Coastal Chiropractic Center

"The Natural Choice in Health Care"

Date_____

Name: _____ Preferred Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Best Contact: ☐Home ☐Work ☐Cell **Phone #:** _____ Type: _____

Other Phone # *(if applicable):* _____ Type: _____

Date of Birth: _____ **Gender:** _____ **E-Mail**_____

Occupation/Employer: _____

Emergency Contact Name: _____ **Phone:** _____ **Relationship:**_____

If you were referred, who may we thank?

_____

CURRENT COMPLAINT(s):

☐	☐ Headaches	☐R ☐L ☐B☐
☐	☐ Neck Pain/Stiffness	☐R ☐L ☐B☐
☐	☐ Upper Back	☐R ☐L ☐B☐
☐	☐ Low Back Pain	☐R ☐L ☐B☐
☐	☐ Muscle Spasms	☐R ☐L
☐	☐ Hip/Buttocks Pain	☐R ☐L ☐B ☐
☐	☐ Knee/Leg Pain	☐R ☐L ☐B ☐
☐	☐ Ankle/Foot Pain	☐R ☐L ☐B
☐	☐ Shoulder, Arm, Hand	☐R ☐L ☐B
☐	☐ Elbow, Wrist Pain	☐R ☐L ☐B
☐	☐ Tingling-arms/hands	☐R ☐L ☐B
☐	☐ Tingling- legs or feet	☐R ☐L ☐B
☐	☐ Sciatica	☐R ☐L ☐B

MEDICAL HISTORY:

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Cancer Type _____
- ☐ Diabetes Type _____
- ☐ Tobacco/Vape Use Type _____
- ☐ Alcohol use Frequency_____
- ☐ Liver Disease
- ☐ Kidney Disorder, Stones
- ☐ Communicable Disease
- ☐ Osteoporosis
- ☐ Neurological Disorder
- ☐ Stroke / Aneurysm
- ☐ Herniated Disc

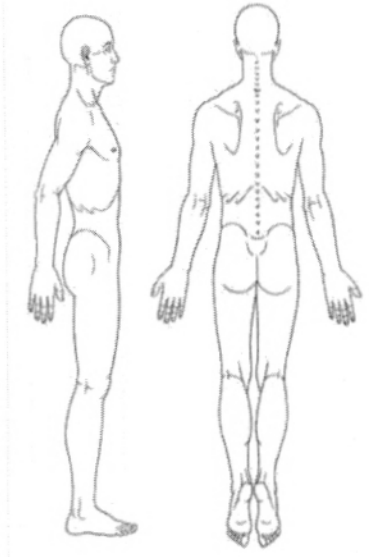
FAMILY MEDICAL HISTORY *(circle below)*

- S, M, F, GP High Blood Pressure
- S, M, F, GP Heart Attack
- S, M, F, GP Cancer
- S, M, F, GP Diabetes
- S, M, F, GP Osteoporosis
- S, M, F, GP Arthritis
- S, M, F, GP Aneurysm
- S, M, F, GP Low Back Pain
- S, M, F, GP Neck Pain
- S, M, F, GP Herniated Disc

Other, Please describe below

- S, M, F, GP _____
- S, M, F, GP _____

Circle or mark the diagram below where you hurt



Pain intensity	**How often?**	**What does it feel like? (circle or write in)**
_____ (0 – 10)	0-25% -50% -75% - 100% (Off and On....Half....Most.. All the time)	Sharp Spasm Aching Throbbing Sore Dull Tingle Stiff
_____ (0 – 10)	0-25% -50% -75% - 100% (Off and On....Half....Most.. All the time)	Sharp Spasm Aching Throbbing Sore Dull Tingle Stiff
_____ (0 – 10)	0-25% -50% -75% - 100% (Off and On....Half....Most.. All the time)|	Sharp Spasm Aching Throbbing Sore Dull Tingle Stiff
_____ (0 – 10)	0-25% -50% -75% - 100% (Off and On....Half....Most.. All the time)	Sharp Spasm Aching Throbbing Sore Dull Tingle Stiff
_____ (0 – 10)	0-25% -50% -75% - 100% (Off and On....Half....Most.. All the time)	Sharp Spasm Aching Throbbing Sore Dull Tingle Stiff
_____ (0 – 10)	0-25% -50% -75% - 100% (Off and On....Half....Most.. All the time)	Sharp Spasm Aching Throbbing Sore Dull Tingle Stiff

Reviewing Doctors Signature: _____ Philip Van Campen, DC, FACO

_____ Tracy Labrecque, DC

_____ Kelly Van Campen, DC

Patient Name:_____ **Date** _____

1). What Caused this Condition? ☐Auto Accident ☐Fall ☐Lifting ☐Bending/Twisting ☐Other: _____

