Voth Family
Chiropractic, L.L.C.

1957 Thompson Rd.
Coos Bay, OR 97420

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

PATIENT CONDITION

Reason for Visit _____

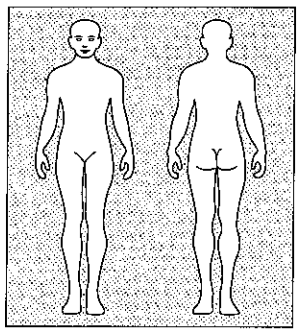
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____
Pharmacy Name_____
Pharmacy Phone (____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

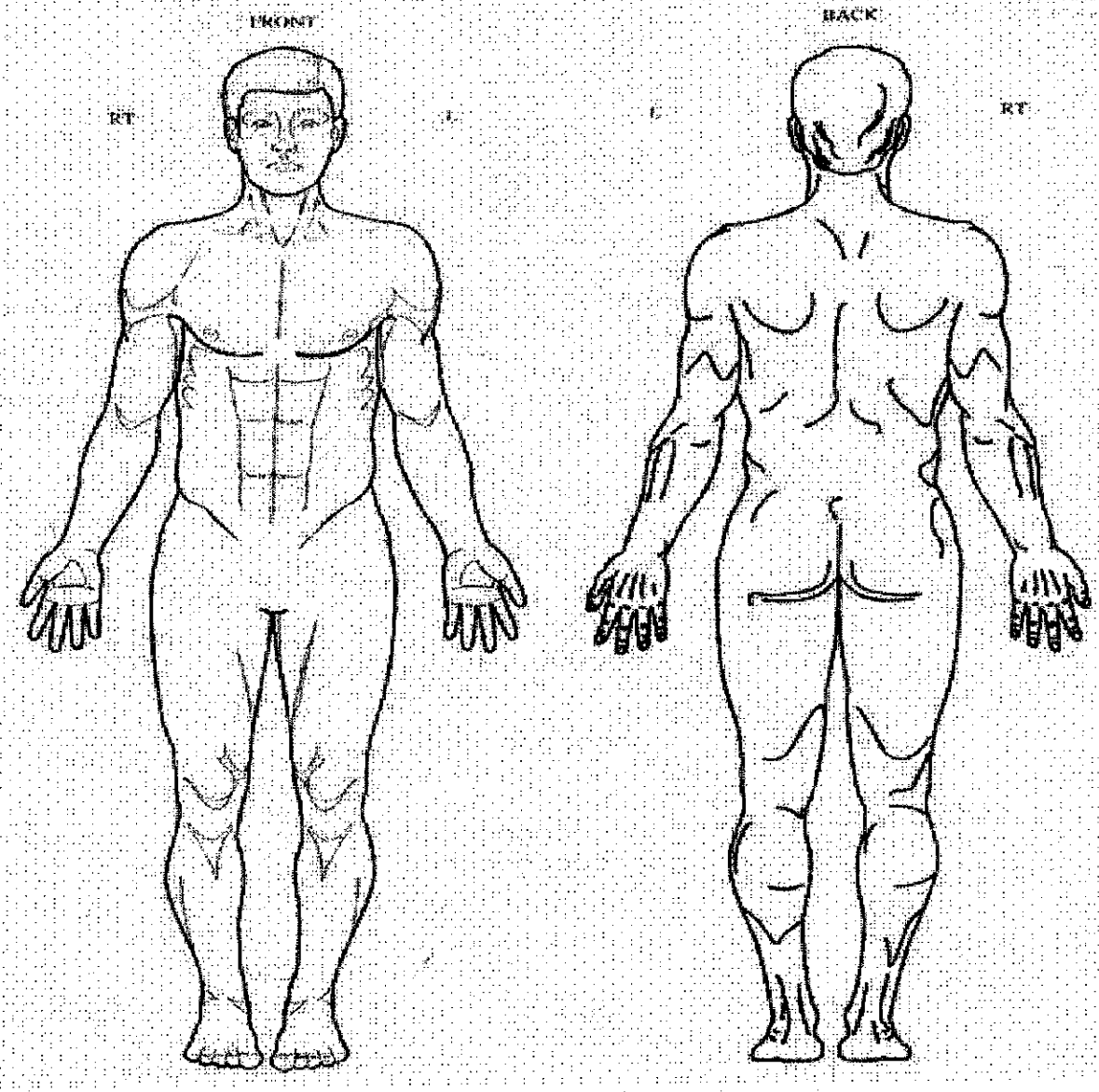
PAIN DIAGRAM

PATIENT NAME:_____TODAY'S DATE:_____

PLEASE COMPLETE THE FOLLOWING "*PAIN DIAGRAM*" BY USING LETTERS AT THE LEFT TO INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN:

PAIN (P)
TINGLING (T)
NUMBNESS (N)
BURNING (B)
STIFFNESS (S)

PATIENT'S SIGNATURE:_____



Voth Family Chiropractic LLC

Benjamin L. Voth, D.C.
1957 Thompson Rd. Suite B Coos Bay, OR 97420
Telephone (541) 266-8000

SIGNATURE ON FILE

I understand that I am responsible for my bill. If it is necessary to refer my account for collection I agree to pay Voth Family Chiropractic L.L.C. reasonable attorney fees and collection costs, including any collection fees charged by a collection agency, even though no suit or action is filed. If a suit or action is filed the amount of such reasonable attorney's fees or collection charges shall be fixed by the court or courts in which the suit or action, including appeal, is tried, heard, or decided.

I authorize use of this form on ALL my insurance submissions.

I authorize release of information to all my insurance companies.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize payment directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

_____

Signature of patient (or parent or legal guardian)

_____

Name of patient (please print)

_____

Date

Voth Family Chiropractic LLC
Benjamin L. Voth, D.C.
1957 Thompson Rd. Coos Bay, OR 97420
Telephone (541) 266-8000

Consent Form

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or the patient named below for whom I am legally responsible).

