David S. Weaver, D.C.

KEIZER CHIROPRACTIC CLINIC

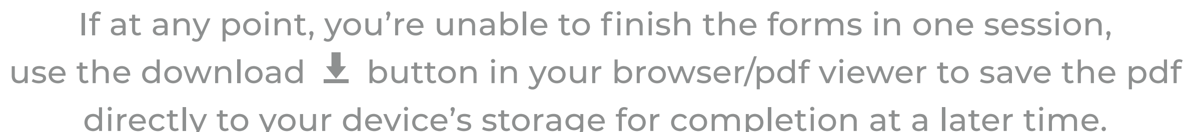
Your trusted partner in a better back

Christian Lichtenthaler, D.C.

Hello New Patient!

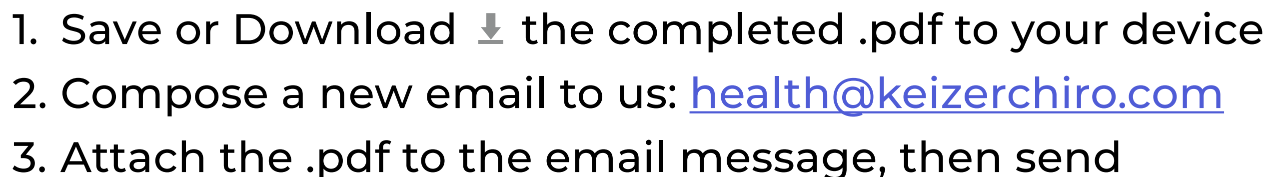
Please complete the forms on the following pages. You may fill them out on your device, or by hand — send by email, or print at home — whatever you prefer.

NOTE:
Ignore the signature fields at this time.
We will ask you to sign the forms at your appointment.



If at any point, you're unable to finish the forms in one session, use the download button in your browser/pdf viewer to save the pdf directly to your device's storage for completion at a later time.

TO EMAIL YOUR COMPLETED FORMS:



1. Save or Download the completed .pdf to your device
2. Compose a new email to us: health@keizerchiro.com
3. Attach the .pdf to the email message, then send

115 McNary Estates Dr N, Suite E, Keizer, Oregon 97303   P: 503-390-5552   F: 503-390-5994

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PATIENT INFORMATION

First & Last Name ______________________ Preferred Name ______________ Date of Birth ___ /___ /_____

Street Address ______________________________ City, State, Zip ____________ , ____ , ________

Phone ____________________ Email ______________________________________

Gender: Male Female Non-Binary Marital Status: Married Single Divorced Widow/Widower

SSN# ______________ Occupation ________________ Employer __________________

Work Address ______________________________ Work Phone __________________

Emergency Contact ______________ Relationship to Patient ________ Phone ______________

Parent's Name (if minor) ________________________ Parent's Work Phone ________________

Parent's Employer & address (if minor) ____

Primary Care Physician ____________________________________ Phone ____________

PRIMARY Health Insur. ________________ Group #__________ ID# __________________

Name of Insured ____________________________ Insured's Date of Birth ________________

SECONDARY Health Insur. ____________ Group # __________ ID# ____________________

Name of Insured ____________________________ Insured's Date of Birth ________________

PURPOSE OF THIS VISIT

Reason for this visit (main complaint): ____

Is this reason related to an auto accident / work injury? Yes No If yes, accident occurred on this date: ______________

On what date did this condition begin: ____________________ It began: Gradual Sudden Progressive Over Time

What makes your symptoms worse? Sitting Walking Bending Lying Down Lifting Moving Other ____________

What makes your symptoms better? Rest Heat Ice Massage Stretching Movement Medication Other ________

Type of pain? Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

The pain radiates into my: Arm Leg Does not radiate Is this condition getting worse? Yes No

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity

Complaint(s) interfere with: Work Sleep Hobbies Daily Routine

When are symptoms worse? Morning Afternoon Evening Wakes Me Sleep Varies

Have you experienced this condition before? Yes No If yes, explain: ______________________________

Who have you seen for this condition? ____________________ What did they do? ____________________

How did your body respond? ____

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MEDICAL HISTORY

Please mark if you have had or currently have any of the following conditions:

