OIEN
FAMILY CHIROPRACTIC

Welcome to Oien Family Chiropractic

Date: _____ Social Security #(of responsible party)_____

Name: _____
Last First

Address_____City_____Zip_____

E-mail _____

Cell Phone:_____ Home Phone: _____Work Phone:_____

Preferred method of communication: (Check one) Email___ Cell___ Text___

Sex: _____Male _____ Female Age:_____ Birthdate:_____

___Married ____Single ____ Spouse's Name _____

Are you currently employed? □Yes □No Occupation_____

Who is your current employer? _____

ACCIDENT INFORMATION: Is condition due to an accident? Yes____ No____ Date of Accident _____

TYPE OF INSURANCE: Auto Accident* ____ Workmans' Comp* ____ Personal(Sanford, Avera, Wellmark, etc.)___ Cash __

**If you are seeking care due to an accident. Please tell the receptionist.*

Have you seen a Chiropractor before? □ Yes □ No If yes, when _____

We appreciate you choosing our office. Whom may we thank for referring you? _____

YOUR HEALTH HISTORY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problems.

- □ Headaches
- □ Pins and Needles in arms
- □ Dizziness
- □ Numbness in fingers
- □ Fatigue
- □ Sleeping problems
- □ Cold Sweats
- □ Mood Swings
- □ Pins and Needles in legs
- □ Loss of smell
- □ Buzzing in ears
- □ Numbness in toes
- □ Depression
- □ Neck Stiff
- □ Constipation
- □ Lights bother eyes
- □ Menstrual Pain
- □ Fainting
- □ Back Pain
- □ Ringing in ears
- □ Loss of taste
- □ Irritability
- □ Cold hands
- □ Fever
- □ Problem urinating
- □ Menstrual irregularity
- □ Neck Pain
- □ Loss of Balance
- □ Nervousness
- □ Stomach upset
- □ Tension
- □ Cold feet
- □ Hot flashes
- □ Heartburn
- □ Ulcer

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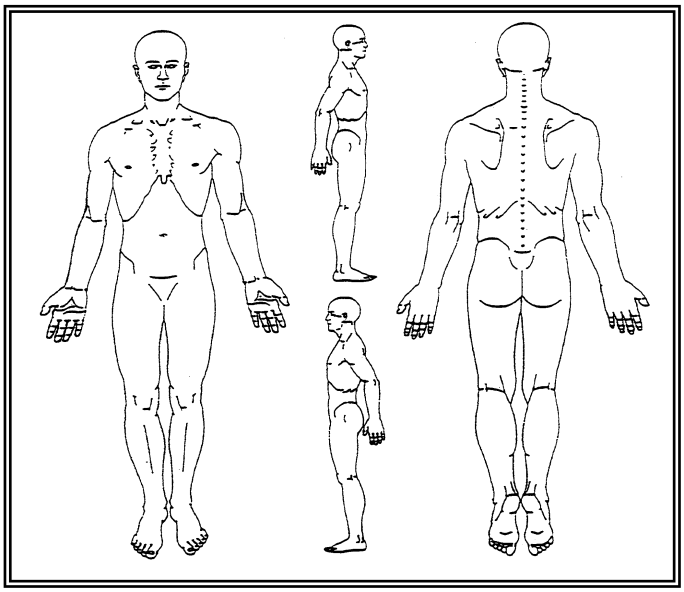
Please indicate the main reason you are seeing us today:

_____



Using the pain scale below, CIRCLE the pain level you experience when your problem is at its very worst:

0 = No Pain. No Discomfort
1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs? □Yes □No **Is there any numbness or tingling?** □Yes □No

How often do you experience your problem? (Please indicate for each of the body location if applicable)

□ Constant (75 – 100% of the time) □ Frequent (50 – 75% of the time)
□ Occasional (25 – 50% of the time) □ Intermittent (0 – 25% of the time)

What makes your problem <u>worse</u>? Check all that apply:

□ Sitting □ Standing □ Changing Position
□ Walking □ Bending □ Lifting
□ Twisting □ Reaching □ Driving
□ Sleeping □ Sneeze/Cough □ Computer Work
□ Telephone □ Going From Sit To Stand □ Other_____

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PAST MEDICAL HISTORY

Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life:

_____

Please list any surgeries you have had over the course of your life:

_____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? □Yes □No If yes, please list: _____

List any medications, herbs or supplements you are taking and the reason for their use:

_____

SOCIAL HISTORY

Do you drink alcohol? □Yes □No If yes, how much & how often? _____

Do you smoke? □Yes □No If yes, how much, how often & how long? _____

ASSIGNMENT AND RELEASE: *Skip only if not using insurance*

I certify that I, and/or my dependent(s), have insurance coverage with _____(Insurance company) and assign directly to Dr. Benjamin Oien, 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 upon requesting termination of consent at my discretion at which point I would assume full responsibility for outstanding charges.

FINANCIAL RESPONSIBILITY

Oien Family Chiropractic provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.

I have read and understood all the above information.

This office conforms to the current HIPPA guidelines, You may request a copy of our HIPPA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____

Print Name of Patient, Parent, Guardian or Personal Representative **Date**

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Functional Rating Index

MAIN COMPLAINT: _____

In order to properly assess your condition, we must understand how much your main complaint has affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on shorts trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25 % of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name_____
PRINTED

_____ _____
Signature **Date**