JENNIFER SANSEN, D.C.
200 Bethel Road
Port Orchard, WA 98366
(360) 876-4171

CASE HISTORY

Date: ____________________

Name:____ Social Security #: ______________________________
Address:__________________________________City:_________________________ State:_______ Zip:_________
Phone: (   )______________________ Cell #: _____________________Email:_____________________________
Age: _____ Birth Date: ____________ Marital Status: S M W D How many children: ______ Ages:_____________
Occupation: ________________________________ Employer:____
Employer Location (city): ____________________________________ Work Phone: (   )__________________
Name of Spouse: _____________________________________Occupation of Spouse: ______________________
Birth Date of Spouse: _______________ Social Security # of Spouse (for insurance): _____________________
How were you referred to our office?: ____
Have you ever received chiropractic care? YES NO If yes, when?: _______________________________________

Primary Complaint & Purpose of this Visit: ____

____

How long have you had this complaint? ____

Is this the result of an injury/ accident? YES NO If yes, explain:____________________________________

____

Are the pains (please circle): SHARP DULL ACHY CONSTANT INTERMITTENT

Has it interfered with daily activities such as (please circle): WORK HOME EMOTION SLEEP SPORTS

OTHER (please list): ____

What makes it worse? ____

What makes it better? ____

Is it worse during certain times of the day? YES NO If yes, when? _________________________________

Have you had this before? YES NO If yes, when? ____

Is this condition getting progressively worse? ____

List other doctors consulted for these complaints/injuries:

1. Name: ___________________________________ When consulted_____________________________

   Treatment: _______________________________ Results: _________________________________

2. Name: ___________________________________ When consulted _____________________________

   Treatment: _______________________________ Results: _________________________________

Any home remedies, ice, heat, etc: ____

Other complaints: ____

I give my permission for the doctors at Kitsap Chiropractic to treat a minor child.

Parent/Guardian Signature: ____ Date:_____________________

Patient Name: ____ Date: ________________________

List surgical operations & years: ____
____
Medications: ____
Age of mattress: ____________ _____ comfortable ____ uncomfortable
Sleeping posture: ____side ____stomach ____back
Are your wearing: ____heel lifts ____Sole lifts ____inner soles ___arch Supports
Have you been in an auto accident: ____past year ____past 5 years ____over 5 years ____never
Describe: ____
List any hobby / sports injuries: ____
Have you ever had any mental or emotional disorders? ____yes ___no When? ________________________
Have others in your family has such disorders? ___yes ___no When? ______________________________

FAMILY HEALTH INFORMATION: (Many health problems are the result of hereditary spinal weakness; thus information about your family member will give us a better picture of your total health. Please include conditions such as heart disease, arthritis, cancer, diabetes, etc.).

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	DESCRIBE
Been knocked unconscious	❑	❑	____________________
Been treated for a spine or nerve disorder	❑	❑	____________________
Had a fractured bone	❑	❑	____________________
Been hospitalized other than surgery	❑	❑	____________________
DO YOU:			**Please list all supplements:**
Now take vitamins or minerals	❑	❑	____________________
Think you may need vitamins/minerals	❑	❑	____________________

DATE OF LAST:	0-6 months	6-18 mo.	over 18 mo.	never
Spinal examination	❑	❑	❑	❑
Physical examination	❑	❑	❑	❑
Chest x-ray	❑	❑	❑	❑
Spinal x-ray	❑	❑	❑	❑
Urine test	❑	❑	❑	❑

HABITS:	HEAVY	MOD.	LIGHT	NONE
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Physical Stress	❑	❑	❑	❑
Mental Stress	❑	❑	❑	❑

List all conditions for which you have been treated in the last 10 years:
____
____
____
____
____
____

IN CASE OF EMERGENCY: (Name of relative or close friend):
Address: ____ Phone:______________________________________
Name: ____

KITSAP CHIROPRACTIC

JENNIFER SANSEN, D.C.
200 Bethel Road
Port Orchard, WA 98366
(360) 876-4171

PAST HEALTH HISTORY

Name:____ Date:___________________________

Please indicate for each of the questions below your experience by use of the following codes:

1- Never had; 2- Previously had; 3– Presently have; 4– Previously had & presently have

Musculoskeletal System
___ Low back problems
___ Pain between shoulders
___ Neck pain
___ Head pain
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joints
___ Weak muscles
___ Walking problems
___ Disc problems
___ Poor posture
___ Pain-shoulder/arm/hand
___ Rib cage pain
___ Painful tailbone
___ Hip pain
___ Leg pain–lower/upper

