weight Loss 783	<input type="checkbox"/>	Colon Troubles 789	<input type="checkbox"/>	Hoarseness 784.49
<input type="checkbox"/>	Pain/Numb limbs 782	<input type="checkbox"/>	Hemorrhoids/Piles 455.6	<input type="checkbox"/>	Hay Fever 477.9
<input type="checkbox"/>	Allergy 995.3	<input type="checkbox"/>	Liver Trouble 785.1	<input type="checkbox"/>	Asthma 493.9
<input type="checkbox"/>	Wheezing 786.09	<input type="checkbox"/>	Jaundice 782.4	<input type="checkbox"/>	Frequent Colds 460
<input type="checkbox"/>	Neuralgia 729.2	<input type="checkbox"/>	Gall Bladder Trouble 575.9	<input type="checkbox"/>	Enlarged Thyroid 240.9
				<input type="checkbox"/>	Tonsillitis 463
				<input type="checkbox"/>	Sinus Troubles 686.9

Past Now FOR WOMEN ONLY		Past Now MUSCLES & JOINTS		Past Now CARDIO-VASCULAR	
<input type="checkbox"/>	Painful Periods 786.2	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	Rapid Heart 783
<input type="checkbox"/>	Excessive Flow 626.2	<input type="checkbox"/>	Twitching	<input type="checkbox"/>	Slow Heart 427.89
<input type="checkbox"/>	Irregular Cycles 626.4	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	High Blood Pressure 401.9
<input type="checkbox"/>	Hot Flashes 627.2	<input type="checkbox"/>	Backache 722.10	<input type="checkbox"/>	Low Blood Pressure 458.9
<input type="checkbox"/>	Cramps/Backache 625.3	<input type="checkbox"/>	Swollen Joints 719	<input type="checkbox"/>	Pain over Heart 786.51
<input type="checkbox"/>	Miscarriage 634.9	<input type="checkbox"/>	Tremors 781	<input type="checkbox"/>	Heart Trouble 438
<input type="checkbox"/>	Vaginal Discharge 623.5	<input type="checkbox"/>	Foot Troubles 729.5	<input type="checkbox"/>	Ankle Swelling 719.07
<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	Painful Tail Bone 724.79	<input type="checkbox"/>	Poor Circulation 459.9
		<input type="checkbox"/>	Pain between Shoulders 724.5	<input type="checkbox"/>	Varicose Veins
		<input type="checkbox"/>	Hernia 553.9	<input type="checkbox"/>	Strokes 436
		<input type="checkbox"/>	Spinal Curvature 737.3		

Past Now SKIN OR ALLERGIES		Past Now GENITAL/URINARY		Past Now RESPIRATORY	
<input type="checkbox"/>	Skin Eruptions 368.9	<input type="checkbox"/>	Frequent Urination 788.3	<input type="checkbox"/>	Chronic Cough 786.2
<input type="checkbox"/>	Itching 698.9	<input type="checkbox"/>	Pain on Urination 788.1	<input type="checkbox"/>	Spitting Blood 786.3
<input type="checkbox"/>	Bruise Easily 287.8	<input type="checkbox"/>	Blood in Urine 599.7	<input type="checkbox"/>	Spitting Phlegm 933.1
<input type="checkbox"/>	Dryness 701.1	<input type="checkbox"/>	Kidney Infection 592	<input type="checkbox"/>	Chest Pain 786.50
<input type="checkbox"/>	Boils	<input type="checkbox"/>	Bed Wetting 788.3	<input type="checkbox"/>	Difficulty Breathing 786.09
<input type="checkbox"/>	Sensitive Skin 782	<input type="checkbox"/>	Can't control Urination 788.1		
<input type="checkbox"/>	Hives/Allergy 708.9	<input type="checkbox"/>	Prostate Trouble 601.9		
<input type="checkbox"/>	Eczema 692.9				
<input type="checkbox"/>	Medicines				

