Confidential Patient Information

If you need any assistance completing this form, please ask the receptionist

Today's Date _____

Patient Information

Name _____ Date of Birth _____ Age _____

Address _____

E-Mail _____

Home _____ Cell: _____ Work: _____

( ) Male ( ) Female

Marital Status ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Other _____

Name of spouse or nearest relative _____ Phone _____

Your occupation _____ Employer _____

Referred to office by: ( ) Friend / Family Name _____

( ) Yellow Pages ( ) Mail ( ) Clinic Location _____

Payment for service will be by: ( ) Cash ( ) Credit/Debit Card ( ) Health Insurance
( ) Auto Insurance ( ) Workers Compensation

Insurance Information

Insurance _____ Insured's Employer _____

Insurance Member ID No.: _____ Employer Phone _____

Are you covered by more than one insurance? ( ) Yes ( ) No

If yes, name & insurance ID No.: _____

Medical / Family History **S= Self M= Mother F= Father**

S	M	F	
O	O	O	Aids
O	O	O	Anemia
O	O	O	Arthritis
O	O	O	Ashtma
O	O	O	Back Pain
O	O	O	Bladder trouble
O	O	O	Bone Fracture
O	O	O	Cancer
O	O	O	Chest pain
O	O	O	Concussion
O	O	O	Convulsions
O	O	O	Diabetes
O	O	O	Indigestion

S	M	F	
O	O	O	Dislocated joints
O	O	O	Epilepsy
O	O	O	Measles
O	O	O	Headaches
O	O	O	Heart trouble
O	O	O	Reproductive disorder
O	O	O	High blood pressure
O	O	O	HIV/ ARC
O	O	O	Kidney disorder
O	O	O	Bowel control loss
O	O	O	Menstrual cramps
O	O	O	Multiple Sclerosis
O	O	O	Muscular Dystrophy

S	M	F	
O	O	O	Neck Pain
O	O	O	Nervousness
O	O	O	Numbness
O	O	O	Polio
O	O	O	Poor circulation
O	O	O	Hepatitis
O	O	O	Rheumatic fever
O	O	O	Rheumatism
O	O	O	Scarlet fever
O	O	O	Serious injury
O	O	O	Sinus trouble
O	O	O	Tuberculosis
O	O	O	Venereal disease

Have you been ever treated by a physician for any health condition in the last year? ( ) Yes ( ) No

Describe condition _____ Date of last physical Exam _____

Have you ever had a metal implant? ( ) Yes ( ) No Ever been gunshot? ( ) Yes ( ) No

Surgical History: **Accident History:**

1. _____ Date: _____ ( ) Job ( ) Auto ( ) Other _____ Date: _____
2. _____ Date: _____ ( ) Job ( ) Auto ( ) Other _____ Date: _____

Describe major complaints:

Please rate your symptom from 1 - 10 (1 being less painful)

1. _____
2. _____
3. _____
4. _____
5. _____

Symptoms are worse in: ( ) Morning ( ) Afternoon ( ) Night

When and how did it occur?

_____

_____

Symptoms developed from: ( ) Job related ( ) Auto Accident ( ) Other
Symptoms have persisted for _____ Hours _____ Days _____ Weeks _____ Months _____ Years
Symptoms / Complaints ( ) Come and go ( ) Constant
Have you ever experienced before? ( ) Yes ( ) No If yes, when? _____
If you were to guess, what do you think is causing your complaints? _____
Name and location of doctors you have seen for present condition(s):

_____

_____

Are you allergic to any medications? ( ) Yes ( ) No If yes, which? _____
Are you taking medication? ( ) Yes ( ) No If yes, which? _____
Are you pregnant? ( ) Yes ( ) No Date of last menstrual period: _____

Please check the following activities that a aggravate your condition:

( ) Bending ( ) Reaching ( ) Turning head
( ) Coughing ( ) Sitting ( ) Lying down
( ) Standing ( ) Straining ( ) Walking
( ) Sneezing

Please check the following activities that relieve your condition:

( ) Bending ( ) Sitting ( ) Lifting ( ) Standing ( ) Lying down ( ) Turning head ( ) Reaching ( ) Walking

Please check any additional symptoms you may be experiencing:

() Blurred vision	() Buzzing in ears	() Cold feet	() Cold hands	( ) Cold sweats
() Lost concentration	() Constipation	() Depression	() Diarrhea	() Dizziness
() Face flushed	() Fainting	() Fatigue	() Fever	() Headaches
() Head feels heavy	() Insomnia	() Muscle jerking	() Stiff neck	() Loss of smell
() Numbness in fingers	() Ringing in ears	() Loss of taste		() Upset stomach
() Sensitivity to light	() Pins & needles	() Shortness of breath		

