Olympic Spine & Sports Therapy
6603 220th St. SW Ste. 102
Mountlake Terrace, WA 98043
425-774-2411

Welcome to Olympic Spine & Sports Therapy! At your first appointment you will be meeting with the doctor for your complimentary consultation. The doctor will review your history, current symptoms, and perform a screening examination to determine if it's likely you are a candidate for our treatment procedures. If you are a candidate for treatment, the doctor will make recommendations for a comprehensive examination, testing, x-rays, and/or treatment; these are not covered in your complimentary consultation. If you choose to receive additional examination, testing, and/or treatment, you will incur normal charges.

Comprehensive examination, testing, x-rays, and/or treatment are not included in your complimentary consultation.

It is our desire that no one is denied health care due to finances. If a patient makes their health care a priority, we will work with them to make arrangements that also work financially.

Respectfully yours,

Kaiya Hunsaker
Office Manager

Please sign this letter to indicate that you have completely read and understood its contents.

Print Name _____ **Date** _____

Signature _____

Olympic Spine & Sports Therapy
6603 220th St. SW Ste. 102
Mountlake Terrace, WA 98043
425-774-2411

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Name Printed: _____ **ID #: _____**

Patient Signature: _____ **Date: _____**

Authorization to Release Information to Physician

At Olympic Spine & Sports Therapy, we believe it is important that all your physicians work together for your benefit. By signing this release, you are authorizing us to release reports and information to your doctor(s) regarding your treatment at Olympic Spine & Sports Therapy.

Patient Signature: _____ **Date: _____**

Authorization to Release Information to Designated Individuals

I authorize that Olympic Spine & Sports Therapy can share my healthcare information with the following individuals:

Name: _____ **Relationship to Patient: _____**

Name: _____ **Relationship to Patient: _____**

Patient Signature: _____ **Date: _____**

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date_____ Attempt_____

Staff Name_____

OLYMPIC SPINE & SPORTS THERAPY

Reviewed w/Patient: _____/_____

(Complete with blue ink pen) **(**Doctor's Signature and Date)

Last Name _____ First Name _____ **Date ____/____/____**

Address _____ City_____ Zip _____

Home Phone _____Cell Phone _____Email _____

Birthday ___/____/____ Sex: M/F Marital Status:_____ Spouse's or Significant Other's Name _____

Occupation:_____ Employer:_____

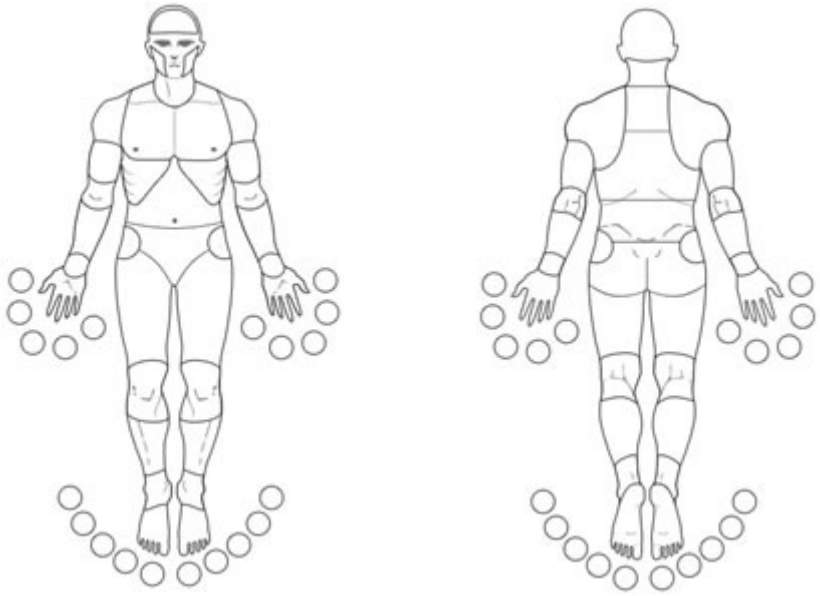
Emergency Contact (name) _____ (phone) _____ (relationship) _____

