New Patient Intake

Today's Date: _____________

Full Name: ____________________________________ Gender: □M □F □Other:______Date of Birth: ________________

Address: ____ City: ____________________ State: ____ Zip: ____________

Home Phone: ______________________ Cell: _______________________ SSN#_________________________________

E-mail: ____

Employer: _____________________________________ Occupation: ____

Have you seen a chiropractor before? □ No □ Yes If yes, when? ____

In case of emergency, contact: ___________________________________Relationship: ___________________________

Primary phone number: _____________________________ Secondary number: _________________________________

Who may we thank for referring you? ____

What brings you in today:

1.____

2. ____

3.____

Please mark the diagram to the right with the abbreviations listed below to indicate your symptoms.

S = Spasms

H = Shooting Pain

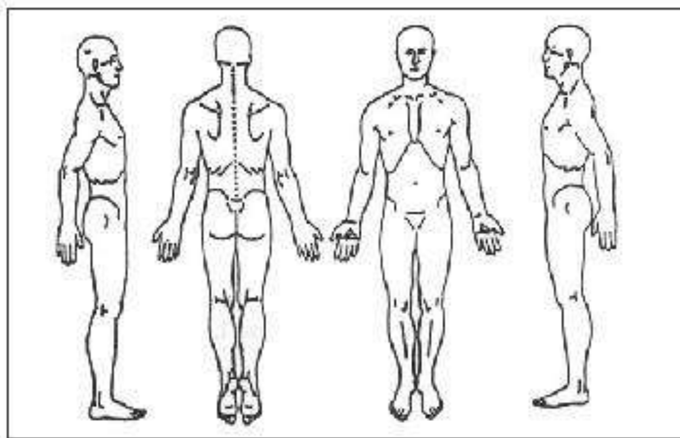
P = Sharp Pain

D = Dull Pain

F = Stiffness

T = Tingling

N = Numbness



How long ago did this episode of symptoms begin? ____

Have you had any similar problems in the past? How long ago was the first time? ______________________________

What do you think caused the problem? ____

____

Is this the first time you've sought treatment for this symptom? □ Yes □ No

Who else has treated you for this symptom? ____

What other methods/treatments have you tried so far? □ Medication (□Rx □OTC) □ Surgery

□ Physical Therapy □ Rest □ Lifestyle Change □ Chiropractic Care □ Massage Therapy □ Acupuncture

□Other ____

Patient Name: ____ Date of Birth: ___________

Recently, have your symptoms been... □ Same □ Better □ Gradually worse □ Much worse □ Intermittent

How often are you experiencing your symptom(s)? □Constantly □ A few hours at a time □ A few minutes at a time □Briefly □ Only with certain activities □ Randomly □ Other ____

Does anything help to relieve your symptom(s)? □ Ice □ Heat □ Stretching □ Pressure/Massage □ Rest □ Exercise □ Sitting □ Standing □ Lying down □ Medication □ Other ____

What makes your symptoms worse? □ Sitting □ Standing □ Walking □ Lying □ Bending □ Stretching □ Lifting □ Twisting □ Reaching out □ Other ____

What activities, if any, is your pain interfering with? □ Work/School □ Sleep □ Recreation □ Daily Routines □ Mood □ Stress □ Social Interactions □ Relationships □ Other ____

____

____

____

____

How would you rate your pain on a scale of 1-10, where 1 is no pain and 10 is intolerable pain?

Right now:	1	2	3	4	5	6	7	8	9	10
At its Worst:	1	2	3	4	5	6	7	8	9	10
At its Best:	1	2	3	4	5	6	7	8	9	10

Patient Health History Current **medications, vitamins**, etc.	Taking for:

Please list all **allergies** and/or sensitivities you have: ____

____

List and describe any **serious accidents** (please give approximate dates) ____

____

List and describe any **surgeries and hospital stays** (please give approximate dates) _________________________________

____

Please list all **broken bones and sprains**: ____

____

Do you have a primary care physician? □ No □ Yes (Who? ____________________________________) Do you give consent for us to share your treatment progress with the above providers? □ No □ Yes

Patient Name: ____ Date of Birth: ___________

Functional Rating Index

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For use with Neck and/or Back Problems

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain;need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25%	Intermittent pain; 50%	Frequent pain; 75%	Constant pain; 100%

8. Lifting

0	1	2	3	4
No pain with heavy weight	Mild pain with heavy weight	Moderate pain with moderate weight	Moderate pain with light weight	Severe pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain any standing