CHECK ANY CONDITIONS OR DISEASES YOU HAVE HAD:							
<input type="checkbox"/>	Appendicitis 541	<input type="checkbox"/>	Anemia 285.9	<input type="checkbox"/>	Heart Disease 429.9	<input type="checkbox"/>	Arthritis 716.9
<input type="checkbox"/>	Pneumonia 541	<input type="checkbox"/>	Measles 285.9	<input type="checkbox"/>	Goiter 429.9	<input type="checkbox"/>	Epilepsy 716.9
<input type="checkbox"/>	Rheumatic Fever 541	<input type="checkbox"/>	Mumps 285.9	<input type="checkbox"/>	Influenza 429.9	<input type="checkbox"/>	Mental Disorder 716.9
<input type="checkbox"/>	Polio 541	<input type="checkbox"/>	Chicken Pox 285.9	<input type="checkbox"/>	Pleurisy 429.9	<input type="checkbox"/>	Lumbago 716.9
<input type="checkbox"/>	Tuberculosis 541	<input type="checkbox"/>	Diabetes 285.9	<input type="checkbox"/>	Alcoholism 429.9	<input type="checkbox"/>	Eczema 716.9
<input type="checkbox"/>	Whooping Cough 541	<input type="checkbox"/>	Cancer 285.9	<input type="checkbox"/>	Venereal Disease 429.9		

FAMILY HISTORY							HABITS Are you currently?	
	Diabetes	Heart	Kidney	Cancer	Back	None	Tobacco _____ pack(s) / day	
Mother:	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol _____ drink(s) / day	
Father:	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coffee _____ cups(s) / day	
Brothers:	How Many? ()	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soft drinks _____ cups(s) / day	
Sisters:	How Many? ()	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep _____ hours(s) / day	
							Water _____ oz(s) / day	

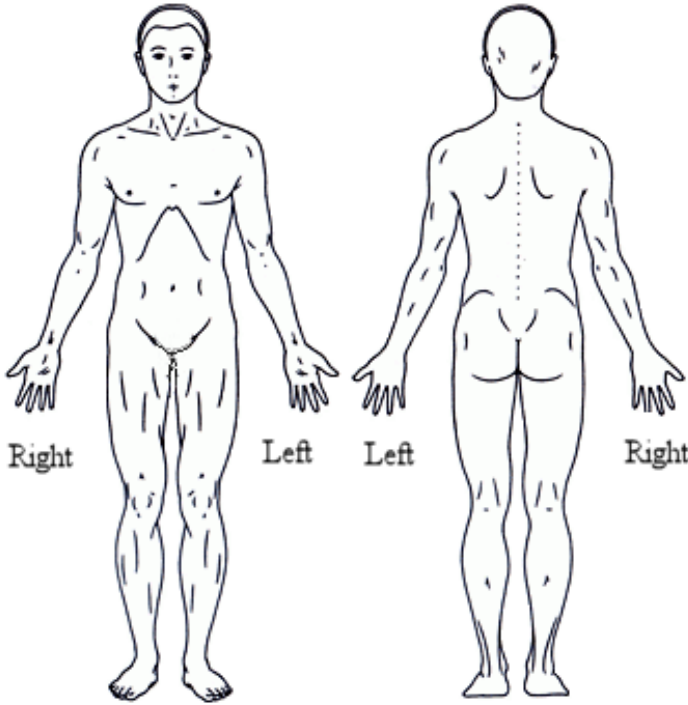
General Family History:				None				Light				Mod.				Heavy			
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Sugar	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Salty foods	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Stress	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	High Blood Pressure					<input type="checkbox"/>	Exercise	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			

PAIN INDEX AND LOCATION CHART

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols from this chart. Mark areas of radiation (pain that spreads). Include all affected areas.