2). Please Explain:_____

3). Date This Started: _____ ☐1week or less ☐1-2 weeks ☐2-4 weeks ☐4-12 weeks ☐3-6 months ☐6+Months

4). Ever had this *Same Exact* Problem Before? ☐Yes ☐No **Similar to This?**☐Yes ☐No **What year?**_____

5). My Pain is Getting: ☐Better ☐Worse ☐No Change **Any Missed Work Days? If so, when?**_____

6). My Pain is Worse: ☐ Mornings ☐Afternoon ☐Evening ☐When I Sleep, it is ☐ Hard to Fall Asleep ☐Wakes me up

7). My Pain: ☐Prevents Daily Activities ☐Moderately Affects Activities ☐Somewhat Affects Activities ☐No Affect

8). My Pain is Worsened by: ☐Sitting ☐Standing ☐Bending/Twisting ☐Getting up from a chair ☐Walking ☐Reaching

9). My Pain is Helped by: ☐Rest ☐Activity ☐Heat ☐Ice ☐Pain Meds ☐Sitting ☐Standing ☐Lying down ☐Exercise

10). Do you take pain relievers, either over-the-counter or prescription? ☐Yes ☐No Name(s):_____

_____

11). Are You Currently Undergoing Medical Treatment? ☐Yes ☐No **If 'yes', for what?**_____

12). Do You Have a Primary Care Physician? ☐Yes ☐No **Who?**_____

13). Previous Surgeries (Year and Type): ☐_____ ☐_____

☐_____ ☐_____ ☐_____

14). Do you have a history of blood clots? ☐Yes ☐No **History of ever having an Aneurysm or Stroke?** ☐Yes ☐No

15). How is your overall health status? ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

16). Have you seen a Chiropractor before? ☐Yes ☐No **When and what for?** _____

17). Do you twist your spine *or* your neck to make it "pop", "crack" or "click"? ☐Yes ☐No

18). Has anyone besides a chiropractor adjusted you? ☐Yes ☐No

NOTES

_____

_____

_____

_____

Reviewing Doctors Signature: _____ Philip Van Campen, DC, FACO _____ Tracy Labrecque, DC _____ Kelly Van Campen, DC

HIPAA Patient Consent Form

This form will be retained in your medical record

I understand that I have certain rights to privacy regarding my protected health information (PHI) and that they are given to me under the Health Insurance Portability & Accountability Act of 1966 (HIPAA). I understand that by signing this consent, I am authorizing Coastal Chiropractic Center to use and disclose my PHI to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment
- Day-to-day healthcare operations

I have the right to request restrictions on how my PHI is used and disclosed and I have a right to revoke my consent. Coastal Chiropractic Center is not required to agree to requested restrictions, but will recognize the revocation upon receipt. It will not be retroactive.

I acknowledge that Coastal Chiropractic Center's "Notice of Privacy Practices", effective date of April 14, 2003 (rev 08-31-2024), has been made accessible to me and that it provides a more complete description of the use and disclosure of my PHI and rights under HIPAA. The "Notice" can be obtained:

- Front desk
- Copies available throughout our office
- Our website: **coastalchiros.com**

_____ _____

Print Name Date

_____

Signature of Patient

_____

If Patient Representative, indicate name and relationship to Patient

(optional) **Please list the name and relationship of any individuals whom you would allow us to release and divulge your Protected Health Information (PHI) to without additional authorization:*

Name_____ Relationship: _____

Name _____ Relationship: _____

Do you authorize us to communicate with you by:

Text Message? **Email?**

□ Yes □ No □ Yes □ No *If so, please provide email:*_____

Leaving a detailed voicemail?

□ Yes □ No

OFFICE STAFF USE ONLY

☐ ***Entered/Updated*** the above information into Patients EHR

☐ ***Scanned the following SIGNED*** documents into Patients EHR: **1)** HIPAA Patient Acknowledgement and Consent **2)** Consent to Chiropractic Treatment

"The Natural Choice in Health Care"

COASTAL CHIROPRACTIC CENTER, PA

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks, and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with care. Common Chiropractic Treatment includes, but is not limited to Examinations, X-Rays, Spinal Manipulation, Mobilization of the Joints of the Spine and Extremities, Therapeutic Exercise, Massage, Myofascial Therapy and Physical Therapy modalities, Electrical Stimulation, Acupuncture, Dry needling Moist Heat, Ice, Traction, Spinal Decompression.