Signature: ____ Date: __________

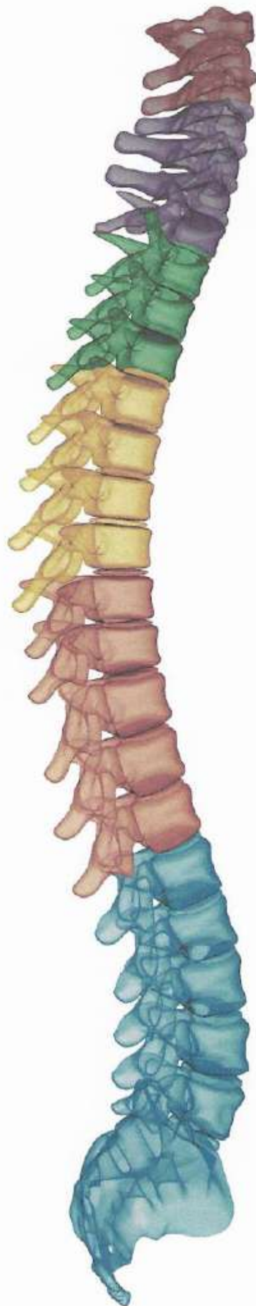
(Office use only)Total Score: ___________________

Patient Name: ____ Date of Birth: ___________

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	PAST	PRESENT	SYMPTOMS	PAST	PRESENT	SYMPTOMS
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐	Colic & Excessive Crying	☐	☐	Epilepsy & Seizures
		☐	☐	Ear & Sinus Infections	☐	☐	Sensory & Spectrum
		☐	☐	Allergies & Congestion	☐	☐	ADD / ADHD
		☐	☐	Immune Deficiency	☐	☐	Focus & Memory Issues
		☐	☐	Headaches & Migraines	☐	☐	Anxiety & Stress
		☐	☐	Vertigo & Dizziness	☐	☐	Balance & Coordination
		☐	☐	Sore Throat & Strep	☐	☐	Speech Issues
		☐	☐	Swollen Tonsils & Adenoids	☐	☐	TMJ / Jaw Pain
		☐	☐	Vision & Hearing Issues	☐	☐	Stiff Neck & Shoulders
		☐	☐	Low Energy & Fatigue	☐	☐	Depression
		☐	☐	Difficulty Sleeping	☐	☐	High Blood Pressure
		☐	☐	Pain, Numbness & Tingling in Arms to Hands	☐	☐	Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐	Reflux / GERD	☐	☐	Bronchitis & Pneumonia
		☐	☐	Chronic Colds & Cough	☐	☐	Functional Heart Conditions
		☐	☐	Asthma			
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐	Gallbladder Pain / Issues	☐	☐	Indigestion & Heartburn
		☐	☐	Jaundice	☐	☐	Stomach Pains & Ulcers
		☐	☐	Fever	☐	☐	Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐	Behavior Issues	☐	☐	Allergies & Eczema
		☐	☐	Hyperactivity	☐	☐	Skin Conditions / Rash
		☐	☐	Chronic Fatigue	☐	☐	Kidney Problems
		☐	☐	Chronic Stress	☐	☐	Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐	Constipation	☐	☐	Sciatica & Radiating Pain
		☐	☐	Chrohn's, Colitis & IBS	☐	☐	Lumbopelvic / SI Joint Pain
		☐	☐	Diarrhea	☐	☐	Hamstring Tightness
		☐	☐	Bed-wetting	☐	☐	Disc Degeneration
		☐	☐	Bladder & Urination Issues	☐	☐	Leg Weakness & Cramps
		☐	☐	Cramps & Menstrual Issues	☐	☐	Poor Circulation & Cold Feet
		☐	☐	Cysts & Endometriosis	☐	☐	Knee, Ankle & Foot Pain
		☐	☐	Infertility	☐	☐	Weak Ankles & Arches
		☐	☐	Impotency	☐	☐	Lower Back Pain
		☐	☐	Hemorrhoids	☐	☐	Gluten & Casein Intolerance

Patient Name: ______________________________ Date: ___/___/___

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Patient Name: ____ Date of Birth: ___________

Family Health History

Please check all of the **conditions/symptoms** that apply to you or your family (P = Personal, F = Family

P/F	P/F	P/F	P/F
□ □ Alcoholism	□ □ Eczema	□ □ Miscarriage(s)	□ □ Ulcer(s)
□ □ Anemia	□ □ Emphysema/COPD	□ □ Mumps	□ □ Other:
□ □ Cancer	□ □ Epilepsy	□ □ Pleurisy	____________________
□ □ Cold sores	□ □ Goiter	□ □ Pneumonia	□ □ Other:
□ □ Deep vein thrombosis	□ □ Gout	□ □ Polio	____________________
□ □ Detached retina	□ □ Heart Disease	□ □ Rheumatic Fever	□ □ Other:
□ □ Diabetes Type 1	□ □ High Cholesterol	□ □ Stroke	____________________
□ □ Diabetes Type 2	□ □ HIV/AIDS	□ □ Tumor(s)	

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: ______________

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Release of Information: Your Protected Health Information (PHI) will be used by Central Oregon Chiropractic to disclose to others for the purposes of treatment, obtaining payment, and/or supporting the daily operations of this office. You should review the Notice of Patient Privacy Policy for a more complete description of how your PHI may be used or disclosed. It describes your rights to the limited use of your PHI, including your demographic information. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the front desk. This office reserves the right to modify the Privacy Practices outlines in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations.