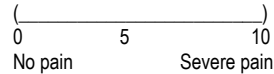
Numbness	Burning	Pins & Needles	Shooting Pain	Aching/Dull	Stabbing
-----	#####	0000000	x x x x x x	*****	/////////

Please mark the pain scale from Zero to 10 the pain you feel with this condition. 1-4 uncomfortable, 5-6 distressing, 7-8 affecting daily activities, 9-10 unbearable.



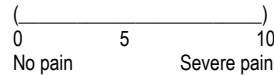
Neck-Shoulder-Arm Pain

On a scale of zero to 10, I rate my Discomfort as follows



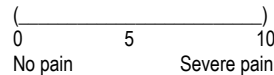
Mid Back Pain

On a scale of zero to 10, I rate my Discomfort as follows



Low Back and Leg Pain

On a scale of zero to 10, I rate my Discomfort as follows



CURRENT MEDICAL SYMPTOMS

CHECK ANY SYMPTOMS YOU HAVE NOTICED SINCE THIS INCIDENT:

- | | | | | | |
|---|---|--|---|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Difficulty with Memory | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Concentration Problems | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Heavy Head |
| <input type="checkbox"/> Jaw Pain, itch, and sharp | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Aggravation by noise | <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Jaw Clicking | <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Foot Pain | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Depression | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Uncoordinated |
| <input type="checkbox"/> Ear fullness, plugged | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Irritable | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Grind teeth at night | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Fainting | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Fluid in Ears | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Fatigue | <input type="checkbox"/> No longer care | <input type="checkbox"/> Regional Swelling |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Urinary Difficulties |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Change of smell or taste | <input type="checkbox"/> Emotional difficulty | <input type="checkbox"/> Writing problems |
| <input type="checkbox"/> Face Numbness | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Difficulty thinking | <input type="checkbox"/> Intolerance to Heat | <input type="checkbox"/> Loss of attention |
| <input type="checkbox"/> Facial pain (784.0) | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Intolerance to Cold | <input type="checkbox"/> Forget ATM/phone #s | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Pain Radiating into legs (724.4) | <input type="checkbox"/> Mid-back Pain | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Personality Changes | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Pain Radiating into arms (724.4) | <input type="checkbox"/> Low-back Pain | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Relationship difficulty | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Pins and Needle in arm | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> Intolerance to Alcohol | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Pins and Needle in leg | <input type="checkbox"/> <input type="checkbox"/> | | | |
| <input type="checkbox"/> Whiplash (847.0) | <input type="checkbox"/> Pain Radiating into head from neck (723.2) | | | | |
| | <input type="checkbox"/> Pain Radiating into head from back (724.4) | | | | |

NAME: _____ DATE: _____ CLAIM NUMBER: _____

CURRENT MEDICAL SYMPTOMS (Cont'd)

How long/regularly do you experience the pain or symptom? <input type="checkbox"/> all the time <input type="checkbox"/> during the day <input type="checkbox"/> during the night <input type="checkbox"/> more than 6 hours <input type="checkbox"/> less than 1 hour <input type="checkbox"/> in intervals-how long each time? <input type="checkbox"/> other-please explain: _____	What makes the symptoms better? <input type="checkbox"/> aspirin <input type="checkbox"/> movement - in what direction: _____ <input type="checkbox"/> heat <input type="checkbox"/> ice <input type="checkbox"/> massage <input type="checkbox"/> muscle relaxants <input type="checkbox"/> rest <input type="checkbox"/> stretching <input type="checkbox"/> bed rest <input type="checkbox"/> elevation <input type="checkbox"/> <i>nothing</i> <input type="checkbox"/> other-please explain: _____
Describe any activities that make symptoms worse:	How and when did the pain or symptom begin:
Describe any additional information regarding your condition:	

TYPE OF CARE

People go to a Chiropractor for a variety of reasons. Your Doctor will consider your needs and desires when recommending your treatment program. Please check the type of care you desire so that we may be guided by your wishes whenever possible:

- Comprehensive Care – to bring your body to the highest optimum health
- Corrective Care – to relieve symptoms and correct fundamental problem
- Symptomatic Care – to relieve the symptoms, but not to correct the fundamental problem
- Maintenance Care – to maintain your current level of health
- Annual Physical Exam or D.O.T.
- Check here if you want the Doctor to select the type of care appropriate to your condition

DATE: _____

SIGNATURE: X _____

NAME: _____ DATE: _____ CLAIM NUMBER: _____

FINANCIAL AGREEMENT (Please read and sign)

I authorize my insurance company to issue payment directly to this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions.

