Wellness Doctor Natural Healthcare and Chiropractic Sports Medicine
Jeffrey S. Cobbs, D.C., C.P.T, C.E.S, 1693 SW Chandler Ave Ste 280 Bend, OR 97702
P: 541-318-1000 F: 541-318-7050

Name: _____ **Address**: _____ **City**: _____ **State**: _____ **Zip**: _____ **SSN**: _____ **Gender**: _____M _____F **DOB**: _____ **Marital Status**: S M W D **Spouse**: _____ **Language**: ____English ____Spanish ____Other **Race**: ____White ____American Indian or Alaska Native ____Asian ____Native Hawaiian/Other Pacific Islander ____Black or African American ____Hispanic or Latino ____Decline to Answer ____Other_____ **Ethnicity**: ____Hispanic or Latino ____Not Hispanic or Latino ____Decline to Answer
Home phone: _____**Work Phone**: _____ **Cell Phone**: _____ **Cell phone carrier**: _____ **Home E-mail**: _____ **Work E-mail**: _____
Contact preference: ____Home Phone ____Work Phone ____Cell ____Home E-mail ____Work E-mail ____Mail ___Text
Occupation/Employer: _____ **Who were you referred to us by**: _____
Emergency Contact: _____ **Phone**: _____ **Relation**: _____
Do you give permission for Dr. Kremer to update your general medical physician with the progress of your condition? _____
Name of Medical Doctor: _____

PAYMENT INFORMATION

Please check the following payment methods that apply:
☐ Cash ☐Health Insurance (Move down to primary insured information) ☐Other (Move down to Responsible Party Information)
☐This injury is related to a work injury. Date of Injury: ___/___/_____.
☐This injury is related to an auto accident. Date of Accident: ___/___/_____.

PRIMARY INSURED INFORMATION

If you are the primary insured, mark "self".

Primary insured: ☐Self ☐Spouse ☐Parent ☐Other: _____

Name: _____ **Street Address**: _____ **City**: _____ **State**: _____ **Zip**: _____ **SS#:** _____ **Sex**: ___M ___F **Date of Birth**: _____ **Home Phone**: _____ **Cell Phone**: _____
Occupation/Employer: _____**Work Phone**: _____

RESPONSIBLE PARTY INFORMATION (if different than above)

Person responsible for patient's charges: ☐Spouse ☐Parent ☐Other: _____

Name: _____ **Date of Birth**: _____**SS#:** _____
Street Address: _____ **City**: _____ **State**: _____ **Zip**: _____
Home Phone: _____ **Cell**: _____**Sex**: ___M ___F

ASSIGNMENT AND RELEASE

Scheduling an appointment reserve this time especially for you and no one else. Therefore, our office requires **24 hours notice to cancel an appointment. If 24 hours is not given, a charge of $25** will be billed to your account.

I, _____, clearly **understand and agree that all services provided will be charged to me and that I am personally responsible for payment.** I agree to allow Dr. Jason Kremer, D.C., C.C.S.P., C.S.C.S., to bill my insurance company as a courtesy and permit the release of medical records necessary to process my claims. I authorize payments to be made directly to Dr. Jason Kremer, D.C., C.C.S.P., C.S.C.S., for treatment rendered. **I understand that co-payments and cash fees are due at the time of service and that I may receive an additional bill for services not covered by my insurance.**

Patient's Signature: _____ **Date**: _____
(Parent or Guardian's signature if under 18)

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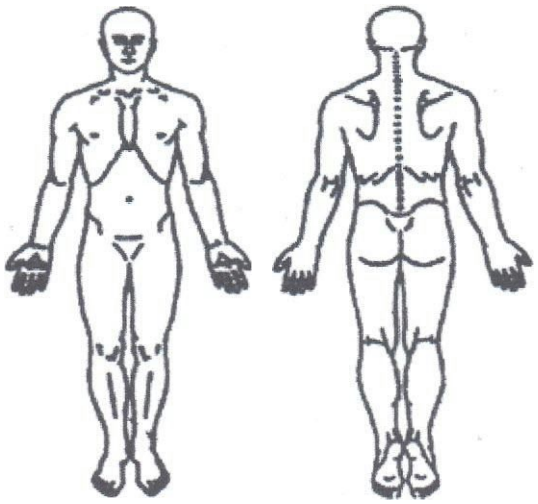
1. What is your major complaint? _____
   Use the following abbreviations to indicate on the figure below where you are experiencing symptoms
   P=Pain S=Stiffness A=Aching B=Burning NT=Numbness/Tingling
2. When did your symptoms begin? _____
3. Did the symptoms begin gradually or suddenly? _____



4. Was there Trauma involved? YES NO
   If yes, describe: _____
   _____
   _____
5. Any changes in the following? YES NO
   If yes, check and describe:
   ___Medication ___Eating habits
   ___Work Duties ___Ergonomics
   ___Hobbies ___Stress
   ___Exercise ___Sleep patterns
   ___Body weight

6. Are the symptoms constant or tend to come and go? _____
7. How often do the symptoms bother you? _____
8. How long do the symptoms last for? _____
9. Do you have pain at night? **YES NO** Is the condition getting progressively worse? **YES NO**
10. Has this condition bothered you before? **YES NO**
11. Would you describe it as (circle all that apply): **SHARP, SHOOTING, ELECTRICAL, DEEP, DULL, ACHING, STIFF, THROBBING, NUMBNESS, TINGLING, CRAMPING, OTHER:**_____
12. How severe are your symptoms? **Mild Moderate Severe Unbearable**
13. Does this condition prevent you from any daily recreational activities? **YES NO**
    If yes, please describe: _____
14. What aggravates the condition: _____
15. What relieves it/What have you done for it? _____
16. Are there any other symptoms that you can associate with this condition? **YES NO**
17. Have you ever received an evaluation or treatment for your current injuries? **YES NO**
    If yes, please fill out the following

