

# Valley Chiropractic Center Welcomes you!

2117 HWY 2 East, Kalispell, Montana 59901 Phone- 406-756-6868 Fax- 406-756-6870  
Dr. John Francis Sr and Dr. John Francis Jr Website- spinaldocs.com e-mail- info@spinaldocs.com

Name: \_\_\_\_\_ Date: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address / City / State / Zip \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Occupation: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Work Address / City / State / Zip: \_\_\_\_\_

Marital Status:  Married  Single Spouse's Name: \_\_\_\_\_ # of Children: \_\_\_\_\_

### MODE OF PAYMENT:

CASH  INSURANCE  PERSONAL INJURY  WORKER'S COMP

Please let us know how you were referred to Dr. John Francis Sr or Dr. John Francis Jr?

Family (Name): \_\_\_\_\_  Friend (Name): \_\_\_\_\_  
 Promotion  Other (please describe) \_\_\_\_\_

## MAIN COMPLAINT

What is your **MAIN** physical complaint?

Around what **date** did the complaint(s) begin and was it **instant or gradual**?

Is this complaint related to an accident:  Work  Car Accident  Other:  
**Describe** what happened:

Have you seen **another professional** for this condition?  Yes  No  
Name: \_\_\_\_\_ Date Consulted: \_\_\_\_\_ Diagnosis/Explanation: \_\_\_\_\_

What **Daily Activities** are more difficult?

What is the intensity of your pain **today** on a scale of 0-10? (Please circle)  
#1 NO PAIN 0 1 2 3 4 5 6 7 8 9 10 EXCRUTIATING PAIN

Have you had the symptom(s) before?  Yes  No  
How often are you having the symptom(s)?  Constantly  Daily  Weekly  Monthly

What movements make the symptom(s) **feel worse**?

What movements or medicine make the symptom(s) **feel better**?

## DO YOU HAVE OTHER PHYSICAL COMPLAINTS?

**HEADACHES?** How often:

Daily  Weekly  Monthly Explain: \_\_\_\_\_

**NECK PAIN? Explain:** \_\_\_\_\_

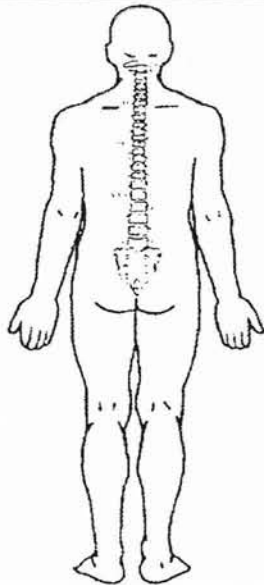
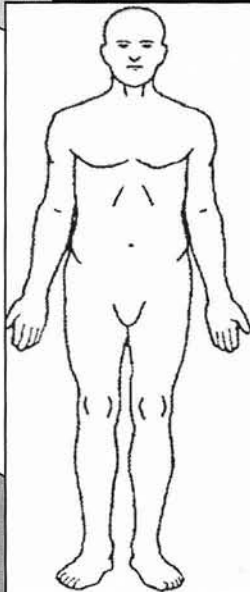
**BACK PAIN? Explain:** \_\_\_\_\_

**ARM/LEG PAIN? Explain:** \_\_\_\_\_

**OTHER? Explain:** \_\_\_\_\_

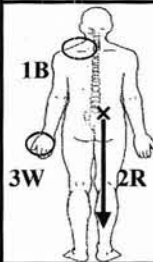
**ANY NUMBNESS, TINGLING OR WEAKNESS? Explain:** \_\_\_\_\_

Please mark and # all complaints. #1 being the worst.



**Symptoms Index**

- B** Burning
- D** Dull Nagging Ache
- N** Numbness / Tingling
- R** Radiating Pain
- S** Spasm/ Sharp/ Stabbing
- W** Weakness



**Example:**  
 The image to the left illustrates a **Burning** pain in the left shoulder, **Weakness** in the left hand and **Radiating pain** into right leg and ankle.

