Active Oregon Chiropractic

357 Warner Milne Road • Oregon City, OR 97045 • p: 503.482.6408 • f: 503.655.6206

NEW PATIENT REGISTRATION

Name: _____ Date: _____
Last First MI

Address: _____
Street Apt# City State Zip

Date of Birth: _____ SS #: _____ - _____ - _____ Gender: _____

1st Phone: (_____) _____ - _____ ☐ home ☐ cell ☐ work Email: _____

2nd Phone: (_____) _____ - _____ Preferred contact method: ☐ 1st phone ☐ 2nd phone ☐ email

I authorize Active Oregon Chiropractic to leave a message at the phone number(s) above: ☐ yes ☐ no

Marital status: ☐ single ☐ engaged ☐ married ☐ partnered ☐ separated ☐ divorced ☐ widowed

Race: _____ Ethnicity: _____ Preferred language: _____

Occupation: _____ Employer: _____ Phone: (_____) _____ - _____

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____ - _____

Reason for this visit: ☐ routine visit for: _____ ☐ MVA/WC accident, date/state _____

☐ sports physical ☐ illness: _____ ☐ other: _____

RESPONSIBLE PARTY INFORMATION

PLEASE PRESENT INSURANCE CARD SO WE MAY TAKE A COPY.

Policy Holder Name/Guarantor: _____
Last First MI

Relationship to Patient: _____ Date of Birth: _____

Address: _____ Phone: (_____) _____ - _____
Street City State Zip

Employer: _____ Address: _____

Employer Phone: (_____) _____ - _____ ☐ I AM THE POLICY HOLDER ☐ I AM NOT INSURED

Primary Ins: _____ Secondary: _____ Tertiary: _____

HOW DID YOU HEAR ABOUT OUR CLINIC?

☐ Facebook ☐ Website (please list): _____ ☐ Friend: _____

☐ Poster/Flier ☐ Sign ☐ Other (please list): _____

OFFICE USE ONLY. Chart number:

Active Oregon Chiropractic

357 Warner Milne Road • Oregon City, OR 97045 • p: 503.482.6408 • f: 503.655.6206

CONDITION HISTORY

Please describe complaint: _____

When did your problem begin? (approx date) _____ It is getting: ☐Better ☐Worse ☐ Same

Can you attribute this condition to anything? ☐ Yes ☐No If yes, describe: _____

Has the pain moved away from the main site?: ☐ Yes ☐No If yes, describe: _____

Have you had similar symptoms before? ☐ Yes ☐No When? _____ Treatment? _____

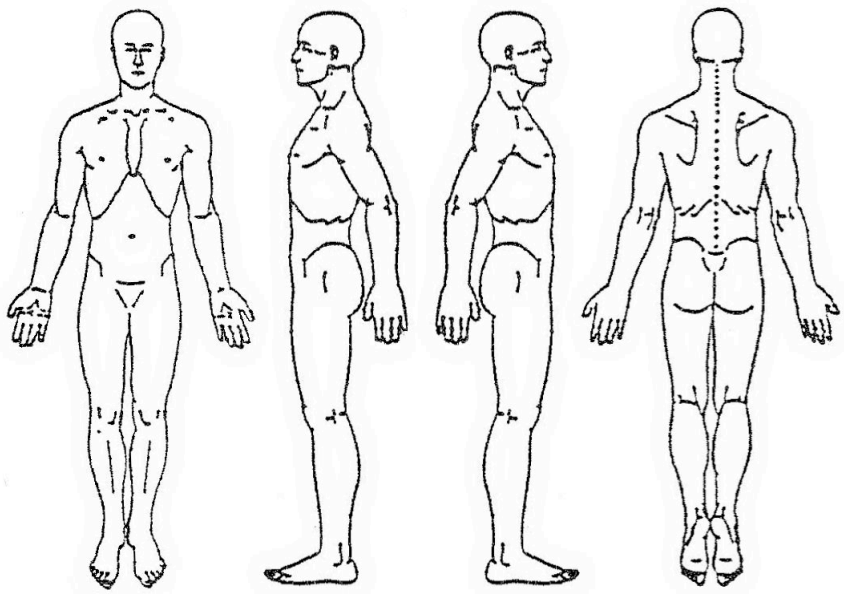
Sleep position? ☐ Side (Left? Right?) ☐ Stomach ☐ Back ☐ Other Handedness: ☐ L ☐ R ☐ Both