Heart Attack / Stroke	Constipation	Numbness (if so, where?)
Congenital Heart Defect	Fatigue	______________________
Alcohol / Drug Abuse	Lower Back Problems	Tingling (if so, where?)
Fainting / Seizures / Epilepsy	Severe / Frequent Earaches	______________________
Shingles	Ringing in Ears	Muscle Spasms (if so, where?)
Psychiatric Problems	Severe / Frequent Headaches	______________________
Difficulty Breathing	Dizziness	
Hepatitis	Emphysema	
Anemia	Glaucoma	
Diabetes	Kidney Problems	
Herpes	Artificial Bones / Joints	
Anxiety	High Blood Pressure	
Arthritis	Digestive Problems	
Frequent Neck Pain	Tuberculosis	
Jaw Pain	Cancer	
Wrist Pain	HIV Positive / AIDS	
Shoulder Pain	Ulcer / Colitis	
Arm Pain	Gout	
Leg Pain	Sciatica	
Migraines	Depression	

CURRENT MEDICATIONS

____

____

____

____

____

____

MAJOR SURGERIES, YEAR

______________ , ______

______________ , ______

______________ , ______

______________ , ______

CURRENT HABITS

	none	light	mod.	heavy
Alcohol				
Tobacco				
Drugs				
Exercise				
Sleep				
Water				
Sugar				
Fast Food				

FAMILY HISTORY

Cancer

Diabetes

Heart Disease

Stroke

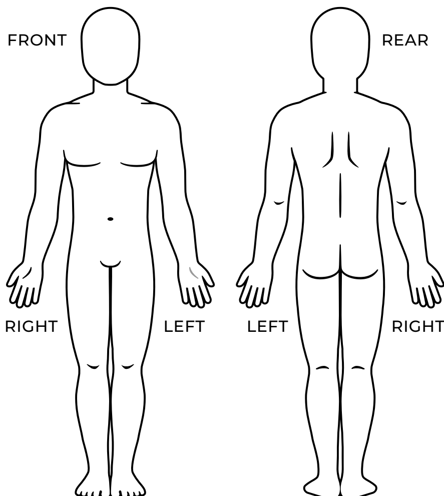
Arthritis

Asthma

Multiple Sclerosis

Other: ________________

PAIN ASSESSMENT



With a pen, mark the areas of pain on the figures to the left.

Using the pain scale to the right as reference, please indicate your pain/ discomfort in the box below (0-10)

— 0 No Pain
— 1
— 2 Mild / Annoying
— 3
— 4 Nagging
— 5
— 6 Distressing
— 7
— 8 Intense
— 9
— 10 Unbearable

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this info will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor. I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether paid or not by insurance. **PAYMENT & INSURANCE:** I understand that payment is expected at time of visit and that the office accepts cash, checks and some credit & debit cards. I understand that my insurance can be billed if confirmation of coverage can be confirmed. If coverage cannot be confirmed, payment must be made in full at the time of the visit. I understand that insurance billing is a courtesy service that may be withdrawn at anytime and that I am ultimately responsible for all charges incurred. **CANCELLATION POLICY:** I understand that this office has a 24-hour cancellation policy, and that if I must cancel my appointment, I will give at least a 24-hour notice. I understand that without a 24-hour notice, I may be charged a missed appointment fee.

____

Signature of Patient or Legal Representative

____

Date

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H.I.P.P.A. — ACKNOWLEDGMENT AND CONSENT

____ ________________

Patient Name (Please Print) Date of birth

I understand that *Keizer Chiropractic Clinic* may use and disclose health information about me. I understand that my health information may include information both created and received by this office, may be In the form of written or electronic records or spoken words, and may include information about my health, history, health status, symptoms examinations, test results, diagnoses, treatments, procedures and similar types of health-related information.

I understand and agree that *Keizer Chiropractic Clinic* may use and disclose my health information in order to:

- Make decisions about and plan for care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how *Keizer Chiropractic Clinic* will handle health Information about me. This written description Is known as the Notice of Privacy Practices and describes the uses and disclosures of health Information made and the information practices followed by the employees and physicians of *Keizer Chiropractic Clinic* and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that am entitled to receive a copy of any revised Notice of Privacy Practices. I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that *Keizer Chiropractic Clinic* is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices (if requested).