We will call to verify eligibility and benefits as a courtesy to our patients. As the insurance policy is a contract between the patient and the insurance company, we cannot guarantee these benefits. Any amount that the insurance company does not cover becomes the responsibility of the patient, regardless of any reduction, denials or arbitrary determination of usual and customary fees. We advise our patients to verify their own insurance.

In order to have insurance billing privileges extended to me, I understand that I must: report my accident to my auto insurance company claims office and provide the auto insurance company with all necessary PIP (Personal Injury Protection) applications.

I have read, understand, and agree to the financial agreement stated above.

_____ X _____
Date Patient Signature, or Parent/Legal Guardian for patient under 18 years

_____ _____
Date Witness' Signature

NAME: _____ DATE: _____ CLAIM NUMBER: _____

OUR CANCELATION POLICY & OFFICE NOTICE

An appointment is a commitment by yourself and the Doctor to set aside time to treat you. Therefore, we request that our patients notify us at least 24 hours in advance when canceling or rescheduling an appointment so that we may make the appointment available to those who need it.

We reserve the right to charge a Missed Appointment Fee of \$25.00 to those patients who miss their appointment without notifying us, or who cancel/ reschedule an appointment with less than 24-hour notice. This fee is not covered by insurance and will need to be paid by the patient.

So as not to inconvenience those who arrive at their appointed time, late comers may receive shortened treatment at the regular treatment fee. Those who arrive for their scheduled appointments will be served first.

Also, we are not responsible for lost or stolen personal items. We are not responsible for your children or any children that might be with you during your visit. We are not responsible for any injuries that occur at home from doing exercises the Doctor gives you.

We value your business and strive to ensure that we are always available to you when you need us. Thank you.

I understand and agree to the above:

X _____
Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & Motor Vehicle Collision General Precautions and Instructions

I, _____ (your name), acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Enterprise Chiropractic and the Motor Vehicle Collision General Precautions and Instructions, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice and provides instructions for care at home.

X _____
Patient Signature Date

Print Name

For Office Use Only

The Practice has made a good-faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practices. In an effort to obtain it, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner: Personally Mail Phone Follow-up Other _____

In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons:
 Patient unavailable Patient physically unable Patient unwilling. Signature/Date _____

NAME: _____ DATE: _____ CLAIM NUMBER: _____



**IRREVOCABLE DOCTOR'S LEIN
AND ASSIGNMENT OF RIGHT TO RECOVERY**

Name: _____ Date: _____ Claim Number: _____

In consideration and exchange for not having to immediately pay a debt owed and in consideration for receiving future care at or by the Clinic and Doctor on whose letterhead this document is printed (hereinafter "Clinic"), I, the undersigned, hereby assign and convey to the Clinic a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain accident or injury-producing event which occurred on or about _____, to the full extent of the cost and treatment provided or to be provided to me by the Clinic.

I hereby authorize and direct my attorney(s) to hold in trust, and to pay directly to the Clinic such sums as may be due and owing the Clinic for treatment and other professional services rendered me both by reason of this accident and by reason of any other bills that are due the Clinic and to withhold such sums from any given, grant and convey a lien on my case to the Clinic against any and all proceeds of any and all causes of action, settlements, judgments or verdicts which may be paid to or through my attorney, or myself, as the result of injuries or conditions for which I have been treated by the Clinic.

If no attorney is trusted with my case, I understand that the insurance will directly pay the Clinic for all services rendered as a result of this accident and any other bills that are due.

