**Personal Information** **Date** ______________

**Name**__________________________ **SS#:**____________________ **Address** ________________________

**City** ___________________________ **State** _______ **Zip** ______________ **Date of Birth** ______________

**Phone:** (Home)______________ (Work)________________ **Occupation and Employer** ____________________

**Referred by**__________________________ **Marital Status: S M D W**

**Spouses Name** ______________________ **Spouses Occupation**_______________________

**Location of Collision**______________________________ **Date of Onset/Collision**_____________________

**Responsible Insurance Company**

**Name**__________________________________________ **Address**________________________________________

**City**_____________________ **State**__________ **Zip**______________ **Phone #**_______________________

**Adjuster**__________________________ **Claim #**_______________ **Fax #**_________________________

---

Please mark areas of pain resulting from this collision on figures below. Use shapes from the legend to describe what type of pain you are experiencing.

**Pain Legend**

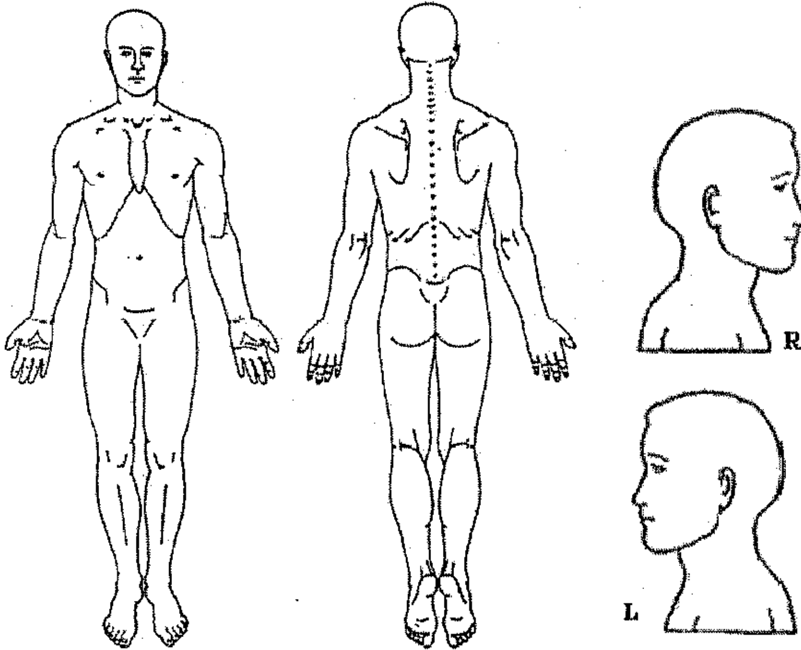
X = sharp

○ = dull/achy

□ = throbbing

Δ = burning

SS = muscle spasm




Is the pain getting worse________ staying the same________ or improving_______?

Is the pain occasional________ frequent________ or constant_________?

What makes the pain better?____________________________________________________________

What makes the pain worse?____________________________________________________________

PAIN SCALE (please mark on the line where you feel your level of pain is at)

**Name** ______________________ **Date** ______________

**Describe the Collision/Injury (if auto accident, please include specifics):**

______________________________________________

______________________________________________

**Car was hit: [ ] In front [ ] Rear end [ ] On Side**

**Specifics of Collision/Injury (Mark each that applies):**

Job or Work Related injury ( ) Yes ( ) No
Your were the [ ] Driver [ ] Passenger [ ] N/A
Sitting [ ] Front seat [ ] Back seat

Aware of Impact: [ ] Braced [ ] Not braced
Head Did: [ ] Strike Object [ ] Not strike Object
Did you experience: [ ] Shock
[ ] Flash of Light Seen Upon Impact
[ ] Air bag Deployed

Immediately Following the Collision/Injury

[ ] Ambulance – Paramedics Called
[ ] Treated at Scene
[ ] Transported to Hospital by Ambulance
[ ] Went to Hospital on your own
[ ] Diagnostics Performed at Hospital
[ ] Medication Prescribed
[ ] Treatment at Hospital
[ ] Follow-up Recommended

