Moore Chiropractic Clinic

1709 NE 27th St., Suite H • McMinnville, OR 97128

Halley Moore, D.C. • Phone: 503-472-1477 • Fax: 503-472-1478

NEW PATIENT REGISTRATION

Today's Date _____

Name _____ Acct# _____
Last First MI

Address
_____*
(Complete Mailing) Street Apt# City State Zip

Social Security # _____ - _____ - _____ Date of Birth_____

Primary Phone* (_____) _____ - _____ ☐ home ☐ cell ☐ work

Secondary Phone* (_____) _____ - _____ ☐ home ☐ cell ☐ work

Email Address: _____*

Employer_____ Occupation_____ Phone (_____) _____ - _____

Emergency Contact_____ Relationship_____ Phone (_____) _____ - _____

Reason for this visit: ☐ routine ☐ accident, date _____ ☐ illness ☐ other: _____

* Please notify our front office staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above.

I have read and understand that this alternative is available to me _____ _____
Signature Date

FAMILY/FRIEND HIPPA AUTHORIZATION

Due to the HIPAA regulations, I hereby authorize the following names of those listed below to discuss and participate in my medical care (names of family members/friends who may be calling on your behalf; it is not necessary to list doctors' names.) I understand that if the names are not listed below, the office of Moore Chiropractic Clinic, can not release any information.

Names	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Signature Date

PATIENT NON-DISCRIMINATION POLICY

Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, gender identity or gender expression.

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ACKNOWLEDGEMENT AND UNDERSTANDING

PLEASE READ AND INITIAL EACH ITEM BELOW.

1. _____ I hereby authorize Moore Chiropractic Clinic to provide Chiropractic services for me.

2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Moore Chiropractic Clinic.

3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

4. _____ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Moore Chiropractic Clinic, 1709 NE 27th St., Suite H, McMinnville, OR 97128.

5. _____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

By signing this application I affirm under penalty that I have given true complete information.

_____ _____

Patient Signature Date

_____ _____

Grantor Signature Relationship to Patient

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

_____ Date of Birth _____

Patient's full name

to any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of _____ and expires _____.

Signature_____ Witnessed by _____

(Parent or Legal guardian)

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CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

_____ _____

Patient Signature Date

Please read the following carefully and initial each statement.

_____ I understand that if I have any prosthetics or surgical implants (including breast implants, pacemaker, an artificial joint, etc.), I should discuss this with the physician because it may affect care.

_____ I understand that if I may become pregnant, I should discuss this with the physician because it may affect care. Devices like interferential current is a contraindication with pregnancy.

_____ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Moore Chiropractic Clinic reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

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PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

We believe that all patients should be treated in a manner that respects their basic rights as human beings. You, as patients, have the right to:

1. Voice grievances or concerns about your care, or about the manner in which you were treated by the doctor. If you have concerns about your care, please contact the doctor.
2. Receive clear and complete information about your care and participate in the decisions concerning your treatment. If you have concerns about insurance or billing, please contact the doctor.
3. Be treated with respect and courtesy by all those involved in providing care and information.
4. Privacy during interviews and examinations. All information about a patient's care and records will be treated in a confidential manner.

Patient Responsibilities

1. Be as accurate and complete as possible when providing information about your medical history or condition.
2. Cooperate in following instructions given to you by those providing your health care.
3. Read and cooperate with the instructions provided by your doctor.
4. Ask for clarification about any aspect of your health care benefits that you do not fully understand.
5. Keep scheduled appointments or give adequate notice of delay or cancellation.
6. Treat those caring for you with respect and courtesy.

PRIVACY PRACTICES ~ PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (4 pages) for Moore Chiropractic Clinic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application for Care) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient Signature Date

_____ _____

Print the Patient Name Date of Birth

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APPOINTMENT CANCELLATION POLICY

We strive to render excellent chiropractic care to you and the rest of our patients at Moore Chiropractic Clinic. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **24 hours'** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Signature of Patient Date

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

As required by the Privacy Regulations, Moore Chiropractic Clinic may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

Patient Name: _____

Date of Birth: _____ Date of Request: _____

I hereby authorize this office and any of its employees to use or disclose my Protected Health Information to the following person(s), entity(s), or business associates of this office:

_____

_____

_____

By initialing the spaces below, I specifically authorize the release of the following records:

_____ Medical records needed for continuity of care

_____ Laboratory records

_____ X-ray(s) and/or imaging including reports (don't send films over 2 years old)

_____ Other: _____

For the specific purpose of (describe in detail) _____

_____

_____

I understand I have the right to: Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization; Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization; Inspect a copy of Protected Health Information being used or disclosed under federal law; Refuse to sign this authorization; Receive a copy of this authorization; Restrict what is disclosed with this authorization. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected health information. Unless revoked earlier, this consent will expire 180 days from the date of signing. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

_____ _____

Signature of Patient, or Patient's Authorized Representative Date

_____ _____ _____

Name of Sending Physician Signature of Requesting Physician Date

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BACK INDEX

Patient Name: _____ DOB: _____ Date: _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is very severe and does not vary much.

Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal sleep is reduced by less than 25%.
- ☐ Because of pain my normal sleep is reduced by less than 50%.
- ☐ Because of pain my normal sleep is reduced by less than 75%.
- ☐ Pain prevents me from sleeping at all.

Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases pain immediately.

Walking

- ☐ I have no pain while walking.
- ☐ I have some pain while walking but it doesn't increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

Personal Care

- ☐ I do not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.

Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel except that done while lying down.
- ☐ Pain restricts all forms of travel.

Social Life

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

Changing degree of pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Calculate Score

Back Index Score _____

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NECK INDEX

Patient Name: _____ DOB: _____ Date: _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ 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.

Sleeping

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

Reading

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I cannot read as much as I want because of moderate neck pain.
- ☐ I can hardly read at all because of severe neck pain.
- ☐ I cannot read at all because of neck pain.

Concentration

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

Work

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

Personal Care

- ☐ 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 I 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.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ I can only lift very light weights.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I cannot lift or carry anything at all.

Driving

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

Recreation

- ☐ I am able to engage in all my recreation activities without neck pain.
- ☐ I am able to engage in all my usual recreation activities with some neck pain.
- ☐ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ☐ I cannot do any recreation activities at all.

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.

Calculate Score

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THE KEELE START BACK SCREENING TOOL

Patient Name: _____ DOB: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	Agree 1
1 My back pain has **spread down my leg(s)** at some time in the last 2 weeks	☐	☐
2 I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks	☐	☐
3 I have only **walked short distances** because of my back pain	☐	☐
4 In the last 2 weeks, I have **dressed more slowly** than usual because of back pain	☐	☐
5 It's not really safe for a person with a condition like mine to be physically active	☐	☐
6 **Worrying thoughts** have been going through my mind a lot of the time	☐	☐
7 I feel that **my back pain is terrible** and **it's never going to get any better**	☐	☐
8 In general I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ Sub Score (Q5-9):_____