

PATIENT NAME (FIRST, MIDDLE, LAST)			SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH (MM/DD/YYYY)	AGE
ADDRESS		CITY		STATE	ZIP
HOME # () -	CELL # () -	WORK # () -		EMAIL	
SOC. SECURITY #	EMPLOYER		OCCUPATION/TITLE		
EMERGENCY CONTACT/RELATIONSHIP				CONTACT # () -	
PLEASE COMPLETE IF PATIENT IS MINOR					
RESPONSIBLE PARTY (RP) NAME/RELATIONSHIP					
ADDRESS				HOME #	
RP EMPLOYER				WORK #	
PLEASE COMPLETE THIS SECTION FOR INSURANCE ONLY					
INSURANCE CARRIER				PHONE #	
ID #				GROUP #	

I hereby authorize my insurance benefits to be paid directly to Ong Family Chiropractic and/or Dr. Nelson S. Ong, D.C. and authorize the release of any information necessary to process my claim. A copy of this authorization shall be as valid as the original.

SIGNATURE OF PATIENT/AUTHORIZED PERSON

DATE

APPOINTMENT CANCELLATION POLICY

PLEASE CALL US AT LEAST 24 HOURS IN ADVANCE IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT. IF A PATIENT FAILS TO CANCEL WITHIN 24 HOURS OF SCHEDULED APPOINTMENT, THEY MAY BE CHARGED A **\$25 CANCELLATION FEE**.

I, THE PATIENT AND/OR GUARDIAN, FULLY UNDERSTAND AND ACKNOWLEDGE THE RECOMMENDED TREATMENT PLAN AND THE CANCELLATION POLICY.

PATIENT/GUARANTOR SIGNATURE

DATE

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedure, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Dr. Nelson S. Ong, D.C. and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in practice of medicine, the practice of chiropractic, which involves the use of hands in such a way to restore proper motion to the joints, there are some risks of treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. Tests are employed in the doctor's exams to identify if I am susceptible to an injury such as stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedure. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I consent the entire course of treatment for my present condition and any future care I may receive from Dr. Nelson S. Ong, DC or any other licensed doctor of chiropractic working in their stead.

PRINT PATIENT'S NAME

SIGNATURE OF PATIENT

DATE SIGNED

SIGNATURE OF WITNESS

DATE SIGNED

PRINT REPRESENTATIVE'S NAME

SIGNATURE OF REPRESENTATIVE

RELATIONSHIP OF REPRESENTATIVE

DATE SIGNED

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient(s):

We are required to provide you with a copy of our Notice of Privacy Practices which outlines how we may use and/or disclose your health information. Please review the Notice of Privacy Practices and complete this form as an acknowledgment of receipt. If you decline to provide a signed acknowledgment, we will continue to provide treatment and will use and disclose your protected health information for treatment, payment, and health care operations consistent with federal and state law.

PRINT PATIENT'S NAME

PRINT REPRESENTATIVE'S NAME (if applicable)

SIGNATURE OF PATIENT

SIGNATURE OF REPRESENTATIVE

DATE SIGNED

RELATIONSHIP OF REPRESENTATIVE (i.e. parent)

DATE SIGNED

HEALTH SURVEY

PATIENT NAME: _____ **DATE:** _____

PLEASE MARK ALL CONDITIONS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

GENERAL

- | PAST | PRESENT | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruise Easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Fevers |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Night Sweats |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |

CARDIOVASCULAR

- | PAST | PRESENT | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Fast Heart Rate |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Open Heart Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Circulation |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |

SYSTEMIC (CONT.)