ANALYSIS EXAMINATION AND TREATMENT

As part of the analysis, examination and treatment, you are consenting to the following procedures:

- Range of Motion testing
- Orthopedic testing
- Basic neurological testing
- Muscle Strength testing
- Postural analysis testing
- Radiographs (X-Rays)
- Taking and recording Vital Signs
- Palpation (Placing hands and fingertips on and touching your body)
- Spinal manipulative therapy (Adjustments)
- Electrical Muscle Stimulation
- Acupuncture, Dry Needling
- Applying Ice and Heat packs
- Mechanical Spinal Traction
- Spinal Decompression
- Laser (light) Therapy
- Moist or Dry Heat and Cryotherapy (Ice)

BENEFITS:

Chiropractic care has been demc d by nerves, muscles, joints, and related tissues in the neck, back, and other areas of the body. Treatment by a chiropractor has also been shown to help relieve many neuromusculoskeletal complaints such as headaches, altered sensation due to nerve impingement, muscle stiffness and spasm, limited range of motion, difficulty sitting, standing, walking, travelling, sleeping, exercising and may also reduce or eliminate the need for drugs or surgery in many cases

RISKS:

As with any medical treatment, it is not possible to list all risks that are associated with providing patient care, including chiropractic treatment. Because each patient is different, and their conditions and medical status is unique, each patient's treatment regimen will vary according to their individual needs in order to provide safe, effective and lasting outcomes.

Skin Irritation or burn - Skin irritation or burns may occur in association with the use of moist heat, electrical stimulation or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.

Worsening of symptoms – can occur. Usually temporary, any increase in symptoms of pain, stiffness or dysfunction from chiropractic care should last only a few hours to a few days.

Sprain or strain – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, ice, protection of the area affected and other home care.

Rib and Bone fractures – are uncommon but may occur more frequently due to age, pre-existing bone tumors and in patients with osteopenia or osteoporosis. Rib and certain vertebral fractures usually heal on their own over a period of time but may also require medical or surgical intervention.

Spinal Disc Injury or Aggravation– Over the course of a lifetime, spinal disc damage can occur with common daily activities, such as bending, twisting, prolonged sitting, standing or lifting and the natural aging process. Chiropractic treatment should not damage a healthy disc but if a disc is already degenerated or damaged, or if a pre-existing condition or disk herniation present, chiropractic treatment, like many common daily activities, may aggravate the condition. Patients who already have a degenerated, damaged or herniated disc may or may not have any symptoms and the consequences of injury or aggravating a pre-existing disc condition will vary. In the most severe cases, patient symptoms may include

CONT.

impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, persistent pain, impaired leg or arm function requiring physical therapy or medical and surgical repair.
Stroke – Unfortunately, there is no recognized screening procedure to identify patients who are at risk of arterial stroke with or without neck pain. However, a blood clot may form in a previously weakened artery or blood vessel over time or through aging, disease, or because of an injury or trauma. All or part of a blood clot may break off and travel to the brain, where it can interrupt the blood flow causing damage to the brain. The consequences of a stroke can be very serious and may cause death.

THE PROBABILITY OF THOSE RISKS OCCURRING:
Stroke and arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate and chiropractic manipulation has not been shown to damage a healthy artery. Current research of strokes associated with chiropractic care considers the likelihood to be rare. Factures are rare occurrences and generally result from an underlying weakness of the bone which we check for during the examination and x-rays (if taken) and reviewing your past medical history.

ALTERNATIVE TREATMENT OPTIONS:
Other treatment options for your condition include Self-administered care such as over the counter analgesics and rest; Medical care, including prescription drugs for pain and inflammation; Pain Management injections, Physical Therapy, Acupuncture, Exercise, Rest, Ice and Heat to name a few of the many other options available.

Questions or Concerns? You are encouraged to ask questions at any time regarding your care and treatment. Please bring any concerns you have to your doctor's attention, and if you're not comfortable with the proposed or ongoing care you are receiving you may stop at any time.

I've read (or had have read to me) _____ (INITIAL HERE) the above Consent to Chiropractic Treatment and have been given the opportunity to ask questions about the details of chiropractic procedures and that my questions have been answered to my satisfaction.

I understand that complications, including the risk of death, stroke or serious disability exist with any medical or chiropractic procedure and that no guarantees of the treatment and procedures have been made. By signing below, I state that I understand and weigh the risks involved with chiropractic procedures and decided that it is in my best interest to undergo the chiropractic treatment and procedures recommended by my chiropractor.

I HAVE BEEN INFORMED OF THE RISKS, BENEFITS AND ALTERNATIVES TO CHIROPRACTIC TREATMENT AND I HEREBY GIVE MY CONSENT FOR THE DOCTOR AND STAFF TO PROCEED WITH PROVIDING MY CARE.

Patient Name: _____ **Signature:** _____ **Date:** _____

If Patient Representative/Guardian is present:
Name: _____ Relationship to Patient: _____ Date: _____

Doctors Name: _____ **Signature:** _____ **Date:** _____

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score