Revocation of Consent: You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _________________________________ **(print)** acknowledge that I have reviewed the above information and I authorize this office to release information concerning my condition and treatment to my insurance company, attorney, insurance adjuster and/or other health care providers deemed necessary for treatment purposes, processing my claim, benefits and payment of services rendered to me as well as coordinated treatment. I do understand that if I choose to refuse release of this information, that my PHI will be used within the office for purposes of my care, to those individuals designated by the doctor.

I authorize contact from this office to confirm my appointments, treatments, and billing information by means:

☐ Cell Phone ☐ Home Phone ☐ Text message ☐ Email ☐ All of the above

Patient/Guardian Signature: ____ Date: _______________________

Patient Name: _______________________________________ Date of Birth: ___________

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic procedures, various forms of physio-therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulations and/or manual therapy techniques. The risks of complications due to chiropractic treatment have been labeled as "rare" and include, but are not limited to muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dislocations and sprains.

I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has the right to terminate responsibility for my care. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my symptoms and/or treatment options. If during the course of my care my insurance company requires me to take an examination from any other doctor, I will notify this facility/physician immediately. I understand that failure to do so may jeopardize my case.

This office does some adjusting and therapies in an open room format. Exams and histories are always performed in closed rooms. There are closed rooms available to discuss private information or to receive private care. If a private closed room is preferred please let us know. Central Oregon Chiropractic does have surveillance cameras on the property for security purposes. It is possible that a portion of your time in the office will be captured on a camera. The captured information is deleted after 4 days and only reviewed if there is a security issue.

I, ___________________________________**(print)** have read the above consent and have had the opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures and intend this consent to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with this office.

Patient/Guardian Signature: ____ Date: ______________________

X-Ray Consent

I am pregnant/I could be pregnant, and/or I am late with my menstrual period: □ Yes □ No

The doctor or certified staff of Central Oregon Chiropractic have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child. I am aware that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

In the event that X-Rays are recommended, I hereby authorize the performance of diagnostic x-rays. At this time, I know of no other condition which the taking of x-rays would further complicate and I consent to having diagnostic x-rays performed. With full understanding of the above, and believing that I am currently not at risk, I wish to have an X-ray examination performed in the present and/or future if requested by the doctor.

With full understanding of the above, and believing that I am currently not at risk, I wish to have an x-ray examination performed today if requested by the doctor.

Patient/Guardian Signature: ____ Date: ______________________

Patient Name: ____ Date of Birth: ___________

Financial Policy

Payment is due at the time of treatment. We accept several methods of payment including cash, check, major credit/debit cards. If a balance has exceeded $200.00 or existed over 90 days, your privilege to schedule appointments will be suspended until the account is current. In the event of unforeseen circumstances, please communicate with our office to arrange and sign a payment plan. If you have questions on your recommended treatment plan or the available payment options, please do not hesitate to ask. We are here to help you!

Missed Appointment Policy: Your appointment time is reserved for you; please arrive on time to maximize your time with the doctor. Please give 24-hour notice if you are unable to keep your appointment, or a $25 fee may be applied to your account.

Please initial in the box next to the category that applies to you to indicate you have read and understand your situation obligations.

- ☐ **General (non-insurance):** Fees are to be paid at time of service. Charges will be based on the treatment you receive, which may include an exam, x-ray, adjustments, and other supportive care.

- ☐ **Private Insurance:** Central Oregon Chiropractic will verify your coverage as a courtesy, however, just as your insurance company cannot guarantee payments based on quoting your benefits, neither can Central Oregon Chiropractic. You are responsible for all deductibles, co-payments, coinsurances, and non-covered therapies at the time of service. When necessary the fee will be estimated and you will be billed/refunded the difference when your insurance issues payment. All payments must be made in accordance with agreements with your insurance provider.

I have read and understand the office policies and fees of this office. I understand that I am ultimately responsible for payment of my care and any fees incurred.

Patient/Guardian Signature: ____ Date: _______________________

OFFICE USE ONLY

New patient forms have been reviewed and discussed by the signee below at the time of the appointment.

Signature:____

Scanned:____Demographics:_____I-Pad login:______Referral info:______Note Complete:______Adjusted:_____