- | PAST | PRESENT | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Mumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | Polio |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Smoking/Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |

GENITOURINARY

- | PAST | PRESENT | |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |

FEMALES ONLY

- Never Pregnant
 Currently Pregnant (# of months: ___)
 # of Births: _____

MUSCLE/JOINT

- | PAST | PRESENT | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Bursitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen/Stiff Joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Whiplash |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Lower Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot/Ankle Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip/Upper Leg Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee/Lower Leg Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular |

SYSTEMIC

- | PAST | PRESENT | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia/Bulimia |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken Pox |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Gout |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | Measles |

OTHER HEALTH PROBLEMS

- | PAST | PRESENT | |
|--------------------------|--------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |

SURGERIES

- _____

FAMILY HISTORY- Indicate conditions present in your family and your relationship to the family member with the condition.

<u>Condition</u>	<u>Relationship:</u>	<u>Condition</u>	<u>Relationship:</u>
<input type="checkbox"/> Auto Immune Disorder	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Back Trouble	_____	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Cancer (indicate type)	_____	<input type="checkbox"/> Seizure Disorder	_____

PATIENT SIGNATURE: _____

DATE: _____

VISUAL ANALOG SCALE, PAIN DRAWING & ADL

PATIENT NAME: _____ **DATE:** _____

SECTION 1- PAIN INTENSITY & FREQUENCY:

Please circle the appropriate # that describes your present pain levels, with 0 being no pain and 10 being the worst pain you can imagine, and indicate how frequent the pain is.

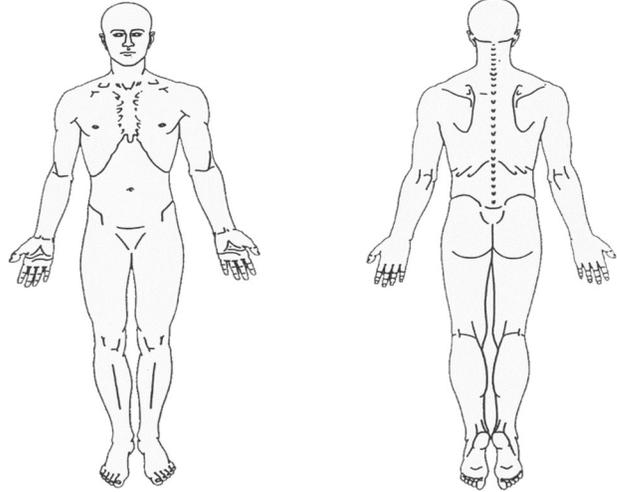
AREA OF PAIN	NORMAL		MILD			MODERATE			SEVERE		FREQUENCY OF PAIN					
NECK	0	1	2	3	4	5	6	7	8	9	10	0%	25%	50%	75%	100%
HEADACHES	0	1	2	3	4	5	6	7	8	9	10	0%	25%	50%	75%	100%
MID BACK PAIN	0	1	2	3	4	5	6	7	8	9	10	0%	25%	50%	75%	100%
LOW BACK PAIN	0	1	2	3	4	5	6	7	8	9	10	0%	25%	50%	75%	100%
HIP(S) L R	0	1	2	3	4	5	6	7	8	9	10	0%	25%	50%	75%	100%
SHOULDER(S) L R	0	1	2	3	4	5	6	7	8	9	10	0%	25%	50%	75%	100%
ARM(S) L R	0	1	2	3	4	5	6	7	8	9	10	0%	25%	50%	75%	100%
LEG(S) L R	0	1	2	3	4	5	6	7	8	9	10	0%	25%	50%	75%	100%
OTHER: _____ L R	0	1	2	3	4	5	6	7	8	9	10	0%	25%	50%	75%	100%

SECTION 2- PAIN DRAWING:

Please indicate the appropriate location of your pain and use the symbol that best describes the discomfort that you are feeling currently.