AVERAGE intensity of symptoms: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

WORST intensity of symptoms: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Circle the area(s) of complaint and put the number(s) that describe your pain in the appropriate area(s)

1. Deep
2. Dull ache
3. Burning
4. Tingling
5. Stiffness
6. Cramping
7. Headache
8. Weakness
9. Throbbing
10. Numbness
11. Inflammation
12. Radiating pain
13. Sharp/shooting
14. Pain with movement
15. Other (please describe)



BELOW, please note all that apply

MADE IT BETTER	MADE IT WORSE	DID NOT CHANGE IT

My symptoms are present: 0-25% of time 26-50% of time 51-75% of time 76-100% of time
My pain has interfered with my activities: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Have you had treatment for your ***current*** symptoms? Have you had any tests performed (and when)?
☐ Chiropractic ☐ Massage ☐ Acupuncture ☐ Physical therapy ☐ Surgery ☐ Medication ☐ Injections
☐ Exercise/stretching ☐ Bracing/taping/orthotics ☐ Nutrition/naturopathy ☐ ER/ambulance
→→→ ☐ X-ray _____ ☐ MRI _____ ☐ CT scan _____ ☐ Lab _____ ☐ Other _____

Please describe your primary treatment goals:
☐ Reduce pain ☐ Symptom control/palliative care ☐ Wellness ☐ Improve athletic performance
☐ Compete in athletic event (type, date): _____ ☐ Other: _____

OFFICE USE ONLY. Chart number:

Active Oregon Chiropractic

357 Warner Milne Road • Oregon City, OR 97045 • p: 503.482.6408 • f: 503.655.6206

HEALTH HISTORY

PRESCRIPTION MEDICATIONS: _____
_____
_____

SUPPLEMENTS, VITAMINS, OVER THE COUNTERS: _____
_____

SURGERIES: _____
_____
_____

HOSPITALIZATIONS: (when, why?) _____
_____
_____
_____

→**FOR OUR FEMALE PATIENTS ONLY:**
Previous pregnancies/births: ☐ Yes ☐No. If yes: ☐ Male (ages?) _____ ☐ Female (ages?) _____
Difficult labor? ☐ Yes ☐ No. If yes: describe: _____
Currently pregnant? ☐ Yes ☐ No. If yes: due date: _____ First day of last menstrual period: _____
Changes/concerns with cycle? ☐ Yes ☐No. If yes: describe *or circle below*: _____
Breast pain? Cycle irregularity? Excessive flow? Cramps/backaches? Painful periods? Hot flashes?
If in menopause, natural or surgical? Are you on hormonal therapy? ☐ Yes ☐ No

ACCIDENTS AND TRAUMA:
☐ Car accidents ☐ Falls ☐ Broken bones: _____ ☐ Other: _____
_____

ALLERGIES/intolerances: (food, medication, scent, skin, seasonal?) _____
_____
Do you follow a special diet?: ☐ Yes ☐ No / Describe _____

FAMILY HISTORY- do/did your parents, siblings, children, or grandparents have:
☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart problems ☐ High blood pressure ☐ High cholesterol ☐ Stroke
☐ Psychological disorders ☐ Thyroid disease ☐ Other: _____

SOCIAL HISTORY/HABITS: (C: current, P: past)
☐ C ☐ P - ☐ NA: Caffeine - ____ cups of coffee/tea per day; ____ energy drink per day.
☐ C ☐ P - ☐ NA: Tobacco - ____ cigarettes/packs of cigarettes/pipe/chew per day/week.
Used since: _____. Quit: _____.
☐ C ☐ P - ☐ NA: Alcohol - ____ servings* of _____ per day/week (circle). *1 serving= 12 oz beer, 1.5 oz liquor, 5 oz wine
Drank since: _____. Quit: _____.

Exercise types and how often: _____

RECREATIONAL ACTIVITIES AND HOBBIES: _____
_____

OFFICE USE ONLY. Chart number:

Active Oregon Chiropractic

357 Warner Milne Road • Oregon City, OR 97045 • p: 503.482.6408 • f: 503.655.6206

REVIEW OF SYSTEMS

Please check "P" for past or "C" for the symptoms listed below. If applicable, please describe.