I am informed and I understand that, as in the practice of medicine, there are some risks to treatment, including, but not limited to, soreness and a temporary worsening of symptoms. I do not expect the doctor to be able to anticipate and explain all the risks and complications I understand the results and are not guaranteed. I wish to rely on the doctor to exercise good judgement and prescribe a course of treatment that, based on the facts know, will be in my best interests.

I have read (or have read to me) this consent form. By signing below I agree to the above-named conditions. I intend this consent form to cover the entire treatment for my present condition, and for any future conditions for which I seek treatment at Voth Family Chiropractic LLC.

_____

Print patient's name

_____

Signature of patient or guardian

_____

Date

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Telephone (541) 266-8000

FINANCIAL AGREEMENT

I_____understand that I am responsible for payment in full for services provided to me at Voth Family Chiropractic L.L.C.

Please be aware that each modality (therapy) has a reasonable fee. If you do not wish to pay for a particular therapy please let the doctor or a staff member know BEFORE the therapy is performed.

If it is necessary to refer my account for collection I agree to pay Voth Family Chiropractic L.L.C. reasonable attorney fees and collection costs, including any collection fees charged by a collection agency, even though no suit or action is filed. If a suit or action is filed the amount of such reasonable attorney's fees or collection charges shall be fixed by the court or courts in which the suit or action, including appeal, is tried, heard, or decided.

I have read (or have had read to me) the above statement and terms, and understand fully the content.

I agree to the terms as stated above.

Signature of Patient
(or parent or legal guardian)

Print patient name

Date

VOTH FAMILY CHIROPRACTIC
Benjamin L. Voth, D.C.
1957 Thompson Rd. Ste. B Coos Bay, OR 97420
Telephone (541) 266-8000
Fax (541) 266-8022

MEDICARE NON-COVERED SERVICES

This is to advise you that the only chiropractic service covered by Medicare is manipulation of the spine.