Date	**Doctor/Therapist**	**Evaluation/Treatment/Surgeries**

18. Please list all current medications

Medication	**Dose**	**Frequency**	**Start date**	**Reason for use**

INDEPENDENT MEDICAL EXAMINATION STANDARDS

As developed by the Independent Medical Examination Association

1. Communicate honestly with the parties involved in the examination.
2. Conduct the examination with dignity and respect for the parties involved.
3. Identify yourself to the examinee as an independent examining physician.
4. Verify the examinee's identity.
5. Discuss the following with the examinee before beginning the examination:
   a. Remind the examinee of the party who requested the examination.
   b. Explain to the examinee that a physician-patient relationship will not be sought or established.
   c. Tell the examinee the information provided during the examination will be documented in a report.
   d. Review the procedures that will be used during the examination.
   e. Advise the examinee a procedure may be terminated if the examinee feels the activity is beyond the examinee's physical capacities or when pain occurs.
   f. Answer the examinee's questions about the examination process.
6. During the examination:
   a. Ensure the examinee has privacy to disrobe.
   b. Avoid personal opinions or disparaging comments about the parties involved in the examination.
   c. Examine the condition being evaluated sufficient to answer the requesting party's questions. d. Let the examinee know when the examination has concluded, and ask if the examinee has questions or wants to provide additional information.
7. Provide the requesting party a timely report that contains findings of fact and conclusions based on medical probabilities for which the physician is qualified to express an opinion.
8. Maintain the confidentiality of the parties involved in the examination subject to applicable laws.
9. At no time provide a favorable opinion based solely or in part upon an accepted fee for service.

NECK DISABILITY INDEX

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

SECTION 1 - PAIN INTENSITY

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

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

SECTION 3 – LIFTING

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – WORK

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

SECTION 5 – HEADACHES

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

SECTION 6 – CONCENTRATION

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

SECTION 7 – SLEEPING

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

SECTION 8 – DRIVING

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

SECTION 9 – READING

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

SECTION 10 – RECREATION

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

PATIENT NAME _____ DATE _____

SCORE _____ [50] BENCHMARK -5 = _____

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: _____

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Medical History

- ☐ Arthritis
- ☐ Allergies/Hay Fever
- ☐ Allergies to coconut, eucalyptus or lavender
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Contact lenses
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins
- ☐ Other: _____

Medical (Men)

- ☐ Benign prostatic hyperplasia
- ☐ Prostate cancer
- ☐ Decreased sexual drive
- ☐ Infertility
- ☐ Sexually transmitted disease
- ☐ Other: _____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease
- ☐ Other: _____

Date of last GYN exam: _____
Mammogram
PAP
Form of birth control
# of children _____
# of pregnancies _____

- ☐ C-section
- ☐ Surgical menopause
- ☐ Menopause

Family Health History *(Parents and Siblings)*

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide
- ☐ Other:_____

Health Habits

- ☐ Tobacco:
- ☐ Alcohol
- ☐ Caffeine
- ☐ Water

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minute duration per workout
- ☐ Less than 30 minutes
- ☐ Walk-#days/wk_____
- ☐ Run, jog, other aerobic-#days/wk_____
- ☐ Weight lift-#days/wk ____
- ☐ Stretch-#days/wk_____
- ☐ Other: _____

Nutrition and Diet

- ☐ Mixed food diet (animal and vegetable source)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/Carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction
- ☐ Specific food restrictions:

□ Dairy □ Wheat □ Eggs

□ Soy □ Corn □ All Gluten

- ☐ Other: _____

Food Frequency

- ☐ Number of servings/day

Fruits (citrus, melons, etc)__
Dark green or deep yellow/orange vegetables___
Grains (unprocessed) _____
Beans, peas, legumes _____
Diary, eggs _____
Meat, poultry, fish _____

Eating Habits

- ☐ Skip meals – which ones _____
- ☐ One meal/day
- ☐ Two meals/day
- ☐ Three meals/day
- ☐ Graze (small frequent meals)
- ☐ Generally eat on the run
- ☐ Eat constantly whether hungry or not

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/GLA
- ☐ Calcium, source _____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe_____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g. lutein, resveratrol, etc.)
- ☐ Herbs
- ☐ Homeopathy
- ☐ Protein shakes
- ☐ Superfoods (e.g. bee pollen, phytonutrient blends)
- ☐ Liquid meals (Ensure)

I would like to:

Energy - Vitality

- ☐ Feel more vital
- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be less tired after lunch
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ☐ Stop using laxative and stool softeners
- ☐ Improve sex drive

Body Composition

- ☐ Lose weight
- ☐ Burn more body fat
- ☐ Be stronger
- ☐ Have better muscle tone
- ☐ Be more flexible

Stress, Mental, and Emotional

- ☐ Learn how to reduce stress

- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less indecisive
- ☐ Feel more motivated

Life Enrichment

- ☐ Reduce my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Change from a “treating-illness” orientation to creating a wellness lifestyle