BEAVERTON FAMILY CHIROPRACTIC

This is the intake paperwork for your first visit with the doctor
Please Print SINGLE Sided
Please use a BLUE or BLACK INK PEN

Here are some helpful hints to make filling out your paperwork easier for you:

- Filling out your paperwork completely ***before*** coming into the office will allow the most time with the doctor.
- Fill out the information about your reason for seeing the doctor on the ***day of your appointment***, so the information is as current as possible. (History information can be completed any time.) ***Leave the signature and dates lines blank - you will complete these in the office on the day of your first visit.***
- Each line/blank should have an answer. If a question does not apply please write N/A or put a line through it.
- You will notice the last pages are to document any specific symptoms you may have. There are enough pages to describe 6 separate symptoms. If you need more pages, please make copies of the last page before filling it out.

If you have any questions feel free to call 503.644.8844, or email us at
BFC@BeavertonFamilyChiropractic.com
We are here to help you!

Your health is our primary concern!
Thank you for choosing us to help you on your path to greater health.

We look forward to serving you!

Your Beaverton Family Chiropractic Health Care Team!

Our Mission

To transform lives in our community today, tomorrow and for generations to follow through with Hope, Love, and Service

Beaverton Family Chiropractic, PC - 5075 SW Griffith Drive, Suite 120 - Beaverton, Oregon 97005
www.BeavertonFamilyChiropractic.com - BFC@BeavertonFamilyChiropractic.com
503.644.8844 Office

NEW CONDITION/INJURY APPLICATION AT BEAVERTON FAMILY CHIROPRACTIC, PC

PATIENT DEMOGRAPHICS

ID #_____

Legal Name: _____ Date of Birth: ____ - ____ - ____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Marital Status: S M D W O

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Name of Spouse: _____ Spouse's Employer: _____

Names and Ages of your children: _____

Name & Number of Emergency Contact: _____ Relationship: _____

REASON(S) FOR SEEKING CARE IN OUR OFFICE:

On a scale from 0 to 10, with 10 being the worst pain and 0 being no pain, rate your complaints by circling the number:

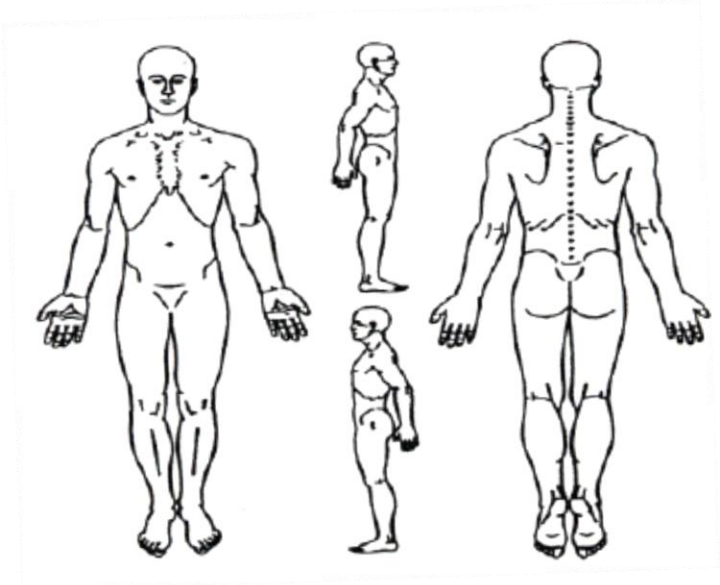
Primary Condition: _____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Secondary Condition: _____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Is this a result of an accident or injury? ☐ Yes ☐ No

*PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating
B = Burning
D = Dull
A = Aching
N = Numbness
S = Sharp/ Stabbing
T= Tingling
O = Other: _____



What activities have been restricted?	**PREVIOUS** activity level?	**CURRENT** activity level?
Ex: *Sleep*	*8 hours of restful sleep*	*2-3 hours of restless sleep*
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

_____ _____ _____ - _____ - _____

Patient or Authorized Person's Signature | Patient Initials | Date Completed

Patient's Legal Name: _____ **DOB:** _____ - _____ - _____ **ID #:** _____

CURRENT HEALTH HISTORY – *CONTINUED*

Other/Previous interventions, treatments, medications, surgery, or care you've sought for your <u>current</u> complaint(s): _____

_____

_____

Any other information relating to you new injury/condition that the doctor should know? ☐ No ☐ Yes

If yes: _____

_____

_____

Have you suffered with this or a similar problem in the past? ☐ No ☐ Yes If Yes how many times? _____

When was the last episode? _____ How did the injury happen? _____

Allergies: _____ ☐ None

List Prescription & Non-Prescription drugs you take: ☐ None

Drug	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries: ☐ None

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

Females – Pregnancies and outcomes: ☐ None – Are you CURRENTLY pregnant? ☐ No ☐ Yes

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

Patient Initials: _____ Today's Date: _____ - _____ - _____

Patient's Legal Name: _____ **DOB:** _____ - _____ - _____ **ID #:** _____

SOCIAL HEALTH HISTORY

Smoking: ❑cigars ❑ pipe ❑ cigarettes ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never ❑ Quit _____ (when?)

Alcoholic Beverage: consumption occurs ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never ❑ Quit _____ (when?)

Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never ❑ Quit _____ (when?)

CURRENT/PAST

Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following:

IDENTIFY TYPE:	EFFECT:
_____	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
_____	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
_____	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform

◆◆◆◆◆

I hereby authorize payment to be made directly to Beaverton Family Chiropractic, PC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Beaverton Family Chiropractic, PC for any and all services I receive at this office.

_____ _____ _____ - _____ - _____

Patient or Authorized Person's Signature | Patient Initials | Date Completed

For Doctor Use Only:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient's Legal Name: _____ DOB: _____ - _____ - _____ ID #: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck			Low Back			
No pain											**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**	

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1 – What is your pain RIGHT NOW?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

2 – What is your TYPICAL or AVERAGE pain?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

OTHER COMMENTS:

_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Patient's Legal Name: _____ **DOB:** _____ - _____ - _____ **ID #:** _____

ACTIVIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Carrying Bag/purse/briefcase	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving (Face – Legs)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Stepping up and/or over curb	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting/Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Relationships	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Patient Initials: _____ Today's Date: _____ - _____ - _____

Patient's Legal Name: _____ **DOB:** _____ - _____ - _____ **ID #:** _____

Primary Condition _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the condition most of the time:
  - 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above condition at the above intensity:
  - 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did the condition begin? _____
- Did the condition begin suddenly or gradually? (circle one) How did the symptom begin? _____
- What makes the condition worse? _____
- What makes the condition better? _____
- Describe the quality of the condition (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
- Does the condition radiate to another part of your body (circle one): ☐ No ☐ Yes
  - If yes, where does the symptom radiate? _____
- Is the condition worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Any other information? _____

Secondary Condition _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the condition most of the time:
  - 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above condition at the above intensity:
  - 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did the condition begin? _____
- Did the condition begin suddenly or gradually? (circle one) How did the symptom begin? _____
- What makes the condition worse? _____
- What makes the condition better? _____
- Describe the quality of the condition (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
- Does the condition radiate to another part of your body (circle one): ☐ No ☐ Yes
  - If yes, where does the symptom radiate? _____
- Is the condition worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Any other information? _____

Patient Initials: _____ Today's Date: _____ - _____ - _____