____ ________________

Signature of Patient or Legal Representative Date

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his hands or a mechanical device in order to adjust your joints. You may feel “click” or “pop,” such as the noise when knuckle is “cracked,” and you may feel movement of the joint. Various ancillary procedures such as heating pad application, massage, manual traction and stretching or exercises may be used to assist in your care.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include muscular strain, ligamentous sprain, or injury to intervertebral discs, nerves or spinal cord. Although extremely rare, cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin Irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare,” about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular Injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare.”

Other treatment options which could be considered may include the following:

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs and analgesics. Risks of these drugs Include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and Induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

____ __________________

Signature of Patient or Legal Representative   Date

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NECK DIABILITY INDEX

If you're NOT experiencing NECK pain, please skip this page

PLEASE RATE THE SEVERITY OF YOUR PAIN BY MARKING A NUMBER BELOW

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **UNBEARABLE PAIN**

PLEASE READ: This questionnaire has been designed to give the doctor information on how your neck pain has affected your ability to manage in everyday life. Please answer every question, and mark only the one statement in each section that applies to you. While you may consider that two of the statements in any one section relate to you, please check just the one which most closely describes your situation.

SECTION 1 – PAIN INTENSITY

0. I have no pain at the moment.
1. The pain is mild at the moment.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE (washing, dressing, etc.)

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

SECTION 3 – LIFTING

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, e.g. on the table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

SECTION 4 – READING

0. I can read as much as I want with no pain in my neck.
1. I can read as much as I want with slight pain in my neck.
2. I can read as much as I want with moderate pain in my neck.
3. I cannot read as much as I want because of moderate pain in my neck.
4. I cannot read as much as I want because of severe pain in my neck.
5. I cannot read at all.

SECTION 5 – HEADACHES

0. I have no headache at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches most of the time.

SECTION 6 – CONCENTRATION

0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty concentrating when I want to.
3. I have a lot of difficulty concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I can't concentrate at all.

SECTION 7 – WORK

0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

OFFICE USE

TOTAL SCORE

SECTION 8 – DRIVING

0. I can drive my car without neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate neck pain in my neck.
3. I cannot drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive my car at all because of severe pain in my neck.
5. I cannot drive my care at all.

SECTION 9 – SLEEPING

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

SECTION 10 – RECREATION

0. I am able to engage in all recreational activities with no pain in my neck.
1. I am able to engage in all recreational activities with some pain in my neck.
2. I am able to engage in most, but not all recreational activities because of pain in my neck.
3. I am able to engage in a few of my usual recreational activities because of pain in my neck..
4. I can hardly do any recreational activities due to neck pain.
5. I can't do any recreational activities at all.

____________________ Name

__________ Date of Birth

__________ Date

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OSWESTRY **LOWER BACK** PAIN SCALE

If you're NOT experiencing LOWER BACK pain, please skip this page

PLEASE RATE THE SEVERITY OF YOUR PAIN BY MARKING A NUMBER BELOW

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **UNBEARABLE PAIN**

PLEASE READ: This questionnaire has been designed to give the doctor information on how your back pain has affected your ability to manage in everyday life. Please answer every question, and mark only the one statement in each section that applies to you. While you may consider that two of the statements in any one section relate to you, please check just the one which most closely describes your situation.

SECTION 1 – PAIN INTENSITY

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE (washing, dressing, etc.)

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

SECTION 3 – LIFTING

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned e.g. on a table.
4. Pain prevents me lifting heavy weights, but I can manage if light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

SECTION 4 – WALKING

0. I have no pain walking.
1. I have some pain walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

SECTION 5 – SITTING

0. I can sit in any chair as long as I like..
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

SECTION 6 – STANDING

0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because It increases the pain immediately.

SECTION 7 – SLEEPING

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

OFFICE USE

TOTAL SCORE

SECTION 8 – SOCIAL LIFE

0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

SECTION 9 – TRAVELING

0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternative forms of travel
3. I get extra pain while traveling which compels me to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour
5. Pain restricts all forms of travel.

SECTION 10 – CHANGING DEGREE OF PAIN

0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Name ____________________ Date of Birth ____________ Date ____________

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Thank You!

Now that your form has been completed, make sure you **SAVE** or **DOWNLOAD** (⬇) the pdf file directly to your device.

Then, simply attach the form to a new email, or print the forms and bring them to your appointment.

More detailed instructions can be found on page 1 of this file.

115 McNary Estates Dr N, Suite E, Keizer, Oregon 97303 P: 503-390-5552 F: 503-390-5994