**PAST HEALTH HISTORY**

If female, are you pregnant?  Yes  No If No, what is the last date of your menstrual cycle: / /

List all medications you are taking, include birth control, over the counter medications and vitamins.

Have you had broken bones, surgeries or hospitalizations?  Yes  No Please list them and give dates:

Have you had an X-ray, MRI, CT scan or other imaging?  Yes  No When:

Have you been seen by a **Chiropractor**?  Yes  No Name(s): \_\_\_\_\_ When:

**Do you have a Family Doctor?**  Yes  No Name(s): \_\_\_\_\_ Phone: \_\_\_\_\_

May we update this Doctor on your condition?  Yes, please do  No thank you

**PLEASE MARK ANY CONDITIONS YOU HAVE OR HAD**

- Anemia  Chest Pain  Depression  Diabetes  Heart Disease  High Blood Pressure
- Irregular Heart Beat  Shortness of Breath  Cancer  Others:

**Do you have, or have you ever had, any diseases or medical problems not listed? If yes, Explain:**

Have you **ever** had a:  Motor Vehicle Injury  Sports Injury  Work Injury  Slip and Fall Injury  
 If yes, please give date(s) and explain:

**Is there any more information you would like the doctor to know about before beginning care?**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Valley Chiropractic Center  
Family Chiropractic and Wellness, Inc**

2117 Hwy 2 East  
Kalispell MT 59901  
406-756-6868  
www.spinaldocs.com

**Office Policies**

- 1) Please be on time for your appointment. Being late, or last minute cancellations will cause severe disruptions, which can interfere with the quality of care you and other patients receive.
- 2) Continued cancellations or missed appointments may result in being released from our care.
- 3) Children are welcome here as patients. If you bring children with you for your appointment, you are responsible for their actions at all times.
- 4) We may schedule you for multiple appointments. This will help insure convenient appointment times for you, as well as provide you with the highest level of care possible.
- 5) If you need to spend extra time discussing your health concerns with your doctor, please let our staff know, so we may schedule your next appointment accordingly.
- 6) Please notify the front desk of any changes in your health status, so your appointment can be scheduled accordingly.
- 7) Please notify the front desk of any change in address, phone number or insurance status.
- 8) Parking is available in front of the building, as well as in the rear. For those parking at the rear of the building, our back entrance is available for your convenience.
- 9) Please be considerate of other patient's privacy! If someone is being helped at the front desk, please step back from the counter until the patient before you is finished.
- 10) Please be courteous to other patient's with regard to cell phone use. We ask that you place your phone on silent or vibrate during your treatment time.

By signing below, I acknowledge that I understand the policies herein.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Financial Policies**

- 1) We accept the following forms of payment: Cash, Personal Checks, Debit Cards, and Visa, MasterCard and Discover.
- 2) Payment is expected at the time of service.
- 3) We will bill your insurance company as a **courtesy** to you, but please be advised that the patient is always responsible for the payment of their care. An insurance contract is between the Insurance Company and the patient.
- 4) Your insurance company determines benefits when they receive our bills. Any statements or verification made by our staff regarding your coverage in no way guarantees that your care here will be covered by your insurance company. You will be responsible for your account regardless of your insurance policy. All deductible payments must be made prior to insurance submittal.
- 5) Insurance coverage is **NEVER** guaranteed! If there are any problems between the insurance company and the patient, the latter may file a grievance directly with their insurance company. This office will provide treatment records to your insurance company as needed in order to process your claim.
- 6) Our Financial Manager will provide you with a payment plan that will fit your needs.
- 7) Please feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service, as well as care.

By signing below, I acknowledge that I understand the policies herein.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Valley Chiropractic Center  
Family Chiropractic and Wellness, Inc.