I fully understand that I am directly and fully responsible to the Clinic for all bills incurred for services rendered me and that this agreement is made solely for the Clinic's additional protection and in consideration contingent on any settlement, judgment or verdict by which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or cause.

I fully understand that if my attorney(s) does/do not protect the Clinic's interest, the Clinic may require me to make payments on a current basis. The Clinic may also bring a cause of action against my attorney(s) for failing to honor this binding and irrevocable agreement between me and the Clinic.

I further understand and agree that the Clinic *is not* responsible for paying any of my attorneys' fees and the Clinic *does not* agree to pay my attorney fees for honoring this agreement between me and the Clinic.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT THE CLINIC'S AND DOCTOR'S INTEREST AT TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS TO THE CLINIC. I ALSO KNOW I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT AND LEIN.

_____ X _____
Print Patient Name Patient Signature Date

_____ X _____
Print Lawyer/Adjuster Name Lawyer/Adjuster Signature Date

NAME: _____ DATE: _____ CLAIM NUMBER: _____

INFORMED CONSENT (Revision II. August 2011)

PATIENT NAME: _____ DATE: _____ CLAIM #: _____

Chiropractors have been providing great health care services to patients for more than 100 years. Many patients with acute and chronic spine-related and extremity disorders and joint stiffness, arm and leg complaints, and other musculoskeletal conditions or injuries have benefited by having chiropractic care. In order for the chiropractor to determine what types of treatment may be beneficial to you, it is necessary to perform a physical examination of your spine and other joints. Identifying subluxations or abnormal joint function is achieved by looking at x-rays and/or during the examination which involves moving various joint(s) or areas of your body in specific directions to determine how well each of the painful or restricted joints or bony structures of your body moves or is positioned when compared to the normal population. Spinal manipulation, a procedure that involves the application of controlled mechanical forces to specific joint structures, has the goal of improving and restoring normal joint motion of the spine and other joints. Better joint alignment and motion improves the function and health of the joint and nerves and thus reduces inflammation and reduces related symptoms. After treatment, most of our patients experience increased flexibility, feel less pain and other symptoms, and are able to return to their normal physical activities at work and home. The goal of chiropractic care is to improve and normalize the quality of joint motion in the affected areas of your body, to encourage you to adopt good lifestyle habits such as exercise and good nutrition, and assist you during the recovery process. Rejecting chiropractic care may lead to progression of joint restrictions and symptoms and further compromise your ability to perform activities at home and work.

There are various alternative types of non-chiropractic treatment available for patients, who have your type of conditions (s), including: acupuncture, physical therapy, or seeking care from a medical doctor.

It is not reasonable to expect the doctor to anticipate, or explain, all possible risks of a given procedure on any particular visit and I wish to rely on the doctor to exercise professional judgment during my course of treatment to be in my best interest. An undesirable result does not necessarily indicate an error in judgment or improper treatment some patients may experience short term increase of pain and other symptoms or muscle and ligaments strains or sprains as a result of manipulation and manual therapy techniques such as joint mobilization or deep massage. Some rare complications of chiropractic care could include sprain/strain, fracture, disc injury, dislocations, nerve injuries and cerebral vascular accidents. These are extremely rare and not expected in this case. I understand my condition and the recommended treatment plan as it was explained to me. I understand that this plan is based upon my current findings and appropriate treatment guidelines but may change according to daily treatment needs and/or service availability.

I voluntarily consent to the performance of chiropractic examination, manipulation and other chiropractic procedures, on myself (or the patient named below, for whom I am legally responsible) by said chiropractor (see below), his/her preceptor (s), and/or other licensed doctors of chiropractic who now or in the future provide chiropractic treatment for me. This consent includes other doctors of chiropractic that are employed by, associated with, or serve as back-up for said chiropractor, whether or not their names are listed on this form. I understand that the results from the chiropractic treatment are not guaranteed for my condition. The doctor has discussed the goals and potential benefits of the proposed treatment, other alternative types of treatment for my condition and the associated risks by having chiropractic examination and procedures. I have had the opportunity to read this form and understand the above statements, accept the risks mentioned, and hereby consent and agree to the recommended chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: X _____

NAME: _____ RELATIONSHIP: _____

Indicate your name and relationship (parent/guardian/personal representative) if signing for a patient (minor):

OFFICE WITNESS SIGNATURE: _____ DATE: _____

NAME: _____ DATE: _____ CLAIM NUMBER: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION-RECORDS

Last name:	MI:	First Name:
Home Address:	City:	State: Zip:
Date of Birth:	Social Security/ID Number:	

The 1996 Health Insurance Portability and Accountability Act (HIPAA) require that all health care providers comply with the patient privacy and security laws (45 CFR Parts 160, 164). Patient confidentiality and privacy/security applies to any protected health information (PHI) contained within the medical records. Federal Law now require signed and dated authorization from patients in several aspects of patient care, transmission of medical information, confidentiality, and patient rights relating to their release of medical records.

LIST PURPOSE(S) FOR WHICH THE INFORMATION IS NEEDED: _____

AUTHORIZATION EXPIRATION. Without my express revocation, this authorization will expire 12 months from the date signed: (1) upon satisfaction of the need for disclosure; (2) on date (supplied by patient) _____; (3) under the following conditions (examples: case closure, termination of plan benefits, ECT) _____

RELEASE AUTHORIZATIONS (Patient, please initial the following section(s) that apply to you.

_____ Initial. **Doctor/Medical Facility.** I authorize release of entire set of my medical records including: intake forms, history, diagnosis, treatment, consultation, neurological/laboratory/radiologic scan or test results, disabilities, billing information, reports, correspondence, and medical records from other sources to the following doctor/facility/person:

List Name/Address: _____

_____ Initial. **Insurance-Medical Plans.** I authorize said doctor to communicate with, send updated billing, reports, and release all medical records necessary to process this claim to the following insurance companies and/ or governmental agencies listed below:

List: _____

_____ Initial. **Attorney.** I authorize said doctor to communicate with my retained attorney (paper, electronic, and oral). I further authorize the release of reports, all medical and treatment records, billing records photos, and other records necessary to process my claim. This authorization is valid until the case is closed or at the conclusion of litigation and said doctors bills have been fully paid.

Name of attorney: _____ Number of attorney: _____

Date of Injury: _____

_____ Initial. **Family/ Friend.** I authorize said doctor to communicate with the following friend/family member about my health condition and recommendations. Name of person(s): _____ Number of person: _____

_____ Initial Yes No: [Special Limitations for Release of Sensitive Protected Health Information.] I specifically authorize the release of HIV/AIDS test results, sexually transmitted or communicable disease notes (such as Hepatitis or venereal diseases), drug, alcohol, or substance abuse or treatment notes, behavioral, mental health disabilities or developmental disability, (including mental retardation), abuse, neglect or domestic violence, sickle cell anemia, government research, or genetic testing information. The recipient is prohibited from redisclosing such sensitive PHI information without my authorization unless permitted by state and Federal law. List any other special restrictions that you want limited (e.g., psychiatric/psychological records): _____

AUTHORIZATION

- ✓ I certify that this request has been made freely, voluntarily and without coercion and that the information is accurate.
- ✓ I voluntarily authorize and request that my health information (including paper, oral, and electronic interchange) be released to the above sources as set forth on this form.
- ✓ I can revoke this authorization at any time by giving my written revocation in writing to said doctor's office. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this authorization.
- ✓ The disclosing health care provider/plan may NOT condition treatment, enrollment in the health plan or eligibility for benefits on whether I sign this authorization.
- ✓ Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal and state law.
- ✓ I have the right to request a list of doctors, facilities, and/or government agencies which have been sent my medical records.

