CHIROFIT
CHIROPRACTIC

Seung Won Lee D.C.
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10700 SW Beaverton-Hillsdale Hwy. Ste. 211, Beaverton, OR 97005

PATIENT INFORMATION(1):

Legal Name_____ Today's Date_____
(FIRST) (MIDDLE) (LAST)

Date of Birth _____/_____/_____ Age_____ Gender M /F Martial Status_____

Address_____
(STREET) (CITY) (STATE) (ZIP)

Home Phone_____ Cell Phone_____ Work Phone_____

Best to reach you during the day: Home___ Cell___ Work___

Email Address_____

Occupation_____ Employers_____ Years Employed_____

Who is your primary care physician?_____ Phone_____

Spouse_____ Date of Birth_____/_____/_____ Phone_____

Minor: Name of Parent or Guardian_____ Phone_____

In case of emergency_____ Phone_____

INSURANCE:

Primary _____ Secondary_____

ID #_____ ID #_____

Group #_____ Group #_____

Insurance release of benefits and information

I authorize my insurance company benefits to be paid directly to the doctor. I am financially responsible for any balance due, including for services exceeding the limits of my insurance policy. I authorize the doctor or insurance company to release any information requested for claims.

PATIENT SIGNATURE_____ DATE_____

ChiroFIT Chiropractic: Patient Information(2)

Patient's Name:_____ **Date:**_____

Please, describe your current problem: _____

_____

Date that the problem began: _____/_____/_____

What treatment have you had for this condition in the past? (Surgery, Medication, Injection, Therapy, Chiropractic)

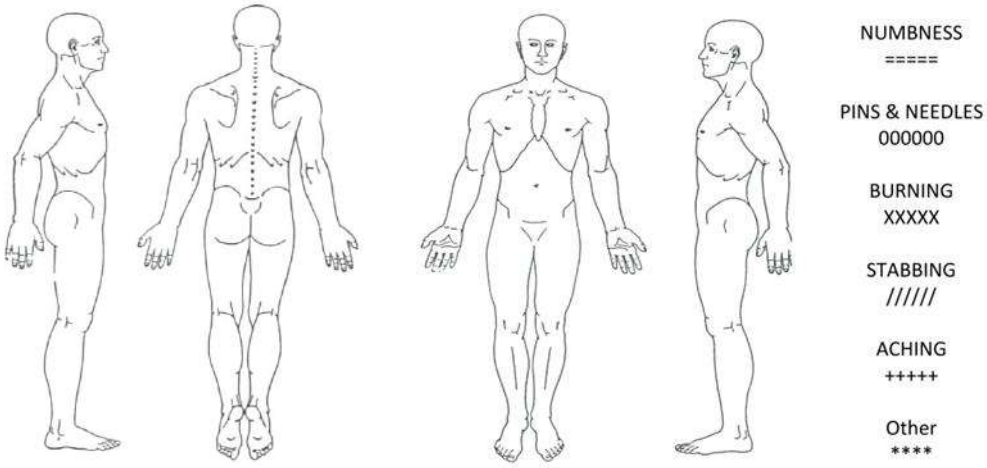
_____

Have you had X-ray, MRI or other test for this condition? _____

What tests? _____ **When?** _____

Please, circle on the pain scale from 0 (No Pain) to 10 (Worst Pain) the pain you feel with this condition & indicate where you have pain or other symptoms below:

Neck Pain
0 1 2 3 4 5 6 7 8 9 10
Shoulder, Arm Pain
0 1 2 3 4 5 6 7 8 9 10
Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10
Elbow, Wrist, Hand Pain
0 1 2 3 4 5 6 7 8 9 10
Lower Back Pain
0 1 2 3 4 5 6 7 8 9 10
Hip, Leg Pain
0 1 2 3 4 5 6 7 8 9 10
Knee Pain
0 1 2 3 4 5 6 7 8 9 10
Foot, Ankle Pain
0 1 2 3 4 5 6 7 8 9 10



Time of day when pain is worst: □Morning □Afternoon □Evening □Wakes Me
Does the pain radiate? □No □Yes If Yes:_____
How often are your symptoms present? □Constantly □Frequently □Occasionally □Intermittently

Describe your current pain/symptoms:
□Sharp/Stabbing □Throbbing □Aches □Dull □Soreness □Weakness □Numbness □Shooting
□Gripping □Burning □Tingling □Other

Since it began, is your problem: □Improving □Getting Worse □No change

What makes the problem better?
□Nothing □Lying Down □Walking □Standing □Sitting □Movement □Exercise
□Inactivity/Rest □Other

What makes the problem worse?
□Nothing □Lying Down □Walking □Standing □Sitting □Movement □Exercise
□Inactivity/Rest □Other

Can you perform your daily home activities?	□Yes	□Yes, only with help	□Not at all
Do you exercise?	□Yes, almost daily	□Yes, occasionally	□Not at all
Describe your job requirements:	□Mainly sitting	□Light labor	□Heavy labor
Can you perform your daily work activities?	□Yea, all activities	□Only some	□Not at all
Describe you stress level:	□None to mild	□Moderate	□High

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Patient Health Questionnaire