**Time Loss**

[ ] NO time loss from work due to injury. I am currently working with No limitations.
[ ] NO time loss form work due to injury BUT I do have limitations*.
[ ] I have experienced time loss from work due to injury (Indicate number of days, weeks, etc. ________ ).
[ ] N/A

*Describe limitations due to collision/injury:______________________________

______________________________________________

**Mechanism of Injury (Skip this section if this incident was not involved in a motor vehicle)**

Were you surprised by the impact? __Yes __No

In relation to the back of your head, was your headrest set: __Low __Middle __High __None

Where was your head facing at the time of impact? __Left __Forward __Right __Unknown

Were you leaning forward at the time of impact or out of position? __Yes __No

Were you wearing a seatbelt/harness? __Yes __No

Were you rendered unconscious as a result of the collision? __Yes __No

Did you feel pain immediately after the collision? __Yes __No

Year and type of vehicle were you in? ______________________________

Size of your vehicle? __Small __Mid __Large __Unknown

Year and type of other vehicle involved in the collision? ______________________

Size of other vehicle? __Small __Mid __Large __Unknown

What was the approximate speed of your vehicle when the collision occurred? ______________

What was the approximate speed of the other vehicle when the collision occurred? ______________

Did you have any bruises or cuts as a result of the collision (Yes/No)? Where?______________

Was your foot on the brake at impact? Yes / No

**Social History**

[ ] Single
[ ] Married
[ ] Divorced
Number of Children:______

[ ] Smoker
[ ] Non-Smoker
[ ] Drink Alcohol
[ ] Do not drink Alcohol
[ ] Take Drugs
[ ] Do not take Drugs

Are any activities limited by pain or have you noticed pain while doing these that you didn't have before the collision?
[ ] Work
[ ] Household chores
[ ] Intimate life
[ ] Exercise

List your Hobbies & Exercise Activities (do these make your pain worse? Yes/No)

______________________________________________

**Occupational History of (name)** ______________________

Your Employer ______________________

Job Title ______________________

Are your Job Duties Physically demanding for you? [ ] Yes [ ] No
Have you had any disability time? [ ] Yes [ ] No
If you are currently working which are you performing?
[ ] Regular Duties
[ ] Limited – Light Duties

What is your current job satisfaction:
[ ] Very Satisfied
[ ] Satisfied
[ ] Dissatisfied
[ ] Very Dissatisfied

Your highest level of education attained? (years) _________

**Medical History**

**I have seen the following physician/practitioners for this condition:**
Chiropractor (Name): ______________________
Massage Therapist: ______________________
Neurologist: ______________________
Orthopedist: ______________________
Physical Therapist: ______________________
Physician: ______________________
Psychiatrist/Psychologist: ______________________
Other: ______________________
**Have you ever received Chiropractic Care?** Yes No

**List the treatments you have had done for this condition.**

| | |
|---|---|
| [ ] Ice | [ ] Chiropractic |
| [ ] Heat/Ultrasound | [ ] Osteopathy |
| [ ] Electrical Stimulation | [ ] Injections |
| [ ] Exercises | [ ] Acupuncture |
| [ ] Gravity Inversion – Traction | [ ] Naturopathy |
| [ ] Bed Rest | [ ] Massage |

**List any previous problems with area of complaint (and when)**

______________________

**Were you receiving treatment for these areas at the time of accident? Yes / No**

**Any new symptoms to these areas since the collision? Yes / No**

**Since the collision, do you feel you are troubled with:**
[ ] Anxiety
[ ] depression
[ ] irritability

**Current medications I am taking:**

______________________
______________________

**Past Surgeries:**

______________________
______________________
______________________
______________________

**Past Hospitalizations:**

______________________
______________________

**Doctors seen prior to accident:**

______________________
______________________
______________________

**List the types of Diagnostic Testing that has been done for this condition:**

| | | | |
|---|---|---|---|
| [ ] X-rays | [ ] Discogram | [ ] CT Scan | [ ] Bone Scan |
| [ ] Myelogram | [ ] EMG | [ ] MRI | |