How did you hear about our clinic? _____

How would you like to receive appointment reminders? □ E-mail □Text (Cellular Carrier _____) □None

On the diagrams to the right, please mark where you are experiencing any symptoms:

<u>Use the following as a guide:</u>
P = Pain
T = Tingling
N = Numbness
B = Burning
W = Weakness



Please rate each of your symptoms individually on a scale of 0-10. (0 = no pain, 10 = worst pain you've ever had)

Symptom #1:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Symptom #2:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Symptom #3:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Symptom #4:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Symptom #5:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

When did your symptoms begin?_____

Are your symptoms getting progressively worse? □Yes □No □Unknown

How often do you have this pain? _____

Is it constant or does it come and go? _____

How would you characterize your pain? (check all that apply): □Dull □Sharp □Achy □Shooting □Burning
□Stabbing □Throbbing □Stiffness □Other_____

What makes your condition <u>worse</u>? □Coughing □Sneezing □Bearing Down □Lifting □Bending □Pushing
□Pulling □Sitting □Standing □Lying Down □Walking □Moving Your Head □Other_____

What makes your condition better? □Rest □Movement □Sitting □Standing □Lying Down □Bracing □Heat □Ice □Massage □Stretching □"Popping" □Aspirin □Ibuprofen □Tylenol/Acetaminophen □Prescribed Medication □Other_____

What time of the day are your symptoms worse? □Morning □Afternoon □Evening □ Sleeping □At Work □Other_____

What time of the day are your symptoms better? □Morning □Afternoon □Evening □ Sleeping □At Work □Other_____

Is there any known cause of your symptoms? □Auto Accident □Work Injury □Lifting □Slip/Fall □Overexertion □Strenuous Position □Unknown □Other_____

If known cause, how soon did the symptoms start? □Immediately □Hours Later □Next Day □Days Later □Week Later □Other: _____

Have you experienced symptoms like these before? □No □Yes (when?) _____

Have you missed any work due to this condition? □No □Yes (dates?) _____

Have you had to modify or restrict your activities at work? □No □Yes

When your symptoms are at their worst, describe what happens: _____

_____

Previous Testing:

Have you had any of the following testing?

X-ray: Y/N Area: _____ Date: _____ MRI: Y/N Area: _____ Date: _____

CT Scan: Y/N Area: _____ Date_____ EMG/NCV: Y/N Area: _____ Date: _____

Was there a previous diagnosis for your condition? i.e. Have you been told what is causing your problem? _____

_____

Previous Treatment:

Have you ever seen anyone else for this condition? □Yes □No

If Yes, who and when? _____

_____

Treatment Options:

Is there any type of treatment that you would not consider at this time? _____

_____

What is your most important treatment objective? (Reduce pain, increase function, correct cause, prevent progression) _____

Prescription Medications	**Supplements**	**Allergies**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
□ See attached list	□ See attached list	

Previous/Current Conditions:

Do you currently have or have you ever had any of the following? (check all that apply)

□Alcoholism	□Diabetes	□HIV/AIDS	□Rash/Lesion
□Aneurysm	□Dislocated Joints	□Thyroid Hyper/Hypo	□Rheumatic Fever
□Anemia	□Easily Bruised	□Insomnia	□Scoliosis
□Arthritis_____	□Emphysema	□Kidney Trouble	□Spinal Disc Disease
□Asthma	□Epilepsy/Seizures	□Liver Trouble	□STD
□Bone Fractures	□Erectile Dysfunction	□Mental/Emotional	□Stroke
_____	□Fatigue/weakness	Difficulty: _____	□Tinnitus/Ears Ringing
□ Blood Pressure	□Frequent Nose	□Multiple Sclerosis	□Tuberculosis
HIGH/LOW	Bleeds	□Osteoporosis/	□Ulcer
□Cancer/Tumor	□Hearing Changes	Osteopenia	□Other
□Carotid Artery	□Heart Disease	□Pacemaker	_____
Disease or Blockage	□Heart Palpitation	□Polio	□ **None of the above**
□Change in Appetite	□Hernia	□Prostate Trouble	

