ONG
FAMILY CHIROPRACTIC

9303 Laguna Springs Drive, Ste. 110 • Elk Grove, CA 95758
Ph. (916)513-7949 • Fx. (916)647-4859

| **PATIENT NAME** (FIRST, MIDDLE, LAST) | **SEX** ☐ M ☐ F | **DATE OF BIRTH** (MM/DD/YYYY) | **AGE** |
|---|---|---|---|
| | | | |

| **ADDRESS** | **CITY** | **STATE** | **ZIP** |
|---|---|---|---|
| | | | |

| **HOME #** | **CELL #** | **WORK #** | **EMAIL** |
|---|---|---|---|
| ( ) - | ( ) - | ( ) - | |

| **SOC. SECURITY #** | **EMPLOYER** | **OCCUPATION/TITLE** |
|---|---|---|
| | | |

| **EMPLOYER ADDRESS (STREET, CITY, ZIP CODE & COUNTY)** |
|---|
| |

| **EMERGENCY CONTACT/RELATIONSHIP** | **CONTACT #** |
|---|---|
| | ( ) - |

**WORKERS' COMPENSATION INFORMATION**

| **NATURE OF BUSINESS** |
|---|
| |

| **ADDRESS OF INJURY** | **CITY** | **STATE** | **ZIP** | **COUNTY** |
|---|---|---|---|---|
| | | | | |

| **DATE & TIME OF INJURY** | **DATE LAST WORKED** | **DATE & HOUR OF 1ST EXAM:** |
|---|---|---|
| _____/_____/_____ at _____:_____ ☐ AM ☐ PM | _____/_____/_____ | _____/_____/_____ at _____:_____ ☐ AM ☐ PM |

**PATIENT:** Please complete this portion, if you are able to do so. Inability or failure of a patient to complete this portion shall not affect his/her right to workers' compensation under California Labor Code.

**DESCRIBE HOW THE ACCIDENT OR EXPOSURE OCCURRED** (Provide specifics including objects, machinery, and/or chemicals. Use the reverse side of the form if more space is required.)

_____
_____
_____
_____
_____

| **Did you report this injury at work?** ☐ YES ☐ NO | **Employer Phone #:** ( ) - |
|---|---|

**Did the injury occur while performing normal work activities?** ☐ YES ☐ NO

**If no, explain:** _____

**Have you been treated by any other health care provider for this work injury?**

**If yes, who?** _____ Type of treatment received: _____

**Have you had a prior work-comp injury?** ☐ YES ☐ NO

**If yes, when and what?** _____

**Prior to this injury, have you had similar physical complaints to what you have now?** ☐ YES ☐ NO

**If yes, when?** _____

**I certify that the above information is true to the best of my knowledge. I authorize the release of any information necessary to process this claim. A copy of this authorization shall be as valid as the original.**

**PATIENT'S SIGNATURE:** _____ **DATE:** _____

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**INFORMED CONSENT FOR CHIROPRACTIC CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedure, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Dr. Nelson S. Ong, D.C. 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 back-up for the doctor of chiropractic named above, including those working at the clinic or office listed above 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 above and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in practice of medicine, the practice of chiropractic, which involves the use of hands in such a way to restore proper motion to the joints, there are some risks of treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. Tests are employed in the doctor's exams to identify if I am susceptible to an injury such as stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedure. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I consent the entire course of treatment for my present condition and any future care I may receive from Dr. Nelson S. Ong, DC or any other licensed doctor of chiropractic working in their stead.

| | |
|---|---|
| PRINT PATIENT'S NAME | PRINT REPRESENTATIVE'S NAME |
| SIGNATURE OF PATIENT | SIGNATURE OF REPRESENTATIVE |
| DATE SIGNED | RELATIONSHIP OF REPRESENTATIVE |
| SIGNATURE OF WITNESS | DATE SIGNED |
| DATE SIGNED | |

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# NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

## PLEASE REVIEW THIS NOTICE CAREFULLY

**A. OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

ONG FAMILY CHIROPRACTIC
9303 LAGUNA SPRINGS DR., STE. 110
ELK GROVE, CA 95758
(916)513-7949

**C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:**

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.