**Females – Mark if have the following:**

| | | |
|---|---|---|
| [ ] Vaginal bleeding other than period | [ ] Pap smear within last two years | [ ] Painful menstrual periods |
| [ ] Back pain with menstrual periods | [ ] Other menstrual problems | [ ] Current Pregnancy |

**Mark if you have had any of the following symptoms in the past 5 years:**

| | | |
|---|---|---|
| [ ] Unexplained fevers | [ ] Swollen ankles | [ ] Night sweats |
| [ ] Stomach pain | [ ] Weight loss of 10 lbs or more | [ ] Change in bowel habits |
| [ ] Loss of appetite | [ ] Persistent diarrhea | [ ] Excessive fatigue |
| [ ] Excessive constipation | [ ] Problems with depression | [ ] Dark black stools |
| [ ] Difficulty sleeping | [ ] Blood in stools | [ ] Unusual stress at work |
| [ ] Pain-burning when urinating | [ ] Unusual stress at home | [ ] Difficulty urinating – start / stop |
| [ ] Easy bruising | [ ] Blood in urine | [ ] Excessive bleeding |
| [ ] Need to urinate more at night | [ ] Lumps in neck, armpit or groin | [ ] Morning stiffness |
| [ ] Chest pain or tightness | [ ] Persistent eye redness | [ ] Persistent or unusual cough |
| [ ] Muscle tenderness | [ ] Trouble breathing with exercise | [ ] Dry eyes or mouth |
| [ ] Trouble breathing lying flat | [ ] Skin rashes | |
| [ ] Coughing up blood | [ ] Joint pain or swelling | |

# Camp Chiropractic Center Informed Consent to Treat

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy / physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic indicated below and/or other licensed Doctors of Chiropractic and support staff who now or in the future treat me while employed by, working or associated with, or serving as backup for the Doctor of Chiropractic named below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand that chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, I understand and am informed that, as is with all healthcare treatments, results are not guaranteed, and there is no promise to cure. In addition, I understand and am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short period of time, aggravating and/or temporary increase in symptoms, lace of improvement of symptoms, burns from heat lamps, ice or heating devices, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self administered, over-the-counter analgesics and rest; medical care with prescription drugs, such as anti-inflammatories, muscle relaxants and pain killers; physical therapy; acupuncture, massage, steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options. I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the above-named chiropractic and related procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment from this clinic or Chiropractic doctor.

____________________________________ ____________________

Patient or Representative or Guardian for Patient Date

# NECK DISABILITY INDEX QUESTIONNAIRE

**Patient Name** ________________________________ **Date** ____________________

*Please read carefully:*

*This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only **ONE CHOICE 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 one box, which most closely describes your problem right now.***

**SECTION 1 – Pain Intensity**

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

**SECTION 2 – Personal Care (washing, dressing, etc.)**

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, wash with difficulty and stay in bed.

**SECTION 3 – Lifting**

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives extra pain.
C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

**SECTION 4 – Reading**

A. I can read as much as I want with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

**SECTION 5 - Headaches**

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

**SECTION 6 – Concentration**

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I cannot concentrate at all.

**SETION 7 – Work**

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

**SECTION 8 – Driving**

A. I can drive without any neck pain.
B. I can drive as long as I want with slight pain in my neck.
C. I can drive as long as I want with moderate pain in my neck.
D. I cannot drive as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

**SECTION 9 – Sleeping**

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr. sleepless).
C. My sleep is mildly disturbed (1-2 hrs. sleepless).
D. My sleep is moderately disturbed (2-5 hrs. sleepless).
E. My sleep is greatly disturbed (3-5 hrs. sleepless).
F. My sleep is completely disturbed (5-7 hrs. sleepless).