Nervous System
___ Nervous
___ Numbness
___ Paralysis
___ Dizziness
___ Forgetfulness
___ Confusion / Depression
___ Fainting
___ Convulsions
___ Cold/tingling extremities
___ Stress
___ Tremors

General
___ Fatigue
___ Allergies
___ Loss of sleep
___ Fever
___Headaches

Gastrointestinal System
___ Poor appetite
___ Excessive hunger
___ Excessive thrist
___ Vomiting blood
___ Liver trouble
___ Gall bladder problems
___ Weight trouble
___ Bloating after meals
___ Heartburn
___ Black/ bloody stool

Cardiovascular/ Respiratory System
___ Chest pain
___ Pain over heart
___ Difficult breathing
__ Persistent cough
___ Coughing blood
___ Rapid heart beat
___ Blood pressure problems
___ Heart problems
___ Lung problems
___ Varicose veins
___ Ankle swelling
___ Stroke

Eye, Ear, Nose, & Throat
___ Vision problems
___ Ear noises
___ Difficult speech
___ Facial / jaw pain

Genitourinary System
___ Bladder trouble
___ Painful urination
___ Discolored urine
___ Bed wetting

Male/ Female
___ Prostate
___ HIV positive
___ Breast pain
___ Breast-lumps/congested
___ Periods-painful/ excess
___ Periods-irregular/cramps
___ Hot flashes
___ Menopause

Females Only
When was your last period?
____

Are you pregnant? ____Yes
___No ___Not sure

Childhood injuries/traumas
____
____

DO NOT WRITE HERE: DOCTOR'S NOTES:
____
____
____
____
____
____
____

JENNIFER H. SANSEN, D.C.
200 BETHEL ROAD
PORT ORCHARD, WA 98366
(360) 876-4171

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of the mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than Vertebral Subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice , diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ____ have read and fully understand the above statements.

____ ______________________

(signature) Date

JENNIFER SANSEN, D.C.
200 Bethel Road
Port Orchard, WA 98366
(360) 876-4171

OFFICE POLICY

We believe that a clear definition of our office policies will allow you the patient, us, and the doctor to concentrate on the big issue – REGAINING AND MAINTAINING YOUR HEALTH.

To better serve you and your health care needs our office hours are as follows:

Monday	9:00am	to	6:00pm
Tuesday and Thursday	2:00pm	to	7:00pm
Wednesday and Friday	9:00am	to	3:00pm
Saturday (Two Saturdays a month)	10:00am	to	1:00pm

If you are unable to keep an appointment for any reason, we ask that you call to reschedule your visit. This office reserves the right to charge for missed appointments and those cancelled without 24 hours notice**.**

When entering the office on any given visit, please go directly to the front desk and "sign-in". We attempt to honor all appointments at the scheduled time. You may have to wait for the next available appointment if you are late or early. We try very hard to stay on our schedule so patients may get on with their day.

All co-payments are due at the time of service. **Also any payments going towards your insurance deductible will be needed at time of service until deductible obligation is met.**

Kitsap Chiropractic Clinic offers different educational opportunities at no additional charge to you, to enlighten you about your body, especially the spine and nervous system. We have found that patients attending these classes seem to respond faster because they can help us to help them. Just ask the Doctor or the receptionist to find out what our upcoming classes are and we will reserve a spot for you.

HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to our privacy practice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Office Phone Number.

Your signature below acknowledges that you have received a copy of Kitsap Chiropractic Clinic's brochure "Notice of Privacy Practices":

Patient's Name: ____

Patient's Signature: ____ Date: ________________

Parent signature of minor (under 18 years):____

Case History Update

Name:____ Date:______________

This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage your everyday activities.
Please answer each section by marking the ONE CHOICE THAT MOST APPLIES TO YOU TODAY.

SECTION 1 - Pain Intensity
- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderately increasing
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)
- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. 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 at the most.

SECTION 4 - Walking
- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting
- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 - Standing
- ☐ I can stand as long as I want without pain.
- ☐ I have some pain standing, but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7 - Sleeping
- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life
- ☐ My social life is normal and gives me no 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, e.g. dancing . . .
- ☐ Pain has restricted my social life and I do not go much.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

SECTION 9 - Traveling
- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain prevents all forms of travel except done lying down.
- ☐ Pain restricts all forms of travel.