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If you have *ever* had a listed symptom in the *past*, please check that symptom in the *Past Column.* If you are *presently* troubled by a particular symptom, check that symptom in the *Present Column.* **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
__	__	Neck pain
__	__	Shoulder Pain -R_____ L_____
__	__	Pain in Upper Arm or Elbow -R_____ L_____
__	__	Hand Pain - R____L____
__	__	Wrist Pain - R____L____
__	__	Upper Back Pain
__	__	Low Back Pain
__	__	Pain in Upper Leg or Hip - R____L____
__	__	Pain in Lower Leg or Hip - R____L____
__	__	Pain in Ankle or Foot - R____L____
__	__	Jaw Pain
__	__	Swelling, Joint Stiffness
__	__	Fainting
__	__	Visual Disturbances
__	__	Convulsions
__	__	Dizziness
__	__	Headache
__	__	Muscular Incoordination
__	__	Tinnitus (Ear Noises)
__	__	Rapid Heart Beat
__	__	Chest Pains
__	__	Loss of Appetite
__	__	Anorexia
__	__	Abnormal weight gain
		___gain ___loss
__	__	Excessive Thirst
__	__	Chronic Cough
__	__	Chronic Sinusitis
__	__	General Fatigue
__	__	Irregular Menstrual Flow
__	__	Profuse Menstrual Flow
__	__	Breast __Soreness __ Lumps
__	__	Endometriosis
__	__	PMS
__	__	Loss of Bladder Control
__	__	Painful Urination
__	__	Frequent Urination
__	__	Abdominal Pain
__	__	Constipation/Irregular bowel habits
__	__	Difficulty in Swallowing
__	__	Heartburn/Indigestion
__	__	Dermatitis/Eczema/Rash

Past	Present	Condition
__	__	Depression
__	__	Aortic Aneurysm
__	__	High Blood Pressure
__	__	Angina
__	__	Heart Attack - date_____
__	__	Stroke - date_____
__	__	Asthma
__	__	Cancer - explain_____
__	__	Tumor - explain_____
__	__	Prostate Problems
__	__	Blood Disorder
__	__	Emphysema (chronic lung disease)
__	__	Arthritis
__	__	Rheumatoid Arthritis
__	__	Diabetes
__	__	Epilepsy
__	__	Ulcer
__	__	Liver/Gallbladder problems
__	__	Kidney Stones
__	__	Hepatitis
__	__	Bladder Infection
__	__	Kidney Disorders (by condition)
__	__	Colitis
__	__	Irritable Colon
__	__	Other_____

If a family member has had any of the following, please mark the appropriate box:

__ Cancer	__ Epilepsy
__ Rheumatoid Arthritis	__ Chronic Back Problems
__ Diabetes	__ Chronic Headache
__ Heart Problems	__ Lupus
__ Lung Problems	__ Other_____
__ High Blood Pressure_____	

YES	NO	
__	__	Do you have a permanent disability rating? Location_____
__	__	Date rating received___/___/_____
__	__	Rating Percentage_____%

Present Weight _____pounds **Height**_____feet_____inches

Please check any of the following that apply to you:

Past	Present		Past	Present	
__	__	Pregnancy/# of births_____	__	__	Tobacco
__	__	Birth Control Pills, type_____	__	__	Alcohol
__	__	Medications_____	__	__	Drug or Alcohol Dependence
__	__	Hospitalization/Surgeries_____	__	__	Coffee/Tea/Caffeine Drinks cups/cans per day_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient's Signature_____ **Date**_____

Patient Summary Form

PSF-750 (Rev: 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)

2. Federal tax ID(TIN) of entity in box #1

3. Name and credentials of the individual performing the service(s)

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

4. Alternate name (if any) of entity in box #1

5. NPI of entity in box #1

6. Phone number

7. Address of the billing provider or facility indicated in box #1

8. City

9. State

10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Cause of Current Episode

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other _____

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1°
2°
3°
4°

Patient Type

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Nature of Condition

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942 ○ 98941 ○ 98943

Current Functional Measure Score

Neck Index | DASH | _____ (other FOM)

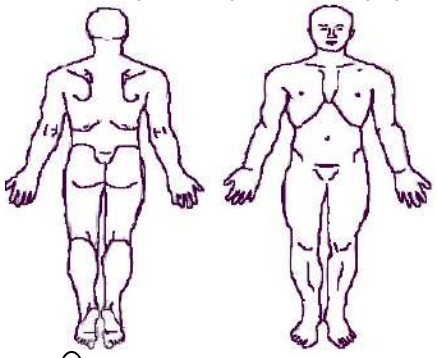
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

4. How often do you experience your symptoms?

1. Constantly (76%-100% of the time)
2. Frequently (51%-75% of the time)
3. Occasionally (26% - 50% of the time)
4. Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

6. How is your condition changing, since care began at *this* facility?

0. **N/A — This is the initial visit**
1. Much worse
2. Worse
3. A little worse
4. No change
5. A little better
6. Better
7. Much better

7. In general, would you say your overall health right now is...

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

Patient Signature: X _____ **Date:** _____

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Optum Patient Summary Form (2)

1. Has your back pain spread down your leg(s) at some time in the last 2 weeks?

   O1 - No / O2 - Yes

2. Have you had pain in the shoulder or neck at some time in the last 2 weeks?

   O1 - No / O2 - Yes

3. Have you only walked short distances because of your back pain?

   O1 - No / O2 - Yes

4. In the last 2 weeks, have you dressed more slowly than usual because of back pain?

   O1 - No / O2 - Yes

5. Do you think it's not really safe for a person with a condition like yours to be physically active?

   O1 - No / O2 - Yes

6. Have worrying thoughts been going through your mind a lot of the time?

   O1 - No / O2 - Yes

7. Do you feel your back pain is terrible and it's never going to get any better?

   O1 - No / O2 - Yes

8. In general, have you stopped enjoying all the things you usually enjoy?

   O1 - No / O2 - Yes

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

   O1 - Not at all O 2 - Slightly O 3 - Moderately O 4 - Very Much O 5- Extremely

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ 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.

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 care.
☐ 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.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are 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 read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ 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 slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

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 when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work 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 can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car 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 slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

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 care.
☐ 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.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

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 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – 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 no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

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 at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204