**SECTION 10 – Recreation**

A. I am able to engage in all my recreation activities with no neck pain at all.
B. I am able to engage in all my recreation activities with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
E. I can hardly do any recreation activities because of pain in my neck.
F. I cannot do any recreation activities at all.

**OTHER COMMENTS:**

________________________________

________________________________

________________________________

________________________________
Examiner

With Permission from: Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.

# THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

**PATIENT NAME:** ______________________________ **DATE:** ______________

Please read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

**SECTION 1 - Pain Intensity**

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

**SECTION 2 - Personal Care**

A I do not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain I am unable to do some washing and dressing without help.
F Because of the pain I am unable to do any washing and dressing without help.

**SECTION 3 - Lifting**

A I can lift heavy weights without extra pain.
B I can lift heavy weights but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights at the most.

**SECTION 4 - Walking**

A I have no pain on walking.
B I have some pain on walking but it does not increase with distance.
C I cannot walk more than one mile without increasing pain.
D I cannot walk more than 1/2 mile without increasing pain.
E I cannot walk more than 1/4 mile without increasing pain.
F I cannot walk at all without increasing pain

**SECTION 5 - Sitting**

A I can sit in any chair as long as I like.
B I can sit only in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than 10 minutes.
F I avoid sitting because it increases pain straight away.

**SECTION 6 - Standing**

A I can stand as long as I want without pain.
B I have some pain on standing but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than 10 minutes without increasing pain.
F I avoid standing because it increases the pain immediately.

**SECTION 7 - Sleeping**

A I get no pain in bed.
B I get pain in bed but it does not prevent me from sleeping well.
C Because of pain my normal night's sleep is reduced by less than 1/4.
D Because of pain my normal night's sleep is reduced by less than 1/2.
E Because of pain, my normal night's sleep is reduced by less than 3/4.
F Pain prevents me from sleeping at all.

**SECTION 8 - Social Life**

A My social life is normal and gives me no pain.
B My social life is normal but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life, and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

**SECTION 9 - Travel**

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling, which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

**SECTION 10 - Changing degree of pain**

A My pain is rapidly getting better.
B My pain fluctuates but overall is definitely getting better.
C My pain seems to be getting better but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

**SIGNATURE:** ______________________________

# Roland Morris Disability Index

Name: ______________________ DOB: ____________ Date: ____________

When your back hurts, you may find it difficult to do some of the things you normally do. Check the box before each sentence that describes you today. Leave the box blank if the sentence does not describe you.

- ☐ I stay home most of the time because of my back.
- ☐ I change positions frequently to try to get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any of the jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back.
- ☐ I have trouble putting on my socks (stockings) because of my back.
- ☐ I only walk short distances because of my back pain.
- ☐ I sleep less well because of my back pain.
- ☐ Because of my back pain, I get dressed with help from someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of my back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.

---

Form by Roland M. Morris R. Spine 1983:8(2):141-144. Lippincott-Raven Publishers

# AUTHORIZATION, ASSIGNMENT, & RELEASE FORM

## AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the names(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorized you to compromise, settle otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect form insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Washington
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization for Assignment will be in continual effect until revoked by both parties.

__________ Date    ____________________ Patient/Insured Signature

---

## RECORDS RELEASE

To __________________, I hereby authorize you to release to Camp Chiropractic Center, Inc. any information including the diagnosis and records of treatment or examination rendered to me for all care during the period from ________ to __________.

__________ Date    ____________________ Patient/Insured Signature

__________ Date    ____________________ Staff Signature

---

Camp Chiropractic Center, Inc.