Medicare **does not cover exams, x-rays, physical therapy, supplies, etc.** ordered by a chiropractor. Payment for these and other services are the patient's responsibility.

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

Prior to receiving treatment at Voth Family Chiropractic, I have read (or have had read to me) the above statement, and understand fully the content.

Patient signature Date

VOTH FAMILY CHIROPRACTIC

Benjamin L. Voth, D.C.

1957 Thompson Rd. Ste. B Coos Bay, OR 97420

REVISED OSWESTRY LOW BACK PAIN AND DISABILITY

Patient Name:_____ Date: ____/____/____

Please read instructions carefully:

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please fill in ONE circle which most closely describes your problem.

SECTION 1 – 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 severe and doesn't vary much.

SECTION 2 – PERSONAL CARE

- ❑ I can look after myself 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 weight without extra pain.
- ❑ I can lift heavy weight but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor.
- ❑ Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights at the most.

SECTION 4 – WALKING

- ❑ I have no pain walking.
- ❑ I cannot walk more than one mile without increasing pain.
- ❑ I cannot walk more than ½ mile without increasing pain.
- ❑ I cannot walk more than ¼ mile without increasing pain.
- ❑ I can walk with crutches.
- ❑ I cannot walk at all without increasing pain.

SECTION 5 – 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 one hour.
- ❑ Pain prevents me from sitting more than a half hour.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ I avoid sitting because it increases pain straight away.

SECTION 6 – STANDING

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than ½ hour without increasing pain.
- ❑ I can't stand for longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain straight away.

SECTION 7 – SLEEPING

- ❑ I get no pain in bed.
- ❑ I get pain in bed but it doesn't prevent me from sleeping well.
- ❑ Because of pain my normal night's sleep is reduced by < ¼.
- ❑ Because of pain my normal night's sleep is reduced by < ½.
- ❑ Because of pain my normal night's sleep is reduced by < ¾.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 – TRAVELING

- ❑ I get no pain while traveling.
- ❑ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ❑ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that are done lying down.

SECTION 9 – SOCIAL LIFE

- ❑ My social live is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain limits my more energetic interests, e.g. dancing, etc.
- ❑ Pain has restricted my social life and I do not go out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of the pain.

SECTION 10 – 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 nor worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

For office use only – **Score:**_____

VOTH FAMILY CHIROPRACTIC

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The Oswestry Neck Disability Index (Confidential)

Patient Name: Date:

Please check only **ONE** statement in each section that describes how you're feeling **TODAY**

Section 1 – Pain Intensity
- ☐ I have no pain at the moment.
- ☐ Pain is very mild at the moment.
- ☐ Pain is moderate at the moment.
- ☐ Pain is fairly severe at the moment.
- ☐ Pain is very severe at the moment.
- ☐ 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 manage most of my personal care.
- ☐ I need help every day in most aspects of self car.
- ☐ 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.
- ☐ I can lift heavy weight items if conveniently .positioned.
- ☐ I can lift light/medium weights if conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

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 just read as much as I want with moderate neck pain.
- ☐ I cannot read as much 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.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating.
- ☐ I cannot concentrate at all.

Section 7 – Work
- ☐ I can work as much 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 cannot do any work at all.

Section 8 – Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as desired with light neck pain.
- ☐ I can drive my car as desired with moderate neck pain.
- ☐ I cannot drive my car much because of moderate neck pain.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 - Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is mildly 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).

Section 10 - Recreation
- ☐ I can engage in all my recreational activities with no neck pa
- ☐ I can do all recreation activities with some neck pain.
- ☐ I can do most, not all recreational activities with some neck
- ☐ I can do some recreational activities with neck pain.
- ☐ I can hardly do recreational activities because of neck pain.
- ☐ I cannot do recreational activities at all.

Section 11 - Rate your overall pain: 0 1 2 3 4 5 6 7 8 9 10

No pain mild discomfort distressing horrible excruciating