Patient Privacy Notice

- 1) **Objective:** To provide a control for the maintenance and release of patient health information.
- 2) **Policy:** The health record is the property of Valley Chiropractic Center/Family Chiropractic and Wellness, Inc. and shall be maintained to serve the patient, the health care provider in accordance with legal, accrediting and regulatory agency requirements. The information contained in the health record belongs to the patient, and the patient is entitled to the protected right of his/her information. All patient care information will be regarded as confidential and available only to authorized users.
- 3) **Data Collection:** All individuals engaged in the collection, handling or disclosure of the patient health information shall be specifically informed of their responsibility to protect patient data and of the penalty for violation of this trust.
- 4) **Storage:** All primary health records kept on paper shall be housed in physically secure areas. All computerized data records are to be accorded the same high level of confidentiality give to manually kept records and all policies herein stated apply to both. Primary health records (from this office) and secondary health records (from another office) shall be retained according to legal, accrediting and regulatory agency requirement. Original health records may not be removed from the premises, except under a court order, request of the physician, or to be stored in an outside storage unit. Access to areas housing health information records shall be controlled by the Office Manager with the exception of the physician. Health care records shall not be left unattended in areas accessible to unauthorized individuals.
- 5) **Access:** All requests for health records shall be directed to the Office Manager/Records Custodian. Authorization for access to patient information is based on the need to know in order to provide health care and related services required by the patient. All employees shall maintain patient information in the strictest confidence, sharing it only with others who have a need to know in order to provide services to the patient. Release of information from the health record shall be carried out in accordance with all applicable legal, accrediting and regulatory agency requirements, and in accordance with written institutional policy. All information contained in the health record is confidential and the release of information will be closely controlled. Medical records shall be released when:
  - a. It is required by law
  - b. For release to another health care provider currently involved in the care of the patient.
  - c. For medical evaluation

Patient  
Signature \_\_\_\_\_

Date \_\_\_\_\_

# Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box for each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just check one box that indicates the statement **which most clearly describes your problem**.

Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

## 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

## 2: Personal Care (i.e. washing, dressing)

- 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 can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, wash with difficulty and stay in bed

## 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed i.e. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

## 4: Walking

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 1 Mile
- Pain prevents me from walking more than ½ Mile
- Pain prevents me from walking more than ¼ mile
- I can only walk using a stick or crutches
- I am in bed most of the time

## 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 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 at all

## 6: Standing

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

## 7: Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

## 8: Job / Chores

- My normal job does not cause pain
- My normal job increases my pain, but I can continue
- I can do my job, but pain prevents me from heavy lifting
- I can only do light jobs due to the pain
- Pain prevents me from even doing light jobs
- Pain prevents me from doing any jobs

## 9: 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 i.e. sport
- 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

## 10: Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive Treatment

Please make an X on the line below to state the degree of pain you are experiencing at this time.

NO PAIN

\_\_\_\_\_

WORST PAIN

## NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE DAILY 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 ARE TRUE, PLEASE MARK ONE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT-DAY SITUATION.

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

### 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.

### 2 - PERSONAL CARE

- I can look after myself without extra pain.
- I can look after myself, but it causes extra pain.
- It is painful to look after myself; I am slow/careful
- I need some help but manage most of my own 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.

### 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.

### 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.

### 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.

### 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.

### 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.

### 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 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 car at all because of neck pain.

### 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 pain.
- I can't read as much as I want due to moderate pain
- I can't read as much as I want due to severe pain
- I can't read at all.

### 10 - RECREATION

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

Please make an X on the line below to state the degree of pain you are experiencing at this time.

NO PAIN \_\_\_\_\_

\_\_\_\_\_ WORST PAIN

# VALLEY CHIROPRACTIC

## CONSENT FORM

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

### Infrared Laser Therapy:

Laser therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasm and promotes vasodilation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks. However, your results may be minimal or significant. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, preexisting health conditions, thermal effects, excessive pressure from the probe, and laser over-stimulation. Laser light can damage the retina in your eye. Always wear the laser protective glasses provided.

The most common adverse effects are:

1. Temporary increase in pain during application of laser.
2. Temporary increase in pain the following day after laser therapy.
3. Mild bruising from vasodilation or direct pressure of laser tip.
4. Temporary dizziness.
5. Reactions when photosensitizing drugs are used with laser therapy.

I understand the risks of laser therapy and agree to the treatment program outlined by the doctor.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Witness: \_\_\_\_\_ Date: \_\_\_\_\_