SECTION 10 - Changing Degrees of Pain
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but slowly improves.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

Office use: Score_______ ______% Disability

Kitsap Chiropractic & Natural Health
200 Bethel Ave
Port Orchard, WA 98366
(360) 876-4171

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE Last visit: _______________

Name: (please print)________________________ Date: ____________ Date of birth: ______________
Different insurance as last visit? ☐Yes ☐No If it has changed, please show new card to front desk
Same address? ☐Yes ☐No New address: __________________ City: ____________ Zip: _______
Same phone number? ☐Yes ☐No New number: _______________ Email: ______________________
Is this a new pain? ☐ Yes ☐ No What started/aggravated it? _________________________________

PLEASE USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF OUR SENSATION TIGHT NOW
(PLEASE REMEMBER TO COMPLETE BOTH SIDE OF THIS FORM)

KEY: A= ACHE B=BURNING N=NUMBNESS
P= PINS & NEEDLES S=STABBING O=OTHER

Rate your pain on a scale of 0-10

0 1 2 3 4 5 6 7 8 9 10

Completely Able to function — **Totally unable to function**

For Doctor's Use:

M99.01Cervical	M54.2 Cervicalgia	M50.322 Cervical Disc C5-6
M99.02 Thoracic	M54.6 Thoracic Pain	M51.36 Lumbar Disc DJD
M99.03 Lumbar	M54.5 Lumbar Pain	M54.31 Sciatica Right
M99.04 Sacral	S13.4xxA Sprain C-Spine	M54.32 Sciatica Left
M99.05 Pelvic	S33.5xxA Sprain L-Spine	M79.1 Myalgia
M99.06 Lower Ext		G44.209 HA
M99.07 Upper Ext		

JENNIFER H. SANSEN D.C.
200 BETHEL RD.
PORT ORCHARD, WA 98366
(360) 876-4171

Cold Laser, photobiomodulation, or Low Level Laser Therapy (LLLT) has been used successfully to treat many conditions. It is an effective therapy for musculoskeletal and neurological pain and injuries including mild to severe sprains/strains, nerve root pain, peripheral nerve pain, carpel tunnel syndrome, plantar fascitis, and reduction of scar tissue. It has clinically been shown, when applied correctly, to result in a significant reduced healing time and the injured tissues heal with increased function and tensile strength.

LLLT is currently being used by chiropractors, medical doctors, physical therapist, plastic surgeons, oncologists, veterinarians, etc… It is extremely safe treatment modality and its clinical potential is just now being developed and recognized. It has become very popular internationally for treating open wounds, pressure sores (bed sores), skin conditions, cosmetic disorders, nerve injuries, and polyneuropathies (i.e. leg, hand, foot pain). It has more recently been used in the treatment of stroke patients, autism, nerve regeneration and the reduction of keloids.

If the doctor recommends this modality in your case, it is important before treatment that you let her know if you (please check any that apply):

- are pregnant
- are light sensitive
- are currently taking light-sensitizing medications (i.e. antibiotics, antidepressants, Retin-A, tetracycline, etc…)
- are currently taking immunosuppressant drug (drugs used after transplants)
- are being treated for cancer
- are using steroids
- sunburn easily or develop sun rashes
- have suffered seizure disorders

The above information is true and accurate to the best of my knowledge. I will inform the doctor promptly if there are any changes.

Dr. Sansen may recommend laser therapy for your course of treatment. In general we have found, although research supports laser therapy, many private insurance do not pay for laser therapy. This is so important to us, that we have made it affordable for our patients.

Please choose an option:

☐ **Option A** – I will pay directly out of pocket to receive a time of service discount of 2 for 1 at $25.00 total.

☐ **Option B** – I do not want to receive laser therapy

____
Print Name

_________________________________ _________________________
Signature Date

Thank you for your cooperation.

Jennifer Sansen

200 Bethel Rd.

Port Orchard, WA 98366

(360)876-4171 OFFICE

(360)876-3495 FAX

AUTHORIZATION OF X-RAYS

I authorize the performance of diagnostic x-ray examination of myself which Dr. Sansen may consider medically necessary or advisable in the course of my examination and treatment.

FEMALES: I AM NOT PREGNANT_______ I AM PREGNANT_______

DATE:____________ AGE:_________ SIGNATURE:____________________

REFUSAL OF X-RAYS

I hereby accept any and all responsibility for undetected disease or other pathology cause by the lack of x-ray and the diagnosis of this case.

Signature:____________________________________

Parent signature if minor (under 18 yrs) :______________________________