Have you had any of the following in the last 3 months? (check all that apply)

□Neck Pain	□Upper Back Pain	□Mid Back Pain	□Low Back Pain	
□Neck Stiffness	□Upper Back Stiffness	□Mid Back Stiffness	□Low Back Stiffness	
□Shoulder Pain	□Hip Pain	□Leg Pain	□Ankle Pain	□Foot Pain

Vascular Screening:

Have you recently experienced any of the following? (mark all that apply):

□ Double Vision / Sudden Onset of Vision Problems	□ Dizziness, Vertigo or Light-headedness
□ Sudden Numbness/Weakness of Face, Arms or Legs	□ Difficulty Speaking
□ Difficulty Swallowing	□ Difficulty Walking
□ Nausea, Vomiting or Queasiness	□ Numbness or Loss of Sensation on one side
□ Involuntary Rapid Eye Movements (nystagmus)	□ **None of the above**

If you are experiencing Headaches or Neck Pain, have you experienced pain like this before?

□Yes, I have had headaches / neck pain like this before.

□No, this pain is different than I have experienced in the past.

Did your headache or neck pain start suddenly? Y / N

Women Only:

Is there any chance that you may be PREGNANT? Y/N Date of last menstrual period ____/____/____

Lifestyle & Habits:

Smoking (packs per day): □Never □1 □2 □3 □4+ □Quit_____ years ago.

Caffeinated drinks (cups per day): □0 □1 □2 □3 □4 □5 □6+

Alcohol consumption (drinks per day): □0 □1 □2 □3 □4 □5 □6+

Drug/Substance use: □Yes □No

Exercise (times per week): □0 □1 □2 □3 □4 □5 □6 □7 Type of exercise: _____

Average amount of sleep per night (hours): □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10 □11 □12

What do you feel your stress level is currently? (0 being no stress and 10 being maximal stress)

□1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Previous Accidents/Injuries/Hospitalizations/Surgeries:

(Please inform us of any/all recent injuries that could have contributed to your current condition.)

Do you have a history of any of the following? □Work Injury □Auto Accident □Slip & Fall Accident

If so please list approximate dates and incident:

1. Date____/____/____Incident _____

2. Date____/____/____Incident _____

Have you ever been hospitalized? □Yes □No If so, when and for what condition?

1. Date____/____/____Condition _____

2. Date____/____/____Condition _____

Have you had any surgeries? □Yes □No If so, when and for what condition?

1. Date____/____/____Surgery _____

2. Date____/____/____Surgery _____

Family History:

Has any member of your family been diagnosed with any of the following?

□Cancer □Diabetes □High Blood Pressure □Stroke □Heart Disease □Other: _____

If yes, what is their relation to you? _____

Have you tried any of the following?				**Results of treatment: (circle one for each)**		
Anti-Inflammatory Meds:	YES	NO	►►	No Relief	Temporary Relief	Worse
Muscle Relaxers (Prescription):	YES	NO	►►	No Relief	Temporary Relief	Worse
Pain Medications (Prescription):	YES	NO	►►	No Relief	Temporary Relief	Worse
Massage Therapy:	YES	NO	►►	No Relief	Temporary Relief	Worse
Physical Therapy:	YES	NO	►►	No Relief	Temporary Relief	Worse
Acupuncture:	YES	NO	►►	No Relief	Temporary Relief	Worse
Chiropractic:	YES	NO	►►	No Relief	Temporary Relief	Worse
Injections (including epidurals):	YES	NO	►►	No Relief	Temporary Relief	Worse
Spinal Surgery:	YES	NO	►►	No Relief	Temporary Relief	Worse

Have you been told you need an injection? YES NO By whom? _____

Have you been told you need spinal surgery? YES NO By whom? _____

What three things has this condition caused you to miss out on the most?