_____ X _____
(Date) (Signature of Patient)

_____ X _____
(Date) (Signature of person authorized by law)

NAME: _____ DATE: _____ CLAIM NUMBER: _____

REQUEST FOR MEDICAL RECORDS

PATIENT NAME: _____ DATE: _____

Patient Identification:	Social security: Medical record No:	Date of Birth:
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Request Records From (Name and address of Doctor/ Facility where patient's medical records are presently located):

Name:	
Address:	

SEND THE SPECIFIED AND AUTHORIZED MEDICAL RECORDS TO:

Doctor's Name:	Dr. Albert Noble D.C. Enterprise Chiropractic Clinic
Address:	10576 SE Washington St, Portland, OR, 97213
Telephone:	503-252-5320

WHAT MEDICAL RECORDS ARE AUTHORIZED TO DISCLOSE AND MAIL:

- All Medical Records
- X-Ray/MRI/CT reports
- EMG, SSEP, Nerve Conduction, Laboratory tests, Diagnostic Test Report.
- Other _____

SPECIFIC DATES AUTHORIZED FOR RECORDS RELEASE

Medical records from (insert date) _____ to (insert date) _____

PURPOSE OF RELEASE OF INFORMATION

- At request of above patient
- Other:

I hereby request and authorize disclosure of the above protected health information in my medical records kept at your office or facility to be photocopied, released and mailed to above doctor/facility at the indicated address for the specified dates. I understand that the Health Insurance Portability and Accountability Act (HIPAA) apply to my medical records and protected health information. I expect the holder of my medical records to mail my specified medical records as soon as reasonably possible, not to exceed 30 days if kept on-site, and 60 days if stored off-site, once this request has been received. This authorization may be revoked by me, at any time, by advising the doctor's office (privacy officer) of this revocation in writing, except to the extent a source of information has already relied on it. I have been advised that if I choose to not sign this authorization that it will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payment.

EXPIRES: This authorization is good for 12 months from the date signed for the disclosure of the information described above.

*This authorization does not apply to any record/notes regarding HIV/AIDS, communicable disease, alcohol or drug treatment, mental health information, behavioral health care, domestic violence, genetic testing, and psychiatric or psychotherapy notes.

PATIENT NAME (Print clearly): _____
 INDIVIDUAL AUTHORIZING DISCLOSURE (Signature): _____ DATE: _____
 If not signed by patient, specify basis for your authority to sign: Parent of minor, Guardian

This general and specific authorization to disclose was developed to comply with the provisions regarding disclosure of medical information under HIPAA: 45 CFR Parts 160 and 164, 42 CFR part 2, 38 CFR parts 99 and 300, and State Law.

PATIENTS COPY

NAME: _____ DATE: _____ CLAIM NUMBER: _____

ENTERPRISE CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of Our Privacy Practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of **04/15/03**, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the Privacy Practices described below at any time in accordance with applicable law. Prior to making significant changes to our Privacy Practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you upon request. Any changes we make to our Privacy Practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our Privacy Practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you, we will likely use and disclose health information about you for treatment, payment, and health care operations. Examples of these activities are as follows:

- **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare Operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

NAME: _____ DATE: _____ CLAIM NUMBER: _____

ENTERPRISE CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES (Cont'd)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

C. **DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. **MARKETING:** We will not use your health information for marketing communications without your written authorization.

E. **USES OR DISCLOSURES REQUIRED BY LAW:** We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. **PATIENT AND THIRD PARTY PROTECTION:** Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. **LAW ENFORCEMENT / NATIONAL SECURITY:** Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities.

H. **APPOINTMENT REMINDERS:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

A. **ACCESS TO RECORDS:** Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you \$0.25 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

NAME: _____ DATE: _____ CLAIM NUMBER: _____

ENTERPRISE CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES (Cont'd)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

B. ACCOUNTING OF CERTAIN DISCLOSURES: Upon written request, you have the right to receive a list of instances in which we, or our business associates, disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions, we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form as well.