Patient Signature: _____ **Date:** _____

Activities that are affected by my current health problems:

0 = Does not affect
1 = I am aware of my problem when I do this activity (mild)
2 = I don't want to do this activity because of my problems (moderate)
3 = I can't do this activity at all (severe)

Basic

_____ Bending
_____ Climbing stairs
_____ Falling asleep
_____ Kneeling
_____ Lifting
_____ Looking over shoulder
_____ Rising out of chair
_____ Sitting
_____ Standing
_____ Staying asleep
_____ Walking

Occupational Duties

_____ Computer Work
_____ Desk work
_____ Driving at work
_____ Using the telephone
_____ Lifting

Personal Care:

_____ Bathing
_____ Dressing
_____ Hair care
_____ Shaving

Daily Living:

_____ Caring for infirm family member
_____ Child care
_____ Computer use (extended time)
_____ Computer use (short time)
_____ Concentrating
_____ Driving
_____ Housework
_____ Lifting children
_____ Pet care
_____ Lifting / Carrying groceries
_____ Reading
_____ Sexual Activity
_____ Yard work

Recreational Activities:

_____ Cycling
_____ Drawing
_____ Exercise
_____ Swimming
_____ Golf
_____ Softball
_____ Tennis
_____ Piano
_____ Running
_____ Needle work

Notes to the doctor:

_____

_____

Patient Signature: _____ Date: _____

Accident & Wellness Chiropractic

4124 SE 82nd Ave, Ste. 700
Portland , OR 97220
(503) 206-8863

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s), and physical therapy techniques on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Accident & Wellness Chiropractic (AWC) and/or other licensed doctors of chiropractic who now or in the future render treatment for me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic of AWC. This authorization also extends to all office staff members of AWC.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I understand the purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed. I also understand that though the doctor will not diagnose or treat any disease or condition other than vertebral subluxation, he/she will advise me of any non-chiropractic or unusual findings and will recommend that I seek the services of healthcare providers who specialize in such areas for proper advice, diagnosis, or treatment of such findings.

I have read the above explanation of the chiropractic adjustments and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment. I intend this consent form to cover the entire course of my treatment for my present condition and for any future condition(s) for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____
Printed name of patient

_____ _____
Signature of patient Date

_____ _____
Signature of Patient's representative (if minor or physically incapacitated) Date

_____ _____
Witness to Patient's signature Date

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Accident & Wellness Chiropractic (AWC) to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that AWC reserves the right to change the terms of this notice from time to time and that I may contact AWC at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that AWC is not required to agree to these requested restrictions. However, if AWC does agree, AWC is then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Signature _____ Date _____

Printed Patient Name _____

Relationship to Patient _____

Accident & Wellness Chiropractic

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Medical Records Release Form

I hereby authorize Physician:

Physician name: _____

Clinic / Hospital: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax: _____

To release any Medical information to: Accident & Wellness Chiropractic

Dates of services to be included: _____

Print patient's name: _____

Maiden or other name: _____

Patient Phone number: _____

Date of birth: _____

I hereby release the facility, physicians, and its employees from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized above.

Patient's Signature: _____ Date: _____

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FINANCIAL POLICY

1. Responsibility for Payment: We consider the patient to be responsible for payment of services. In cases where the patient is a minor, the parent that the child is living with is responsible for payment.

2. Insurance Billing: As a courtesy to you, we will bill your primary insurance company provided that the pertinent identification numbers are provided. It is the patient's responsibility to inform our office of ANY insurance changes.

3. Auto Insurance: If patient is involved in an automobile accident, the responsible party is the insured automobile the patient was in at the time of the accident. The patient is required by this office to fill out and sign all lien agreements.

4. Workers Compensation: If an injured worker has completed the appropriate forms in our office, we will bill his/her industrial accident insurance.

5. Major Medical Insurance: Please see the following regarding major medical insurance:

- If your annual insurance deductible has not yet been met, payment is expected at the time of service.
- Insurance is considered to be a private contract between the patient and insurance company: it is the patient's responsibility to resolve any difficulties with claims processing directly with the insurance company. We will call for benefits, but there is **NO GUARANTEE OF BENEFITS.**

6. All Insurance Claims: Any amount not covered by major medical insurance, auto insurance, workers compensation insurance is the **FULL RESPONSIBILITY** of the patient or patient's guardian.

I, _____ , have read this financial policy and understand its content.

_____ _____

Signature of Patient/Guardian **Date**