# Privacy Practice Notice

**As required by HIPPA, this notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

- Camp Chiropractic Center may be required to share your information with you insurer to obtain payment for services on your behalf. As part of our financial policy you authorize this office to do so when necessary.
- Employees of Camp Chiropractic Center will have access to your records and may need to review them as part of their job duties. They are bound by the same doctor patient relationship and HIPPA regulations.
- Information may be shared with other health care providers that are directly involved with your care upon your written authorization.
- From time to time, Camp Chiropractic Center may utilize your personal information such as mailing address and phone number to contact you regarding your care, such as appointment reminders, to discuss treatment or alternatives or to inform you of a promotional event.

## Patient Rights

- You may request restrictions on certain uses and disclosures of the protected information.
- You may revoke any prior written authorization to release records at any time.
- You have the right to receive confidential communication of protected health information.
- You have the right to inspect and copy protected health information from our office, including medical records.
- You have the right to amend protected information.
- You have the right to an accounting of disclosures of protected health information.

*(Original information will not be permitted to leave the office for copying purposes. You may bring in a copying serve or Camp Chiropractic Center will provide a copy for a standard fee allowed by law. If you wish to review your file or have it copied, you will need to pre-arrange a convenient time for our staff so to accommodate you.)*

**Camp Chiropractic reserves the right to change its privacy policy. You will be notified prior to a changed disclosure only when it applies to you.**

I, ____________________________, have read and understand the above privacy practice notice.

________________________________ ________________________________

Signature Date

Notes:

# Agreement to Doctor's Lien

Patient Name: ______________________________________________

Date of Injury: ______________________________________________

To Attorney or At Fault Insurance Company: ______________________________

I understand that Camp Chiropractic Center, Inc. (CCC) will file a lien against the settlement of my injury claim with Thurston County Auditor's Office and that there will be an additional amount added to my lien for the cost of notarizing and filing that lien in the amount of $100.00. I also acknowledge that if I want CCC to release said lien when paid in full, I will be personally responsible for the additional charge of $73.00 paid in full prior to said lien being released. Furthermore, I authorize and direct my attorney or the at fault insurance company to pay to CCC all such sums as may be due and owing the clinic for said fees or treatment relating to my injury. I specifically direct my attorney or the at fault insurance company to withhold such monies out of any award or settlement that would be otherwise net payable to me when my claim for injuries resolve.

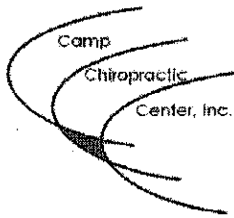
I acknowledge full responsibility for payment of all my bills owing to CCC before or at the time of settlement. I also specifically agree that CCC may withhold collection on my account in exchange for my promise to have my attorney pay my bills out of any resolution of my injury claim. I agree not to rescind the terms of this agreement therefore directing my attorney to not be bound by any attempt at rescission of this agreement on my part. I hereby direct that my attorney or the at fault insurance company pay my bill to CCC out of monies that would be otherwise net payable to me at the time of resolution of my claim.

This direction to my attorney or the at fault insurance company in no way releases me from the obligation to pay CCC on my bill, and I understand that this obligation to pay is not contingent on my recovering on my claim. I agree that if CCC is not paid on my account, CCC may take whatever collection efforts it chooses against me, and I shall be responsible for all costs of collection including reasonable attorney fees and costs incurred by CCC or its assigns in collecting monies owed by me.

If the patient is a minor or handicapped person, I represent that I am the guardian or representative of that person and have lawful authority to execute this document on that person's behalf.

Dated: ________________ Patient's Name (Printed): ______________________________

Patient's Signature: ______________________________




# Goals for Care

In our office, we want to know what you expect from your care with us. What kind of things would you like to do that you are currently unable to. Please write out your short term and long term goals you would like to achieve with chiropractic care.

## Short Term Health Goals

________________________________________
________________________________________
________________________________________
________________________________________

## Long Term Health Goals

________________________________________
________________________________________
________________________________________
________________________________________

*"An unmanned sailboat simply drifts about with the wind, but a sailboat with a goal gets to where it's going, although not in a straight line."*