QUESTIONS AND COMPLAINTS:

If you want more information about our Privacy Practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decision we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

CONTACT: Dr. Albert Noble, Enterprise Chiropractic Clinic
FAX: 503-639-2052
E-MAIL: info@drnoble.net

NAME: _____ DATE: _____ CLAIM NUMBER: _____

GENERAL PRECAUTIONS AND INSTRUCTIONS

Strong and very rapid forces may be involved in your automobile accident. It is important that you watch for any new symptoms that might be a sign of hidden injury and/or increased inflammation. It is normal to feel soreness, pain, and tightness in your body, often getting worse the second or third day. However, more severe pain and new symptoms such as numbness, tingling, balance issues, and weakness in your arms and legs should be reported to your doctor as soon as possible. Although you may have a lot of soreness, stiffness, and/or pain, most people recover over time.

As a result of a motor vehicle collision, some people feel a general sense of stress or anxiety which can lead to trouble sleeping or irritability. Some people feel like avoiding driving in vehicles for some time. In the majority of cases, these feelings go away within a few days or weeks.

AVOID NEW INJURIES

It is important for the first week or two weeks to avoid any high-risk physical activities or contact sports that may re-injure you and cause new injuries. Avoid excessive jarring activities or extreme physical activities, such as heavy lifting.

HOME CARE

It is important to comply with the home recommendations that the doctor gives you. Your doctor will be giving you advice about how important it is to keep physically active during the healing process.

- Do not sit-up in bed watching TV or reading or sit on soft couches. Firmer chairs are advised.
- Avoid twisted positions with your neck and back
- Lie on the floor or bed with your legs and knees bent with a pillow under your knees to reduce back pain
- Change your body position every 30 minutes for the next week
- Do slow and gentle stretches 4-6 times a day for 1-2 minutes. Do not push into moderate or severe pain. Stretches can include sitting shoulder rolls, lying on the floor and gently holding each knee to the chest, and general flexibility motions for the neck and back. As you feel better the stretches can be increased.
- Take short walks every day (start with level surface) for 5-10 minutes and repeat 3-4 times each day. Work up to longer walking periods and gradually increase your walking speed and time. The goal is to get you walking an hour a day. Once you feel better then you can walk up hills.
- Avoid sitting/standing or any awkward positions for prolonged periods for the next two weeks.
- Use good posture and proper body mechanics over the next few weeks.
- Getting an extra 30-60 minutes of extra sleep a night is recommended for the first week. Make certain to get restful sleep.
- Use ice for the following 3-4 days. Place a thin towel between the ice pack and your skin and keep the ice on for the prescribed length of time. Do not fall asleep with ice pack on. Neck: ice for 10-15 minutes Back: ice for 20-30 minutes.

GOALS OF THIS OFFICE

The primary goal of this office is to restore your ability to return to your normal pre-injury physical activities of daily living; including work, home, sports, and recreational activities. Our office focuses on improving joint and soft-tissue function by providing appropriate therapies to injured areas thus assisting your body in healing, reducing pain levels and aiding in your recovery. Your active participation at home and work is important in the recovery process and your compliance with the appointments and exercise recommendations will improve your outcome.

MONITORING YOUR PROGRESS IS IMPORTANT TO OUR OFFICE

Our office staff will periodically ask you to fill out additional paperwork that is designed to document your response to spinal manipulation and other therapies/procedures. Your responses allow our office to determine if your treatment outcome is on track, if your treatment needs to be changed or modified, if further testing is indicated, if a consultation by another health care provider is needed, or if a referral is indicated.

FOLLOW-UP APPOINTMENTS

It is important that you keep all of your appointments and follow all home instructions, including exercise, stretching, use of ice, and watching your posture. Call your doctor if you have any problems. If you miss or do not show-up for two appointments, our office will need to talk to you about your absence and find some way to work with your schedule. If four scheduled appointments are missed the office may refer you to another provider, depending upon circumstances.