1) _____ 2) _____ 3) _____

What is your biggest concern if you are unable to find a solution to your main problem?

_____

Please indicate how important it is for you to improve your current condition, or stop it from progressing:

Not Important *Very Important*

0 1 2 3 4 5 6 7 8 9 10

Activities of Daily Living

This next series of questions are about the effect your condition has had on your activities of daily life. We also will use this information to measure your progress and the results of your treatment if we are able to accept you for care.

Work:

How do your health problems make it harder to do your job? _____

_____

Are you less productive on your job because of your health problems? □Yes □No

Do you enjoy work less? □Yes □No

Do you have to take more breaks? □Yes □No

Are you concerned about your ability to do your job or the security of your job? □Yes □No

Please explain: _____

Social:

How do your health problems affect your relationships with your family and friends? For example: Are you less fun to be with? Do you help less around the house? Are there things you do less? _____

_____

Recreational Activities:

What hobbies or interests do you have outside of work? _____

_____

When your problems are at their worst, do they affect how you do or enjoy your hobby/interest? □Yes □No

If you didn't have this condition how would it affect how you do your hobbies/interests? _____

_____

Is there anything else you would do more of or just enjoy more if it wasn't for these conditions? _____

_____

_____

Sleep Habits:

Do you have trouble falling asleep due to being uncomfortable? Y/N

How long does it take to fall asleep? _____

Do you wake during the night? Y/N Approximately how many times? _____ Can you get back to sleep? Y/N

Additional Information & Resources

If you are interested in receiving additional information about any of the following, please check the boxes below:

Conditions

- ☐ Peripheral Neuropathy
- ☐ Sciatica
- ☐ Chronic Headaches
- ☐ Dizziness/ Balance Disorders
- ☐ Whiplash Injuries
- ☐ Mild Traumatic Brain Injury
- ☐ Chronic Back/Neck Pain
- ☐ Joint Pain (Hip, Knee, Foot, Shoulder, Elbow, Hand)

Treatments

- ☐ Non-Surgical Spinal Decompression
- ☐ Cold Laser
- ☐ Massage Therapy
- ☐ Clinical Nutrition
- ☐ Functional Neurology
- ☐ Vitamins/ Supplements
- ☐ Infrared Therapy
- ☐ Whole Body Vibration
- ☐ Interactive Metronome

FINANCIAL POLICY

As a courtesy to you, we will bill your insurance company for you. In order for us to do this for you, we will need you to provide us with the following information: the name of the company, the address to which claims are to be billed, your policy identification number, your group number (if applicable), and a phone number. It is your responsibility to provide any required information (referrals, authorization numbers, claim forms, accident information). It is also your responsibility to follow the policy guidelines of your insurance company. We will bill your secondary insurance as well, provided you have given us complete insurance information as noted above for your secondary company.

Policies vary widely on which procedures, services or items an insurance company will cover. Because policies are often customized, we cannot be sure what your policy covers. In order to maximize your health insurance benefits, it is very important that you familiarize yourself with the policies and benefits outlined in your health insurance handbook or contact the customer service number on the back of your card.

Insurance Company & Phone: _____

Member ID _____ Group #: _____ Name & Date of Birth of ***Policy Holder***: _____

AUTHORIZATION OF RELEASE, ASSIGNMENT OF BENEFITS, STATEMENT OF RESPONSIBILITY

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable. I understand that if I have insurance, the fees for services I receive will be billed to my insurance company. I also understand that I am responsible for coinsurance or copays at the time I receive the service, unless prior arrangements have been made.

I have read and understand the terms and conditions stated above.

Patient Name or Responsible Party: _____Date: _____

(Signature)

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

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

- ❑ 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 causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – WORK

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

SECTION 5 – HEADACHES

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

SECTION 7 – SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

SECTION 9 – READING

- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

SECTION 10 – RECREATION

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

PATIENT NAME _____ DATE _____

SCORE _____ [50] BENCHMARK -5 = _____

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