8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

**D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

**1. Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

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- Maintaining vital records, such as births and deaths.
- Reporting child abuse or neglect.
- Preventing or controlling disease, injury or disability.
- Notifying a person regarding potential exposure to a communicable disease.
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
- Reporting reactions to drugs or problems with products or devices.
- Notifying individuals if a product or device they may be using has been recalled.
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

**2. Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**3. Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

**4. Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- Concerning a death we believe has resulted from criminal conduct.
- Regarding criminal conduct at our offices.
- In response to a warrant, summons, court order, subpoena or similar legal process.
- To identify/locate a suspect, material witness, fugitive or missing person.
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator).

**5. Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

**6. Organs and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

**7. Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

**8. Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

**9. Military.** Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

**10. National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

**11. Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

**12. Workers' Compensation.** Our practice may release your IIHI for worker's compensation and similar programs.

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# HEALTH SURVEY

**PATIENT NAME:** _____ **DATE:** _____

**PLEASE MARK ALL CONDITIIONS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:**

## GENERAL

| PAST | PRESENT | |
|---|---|---|
| ☐ | ☐ | Abnormal Weight |
| ☐ | ☐ | Allergies |
| ☐ | ☐ | Bruise Easily |
| ☐ | ☐ | Depression |
| ☐ | ☐ | Dizziness |
| ☐ | ☐ | Fainting |
| ☐ | ☐ | Fatigue |
| ☐ | ☐ | Fevers |
| ☐ | ☐ | Headaches |
| ☐ | ☐ | Hernia |
| ☐ | ☐ | Loss of Appetite |
| ☐ | ☐ | Loss of Sleep |
| ☐ | ☐ | Night Sweats |
| ☐ | ☐ | Visual Disturbances |

## MUSCLE/JOINT

| PAST | PRESENT | |
|---|---|---|
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Bursitis |
| ☐ | ☐ | Swollen/Stiff Joints |
| ☐ | ☐ | Whiplash |
| ☐ | ☐ | Neck Pain |
| ☐ | ☐ | Upper Back Pain |
| ☐ | ☐ | Mid Back Pain |
| ☐ | ☐ | Lower Back Pain |
| ☐ | ☐ | Foot/Ankle Pain |
| ☐ | ☐ | Hip/Upper Leg Pain |
| ☐ | ☐ | Knee/Lower Leg Pain |
| ☐ | ☐ | Shoulder Pain |
| ☐ | ☐ | Elbow Pain |
| ☐ | ☐ | Wrist Pain |
| ☐ | ☐ | Hand Pain |
| ☐ | ☐ | Jaw Pain |
| ☐ | ☐ | Muscular |

## CARDIOVASCULAR

| PAST | PRESENT | |
|---|---|---|
| ☐ | ☐ | Chest Pain |
| ☐ | ☐ | Fast Heart Rate |
| ☐ | ☐ | Heart Attack |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Low Blood Pressure |
| ☐ | ☐ | Open Heart Surgery |
| ☐ | ☐ | Poor Circulation |
| ☐ | ☐ | Stroke |

## GENITOURINARY

| PAST | PRESENT | |
|---|---|---|
| ☐ | ☐ | Bladder Problems |
| ☐ | ☐ | Frequent Urination |
| ☐ | ☐ | Painful Urination |
| ☐ | ☐ | Kidney Disorders |
| ☐ | ☐ | Prostate Problems |

## SYSTEMIC

| PAST | PRESENT | |
|---|---|---|
| ☐ | ☐ | Anorexia/Bulimia |
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Cancer |
| ☐ | ☐ | Chicken Pox |
| ☐ | ☐ | Cold Sores |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Drug/Alcohol Dependence |
| ☐ | ☐ | Eczema |
| ☐ | ☐ | Emphysema |
| ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Gout |
| ☐ | ☐ | Hepatitis |
| ☐ | ☐ | Herpes |
| ☐ | ☐ | HIV/AIDS |
| ☐ | ☐ | Lupus |
| ☐ | ☐ | Measles |

## SYSTEMIC (CONT.)

| PAST | PRESENT | |
|---|---|---|
| ☐ | ☐ | Multiple Sclerosis |
| ☐ | ☐ | Mumps |
| ☐ | ☐ | Pneumonia |
| ☐ | ☐ | Polio |
| ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | Rheumatoid Arthritis |
| ☐ | ☐ | Seizures |
| ☐ | ☐ | Smoking/Tobacco Use |
| ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Ulcers |