LEGEND:

- V: DULL & ACHY
- +: SHARP & STABBING
- 0: PINS & NEEDLES



SECTION 3 – ACTIVITIES OF DAILY LIVING OR JOB DEMANDS THAT INCREASE YOUR PAIN LEVELS:

- SITTING STANDING STOOPING BENDING CLIMBING REACHING LIFTING ___ LBS
- DRIVING HOUSEWORK: _____ SPORTS/REC: _____

SECTION 4 – MECHANISM OF INJURY:

DESCRIBE WHAT INITIALLY CAUSED YOUR PROBLEM: _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____ IS THE PAIN GETTING: Better Worse Same

PAIN AFFECTS YOUR: WORK SLEEP ACTIVITIES OF DAILY LIVING

HAVE YOU LOST ANY TIME FROM WORK DUE TO YOUR INJURIES? YES NO IF YES, WHEN? _____

ARE YOU CURRENTLY UNDER MEDICAL CARE FOR THIS CONDITION? YES NO

- IF YES, WHERE & WHAT TYPE? _____

TAKING **ANY** PRESCRIPTION MEDICATIONS? YES NO IF YES, WHAT? _____

TAKING **ANY** NON-PRESCRIPTION MEDICATIONS? YES NO IF YES, WHAT? _____

HAVE YOU SEEN ANOTHER CHIROPRACTOR? YES NO IF YES, WHY? _____

RE-EXAM PATIENTS ONLY:

ANY CHANGES TO YOUR HEALTH SINCE YOUR LAST VISIT? YES NO

IF YES, WHAT? _____

PATIENT NAME: _____ **DATE:** _____

MODIFIED ROLAND-MORRIS LOW BACK & DISABILITY (RMQ) (FOR PATIENTS with BACK INJURIES/PAIN ONLY)

PLEASE READ: If treating for a back injury and/or pain, mark all boxes that apply to you TODAY.

- | | |
|--|---|
| <input type="checkbox"/> I stay at home most of the time because of my back. | <input type="checkbox"/> Because of my back, I try to get other people to do things for me. |
| <input type="checkbox"/> I walk more slowly than usual because of my back. | <input type="checkbox"/> I only stand up for short periods of time because of my back. |
| <input type="checkbox"/> Because of my back, I am not doing any jobs that I usually do around the house. | <input type="checkbox"/> Because of my back, I try not to bend or kneel down. |
| <input type="checkbox"/> I avoid heavy jobs around the house because of my back. | <input type="checkbox"/> My back or leg is painful almost all of the time. |
| <input type="checkbox"/> Because of my back, I use a handrail to get upstairs. | <input type="checkbox"/> I find it difficult to turn over in bed because of my back. |
| <input type="checkbox"/> Because of my back, I go upstairs more slowly than usual. | <input type="checkbox"/> I get dressed more slowly than usual because of my back. |
| <input type="checkbox"/> Because of my back, I lie down to rest more often. | <input type="checkbox"/> I have trouble putting on my socks because of back pain. |
| <input type="checkbox"/> Because of my back, I must hold on to something to get out of an easy chair. | <input type="checkbox"/> I sleep less well because of my back. |
| | <input type="checkbox"/> Because of back pain, I am more irritable and bad tempered with people than usual. |

NECK DISABILITY INDEX (FOR PATIENTS with NECK INJURIES/PAIN ONLY)

PLEASE READ: If treating for a neck injury and/or pain, answer each section by marking the ONE box that most applies to you in regards to your neck pain.

Section 1: Pain Intensity

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

Section 2: Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but can manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, I wash with difficulty and stay in bed.

Section 3: Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed (i.e., 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 only lift very light weights.
- I cannot lift or carry anything.

Section 4: Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate neck pain.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

Section 5: Headaches

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

Section 6: Concentration

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

Section 7: Work

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

Section 8: Driving

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

Section 9: Sleeping

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

Section 10: Recreation

- I can engage in all my recreation activities with no neck pain at all.
- I can engage in all my recreation activities, with some neck pain.
- I can engage in most, but not all, of my usual recreation activities due to neck pain.
- I can engage in a few of my recreation activities due to neck pain.
- I can hardly do any recreation activities because of neck pain.
- I cannot do any recreation activities at all.