CARDIOVASCULAR	P	C		RESPIRATORY	P	C		MISC SYMPTOMS	P	C	
High blood pressure				Asthma				Hernia:			
Heart Attack				Bronchitis				Nausea			
Heart or Vascular Disease				Cold/Flu				Vomiting			
Chest Pain / Heaviness				Coughing/Wheezing				Sleep Disruption			
Irregular Heart Beat (fast/slow)				Difficult Breathing				Swelling in Legs/Feet			
Swelling in Legs/Ankles				Emphysema				Weight Loss			
Pacemaker				Shortness of Breath				Weight Gain			
Poor Circulation				Spitting Blood / Phlegm				OTHER:			
			N/A				N/A				N/A
MUSCULOSKELETAL				**NEUROLOGICAL**				**GENITOURINARY**			
Arthritis				Aneurysm / Stroke / TIA				Bladder Infection			
Artificial Joints:				Cerebral Palsy				Blood in Urine			
Degenerative Disc Disease				Concussions / Head Injuries				Frequent Urination			
Disc Herniation				Epilepsy / Seizures / Convulsions				Painful Urination			
Gout				Headaches/Migraines				Kidney Disease			
Joint Pain / Stiffness				Memory Loss				Kidney Infection			
Joint Swelling				Multiple Sclerosis				Kidney Stones			
Osteoporosis				Muscle Weakness				Prostate Issues			
Sciatica / "Pinched Nerves"				Numbness				Urinary Incontinence			
Scoliosis				Parkinson's Disease				Urinary Retention			
Trouble Walking				Tremors / Twitches				Vaginal Pain			
			N/A				N/A				N/A
EYES/EARS/NOSE/THROAT				**SYSTEMIC**				**GASTROINTESTINAL**			
Balance Issue / Spinning				AIDS/HIV				Belching/Gas			
Dizziness				Anemia				Black Stools			
Blurry Vision				Chicken Pox / Shingles				Bloody Stools			
Double Vision				Fainting				Constipation			
Difficulty Swallowing				Fatigue / Tire Easily				Diarrhea			
Ear Ache				Measles / Mumps				Excessive Hunger			
Glaucoma				Polio				Gall Bladder issues			
Hearing Loss / Deafness				Tuberculosis				Hemorrhoids			
Jaw Pain / Dysfunction							N/A	Heartburn			
Nose Bleeds				**INTEGUMENT**				Liver issues			
Ringing / Buzzing in Ears				Eczema / Dermatitis / Psoriasis				Other Bowel Issues:			
Sinus Infections				Hives				Poor Appetite			
Sore Throat / Tonsillitis				Rashes				Ulcer			
			N/A				N/A				N/A
PSYCHIATRIC				**LYMPHATIC/HEMATOLOGIC**				**ENDOCRINE**			
Anxiety / Nervousness				Blood Clots				Diabetes Type I			
Depression				Cancer:				Diabetes Type II			
Mood Swings				Easy Bruising				Pre-Diabetes			
Other Mental Disorder:				Fever / Chills / Sweats				Excessive Thirst			
Phobias				Hepatitis:				Hair Loss			
Unusual / Excess Stress				Night Sweats				Thyroid Disease			
			N/A				N/A				N/A

OFFICE USE ONLY. Chart number:

Active Oregon Chiropractic

357 Warner Milne Road • Oregon City, OR 97045 • p: 503.482.6408 • f: 503.655.6206

CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, muscle/soft tissue treatment, ultrasound, heat application, and electrotherapy) are considered safe and effective methods of care. Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury (including redness and/or bruising), dizziness, and burns. It is very common to experience a temporary worsening of symptoms, especially if you have never had chiropractic care. However, this soreness should be similar to post-workout soreness and should last no more than two days. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck, which may be associated with stroke and serious neurologic impairment, as well as possible injury to the spinal discs and/or spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request. For most conditions treated in this office, alternatives may include self-care, over-the-counter medications, rest, and ice/heat, in addition to prescription medications and potentially surgery. Should you pursue these pathways, you may wish to discuss the risks and benefits with your primary medical physician. Left untreated, conditions may worsen in regards to pain level and mobility; if postponed, future treatment may be complicated and less effective.

Please read the following carefully and initial each statement.

_____ I have read and understand the above statements regarding treatment side-effects and do not have any questions.

_____ I authorize Active Oregon Chiropractic to provide chiropractic services to me, and understand that there is no guarantee of warranty for a specific cure or result.