## FEMALES ONLY

☐ Never Pregnant
☐ Currently Pregnant (# of months: ___)
☐ # of Births: _____

## OTHER HEALTH PROBLEMS

| PAST | PRESENT | |
|---|---|---|
| ☐ | ☐ | _____ |
| ☐ | ☐ | _____ |
| ☐ | ☐ | _____ |

## SURGERIES

☐ _____
☐ _____
☐ _____
☐ _____

**FAMILY HISTORY-** Indicate conditions present in your family and your relationship to the family member with the condition.

| Condition | Relationship: | Condition | Relationship: |
|---|---|---|---|
| ☐ Auto Immune Disorder | _____ | ☐ Diabetes | _____ |
| ☐ Arthritis | _____ | ☐ Heart Disease | _____ |
| ☐ Back Trouble | _____ | ☐ Kidney Disease | _____ |
| ☐ Cancer (indicate type) | _____ | ☐ Seizure Disorder | _____ |

**PATIENT SIGNATURE:** _____ **DATE:** _____

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# VISUAL ANALOG SCALE, PAIN DRAWING & ADL

**PATIENT NAME:** _____ **DATE:** _____

**SECTION 1- PAIN INTENSITY & FREQUENCY:**

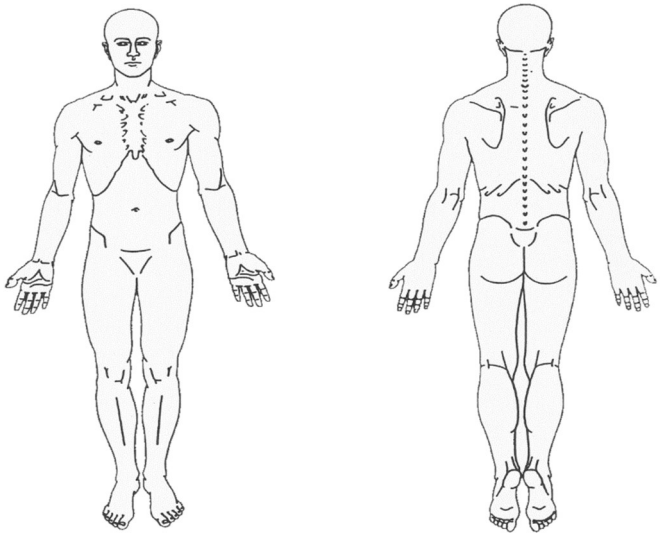
Please circle the appropriate # that describes your present pain levels, with 0 being no pain and 10 being the worst pain you can imagine, and indicate how frequent the pain is.

| AREA OF PAIN | NORMAL | | MILD | | | MODERATE | | | SEVERE | | | FREQUENCY OF PAIN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NECK | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0%----25%----50%----75%----100% |
| HEADACHES | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0%----25%----50%----75%----100% |
| MID BACK PAIN | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0%----25%----50%----75%----100% |
| LOW BACK PAIN | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0%----25%----50%----75%----100% |
| HIP(S) L R | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0%----25%----50%----75%----100% |
| SHOULDER(S) L R | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0%----25%----50%----75%----100% |
| ARM(S) L R | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0%----25%----50%----75%----100% |
| LEG(S) L R | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0%----25%----50%----75%----100% |
| OTHER:_____ L R | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0%----25%----50%----75%----100% |

**SECTION 2- PAIN DRAWING:**

Please indicate the appropriate location of your pain and use the symbol that best describes the discomfort that you are feeling currently.

| **LEGEND:** | **V = DULL & ACHY** | **+ = SHARP & STABBING** | **0 = PINS & NEEDLES** |
|---|---|---|---|



**SECTION 3 – ACTIVITIES OF DAILY LIVING OR JOB DEMANDS THAT INCREASE YOUR PAIN LEVELS:**

☐ SITTING ☐ STANDING ☐ STOOPING ☐ BENDING ☐ CLIMBING ☐ REACHING ☐ LIFTING ____LBS
☐ DRIVING ☐ HOUSEWORK: _____ ☐ SPORTS/REC: _____

**SECTION 4 – MECHANISM OF INJURY:**

DESCRIBE WHAT INITIALLY CAUSED YOUR PROBLEM:_____

HOW LONG HAVE YOU HAD THIS PROBLEM?_____ IS THE PAIN GETTING: ☐ Better ☐Worse ☐ Same

PAIN AFFECTS YOUR: ☐ WORK ☐ SLEEP ☐ ACTIVITIES OF DAILY LIVING

HAVE YOU LOST ANY TIME FROM WORK DUE TO YOUR INJURIES? ☐ YES ☐ NO IF YES, WHEN? _____

ARE YOU CURRENTLY UNDER MEDICAL CARE FOR THIS CONDITION? ☐ YES ☐ NO

- IF YES, WHERE & WHAT TYPE? _____

TAKING **ANY** PRESCRIPTION MEDICATIONS? ☐ YES ☐ NO IF YES, WHAT? _____

TAKING **ANY** NON-PRESCRIPTION MEDICATIONS? ☐ YES ☐ NO IF YES, WHAT? _____

HAVE YOU SEEN ANOTHER CHIROPRACTOR? ☐ YES ☐ NO IF YES, WHY? _____

**RE-EXAM PATIENTS ONLY**:

ANY CHANGES TO YOUR HEALTH SINCE YOUR LAST VISIT? ☐ YES ☐ NO

IF YES, WHAT? _____

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## MODIFIED ROLAND-MORRIS LOW BACK & DISABILITY (RMQ) (FOR PATIENTS with BACK INJURIES/PAIN ONLY)

**PLEASE READ:** If treating for a back injury and/or pain, mark all boxes that apply to you TODAY.

- ☐ I stay at home most of the time because of my back.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I must 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 only stand up for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ My back or leg is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I have trouble putting on my socks because of back pain.
- ☐ I sleep less well because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.

## NECK DISABILITY INDEX (FOR PATIENTS with NECK INJURIES/PAIN ONLY)

**PLEASE READ:** If treating for a neck injury and/or pain, answer each section by marking the ONE box that most applies to you in regards to your neck pain.

**Section 1: Pain Intensity**
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

**Section 2: Personal Care (Washing, Dressing, etc.)**
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but can 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 lifting heavy weights off the floor, but I can manage if they are conveniently placed (i.e., 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 only lift very light weights.
- ☐ I cannot lift or carry anything.

**Section 4: Reading**
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

**Section 5: Headaches**
- ☐ I have no headaches at all.
- ☐ I have slight headaches, which come infrequently.
- ☐ I have moderate headaches, which come infrequently.
- ☐ I have moderate headaches, which come frequently.
- ☐ I have severe headaches, which come frequently.
- ☐ I have headaches almost all the time.

**Section 6: Concentration**
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

**Section 7: Work**
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

**Section 8: Driving**
- ☐ I can drive without any neck pain.
- ☐ I can drive as long as I want with slight pain in my neck.
- ☐ 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 car at all.

**Section 9: Sleeping**
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

**Section 10: Recreation**
- ☐ I can engage in all my recreation activities with no neck pain at all.
- ☐ I can engage in all my recreation activities, with some neck pain.
- ☐ I can engage in most, but not all, of my usual recreation activities due to neck pain.
- ☐ I can engage in a few of my recreation activities due to neck pain.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I cannot do any recreation activities at all.

ONG
FAMILY CHIROPRACTIC

9303 Laguna Springs Drive, Ste. 110 ◆ Elk Grove, CA 95758
Ph. (916)513-7949 ◆ Fx. (916)647-4859

**WC REFERRAL ACKNOWLEDGEMENT**

I have read and clearly understand that, as a referral from my Medical Provider's Office, Dr. Nelson S. Ong, DC is the secondary treating doctor. Therefore, I will direct any case related questions to my primary treating physician (or referring physician). Any forms that need to be filled out by a doctor will be referred to the primary treating (or referring) physician as well. Dr. Nelson S. Ong, DC will not be held responsible for such duties.

**PATIENT NAME:** _____

**PATIENT SIGNATURE:** _____ **DATE:** _____

**APPOINTMENT CANCELLATION POLICY**

PLEASE CALL US AT LEAST 24 HOURS IN ADVANCE IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT. IF A PATIENT FAILS TO CANCEL WITHIN 24 HOURS OF SCHEDULED APPOINTMENT, THEY MAY BE CHARGED A **$25 CANCELLATION FEE**.

I, THE PATIENT AND/OR GUARDIAN, FULLY UNDERSTAND AND ACKNOWLEDGE THE RECOMMENDED TREATEMENT PLAN AND THE CANCELLATION POLICY.

_____ _____

PATIENT/GUARANTOR SIGNATURE DATE