_____ I understand that I need to be honest and truthful with my physician, including my history, habits, and feelings toward treatment. I understand that my voice matters when it comes to my care.

_____ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Active Oregon Chiropractic reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

_____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Active Oregon Chiropractic. These charges include **missed appointment fees**, which are incurred after two missed or tardy appointments (>15 minutes late).

_____ If my account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

_____ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled (Medicare, private insurance and all other health plans) to Active Oregon Chiropractic, address above.

_____ I authorize release of my/patient's records to third parties requiring these records for determination of financial liability.

By signing this application, I affirm under penalty that I have given true complete information.

_____ _____

Patient Signature Date

_____ _____

Guarantor Signature Relationship to Patient

OFFICE USE ONLY. Chart number:

Active Oregon Chiropractic

357 Warner Milne Road • Oregon City, OR 97045 • p: 503.482.6408 • f: 503.655.6206

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

We believe that all patients should be treated in a manner that respects their basic rights as human beings. You, as patients, have the right to:

1. Be treated with respect and courtesy by all those involved in providing care and information.

2. Privacy during interviews and examinations. All information about a patient's care and records will be treated in a confidential manner.

3. Voice grievances or concerns about your care, or about the manner in which you were treated by the doctor or clinic staff. If you have concerns about your care, please contact the physician or office manager at the above address and phone number.

4. Receive clear and complete information about your care and participate in the decisions concerning your treatment. If you have concerns about the front desk staff, insurance or billing, please contact the office manager or billing specialist.

Patient Responsibilities

1. Be as accurate and complete as possible when providing information about your medical history or condition.

2. Cooperate in following instructions given to you by those providing your health care.

3. Read and cooperate with the instructions provided by your doctor.

4. Treat those caring for you with respect and courtesy.

5. Ask for clarification about any aspect of your health care benefits that you do not fully understand.

6. Keep scheduled appointments or give adequate notice of delay or cancellation; please give a minimum of 24 hours notice for cancellations, and 30 minutes notice of delays.

OFFICE USE ONLY. Chart number:

Active Oregon Chiropractic

357 Warner Milne Road • Oregon City, OR 97045 • p: 503.482.6408 • f: 503.655.6206

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____ consent to Active Oregon Chiropractic's use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for Active Oregon Chiropractic's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that Active Oregon Chiropractic's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by Active Oregon Chiropractic, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of Active Oregon Chiropractic, but that Active Oregon Chiropractic is not required to agree to these restrictions. However, if Active Oregon Chiropractic agrees to a restriction that I request, the restriction is binding on Active Oregon Chiropractic.

I have been given the opportunity to review Active Oregon Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. This document is posted in plain view on the front desk near the intake window. Please notify our front desk if you wish to have a copy of our Notice of Privacy practices.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or Active Oregon Chiropractic has acted in reliance on this consent.

_____ _____

Signature of Patient / Personal Representative / Guardian Date

_____

Description of Personal Representative's Authority

OFFICE USE ONLY. Chart number:

Active Oregon Chiropractic

357 Warner Milne Road • Oregon City, OR 97045 • p: 503.482.6408 • f: 503.655.6206

NOTICE OF RECEIPT OF PRIVACY PRACTICES

I have had an opportunity to read the Notice of Privacy Practices on the date below, on behalf of Active Oregon Chiropractic. I understand that the Notice describes the uses and disclosures of my protected health information by the above named clinic, and informs me of my rights with respect to my protected health information. I understand that I may request a paper copy of this notice at any time. At this time, I waive my right to a paper copy.

Printed patient name: _____ DOB: _____

_____ _____
Signature of Patient / Personal Representative / Guardian Date

_____
Description of Personal Representative's Authority

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that certain information cannot be released *without prior authorization*. I authorize Active Oregon Chiropractic to release the information I have initialed below to the person(s) I have listed. I DO NOT authorize the release of anything I have not signed.

_____ appointment history
_____ insurance/billing
_____ treatment plans/history
_____ payment history

Authorized individuals:

Name/Relationship: _____
Name/Relationship: _____
Name/Relationship: _____
Name/Relationship: _____

OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- Patient refused to sign
- Due to an emergency situation, it was not possible to obtain an acknowledgement
- Communication barriers prohibited obtaining the acknowledgement
- OTHER: _____

_____ _____
Employee name and signature Date

OFFICE USE ONLY. Chart number: