

Intake Form

PATIENT _____ Date: _____

Last Name: _____ First Name: _____ Middle: _____

Address: _____ Apartment: _____

City: _____ State: _____ Zip Code: _____ Social Security#: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please include your e-mail and indicate if you would like e-mail or Text Message reminders send to you.

Text Reminders Cell Phone Carrier: _____ E-Mail Reminders:

E-mail: _____ Name of Spouse: _____

Gender: M F Date of Birth: _____ Age: _____ Martial Status: M S W D

Employer: _____ Occupation: _____

Employers Address: _____

City: _____ State: _____ Zip Code: _____

Whom can we thank for referring you to our office? _____

Parent's names (if you are under 18 years of age) _____

MAJOR COMPLAINTS

Describe your major complaint in detail: _____

Date when condition first started: _____

Cause of pain, If Known: _____

Is this condition due to an accident? Y N Date: _____

Auto: _____ Work related: _____ Fall: _____ Other: _____

Have you been treated for this condition? Y N If Yes, when? _____

Name of treating MD: _____ What was done: _____

Name of other therapist assisting you with your care: _____

Have you had a similar condition before? Y N If Yes, when? _____

Were you treated? Y N If Yes by whom? _____

List all medication, vitamins, and minerals, ect. you are taking? _____

Please indicate where and if any X-Rays/Labs have been taken in the past year? _____

What type of chiropractic adjustment do you prefer? Do you have a Heart Device? If yes, please list _____

Manual Activator

Which of these factors affect your condition (please check all that apply)?

	No Effect	Better	Worse		No Effect	Better	Worse
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	End of the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	During heavy activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Before meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	During meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	After meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First thing in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recreation/Play	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SYMPTOMS: CHECK the following symptoms your have now, and UNDERLINE the one you've had before.

GASTROINTESTINAL

- ___ Constipation
- ___ Diarrhea
- ___ Digestive problems
- ___ Stomach Pain
- ___ Vomiting of blood
- ___ Gall bladder trouble
- ___ Hemorrhoids
- ___ Liver trouble

SKIN

- ___ Bruising
- ___ Boils
- ___ Dryness

GENITOURINARY

- ___ Frequent urination
- ___ Painful urination
- ___ Difficulty starting urine
- ___ Inability to control urine
- ___ Blood in urine
- ___ Bed wetting
- ___ Kidney infection
- ___ Prostate trouble

MUSLES AND JOINTS

- ___ Foot problems
- ___ Swollen Joints
- ___ Hernia

CARDIOVASCULAR

- ___ High Blood Pressure
- ___ Low Blood Pressure
- ___ Previous heart problems
- ___ Previous stroke

FOR WOMEN ONLY

- ___ Cramps ___ Backache
- ___ Excessive flow
- ___ Hot flashes
- ___ Irregular cycles
- ___ Painful Intercourse
- ___ Painful menstruation
- ___ Vaginal discharge

RESPRATION

- ___ Chest pains
- ___ Chronic Cough
- ___ Difficulty breathing
- ___ Frequent colds

- ___ Spitting blood
 - ___ Allergies
 - ___ Weight loss
 - ___ Nervousness
 - ___ Emotional issues
- Date of last physical?

EYES-EARS-NOSE

- ___ Eye pain
 - ___ Earaches
 - ___ Ear discharge
 - ___ Ringing of ears
 - ___ Nasal discharge
 - ___ Nose bleeds
 - ___ Sinus troubles
 - ___ Difficulty swallowing
 - ___ Hoarseness
 - ___ Asthma
- Date of last exam?

WHAT ARE YOUR GOALS FOR YOUR HEALTH CHALLENGES? (Please check all that apply)

- ___ Pain/Symptoms relief
- ___ Isolate and fix the cause of the problem
- ___ Adopting a better routine

Pain Diagram

On the diagrams below, mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations

Key: A – ACHE

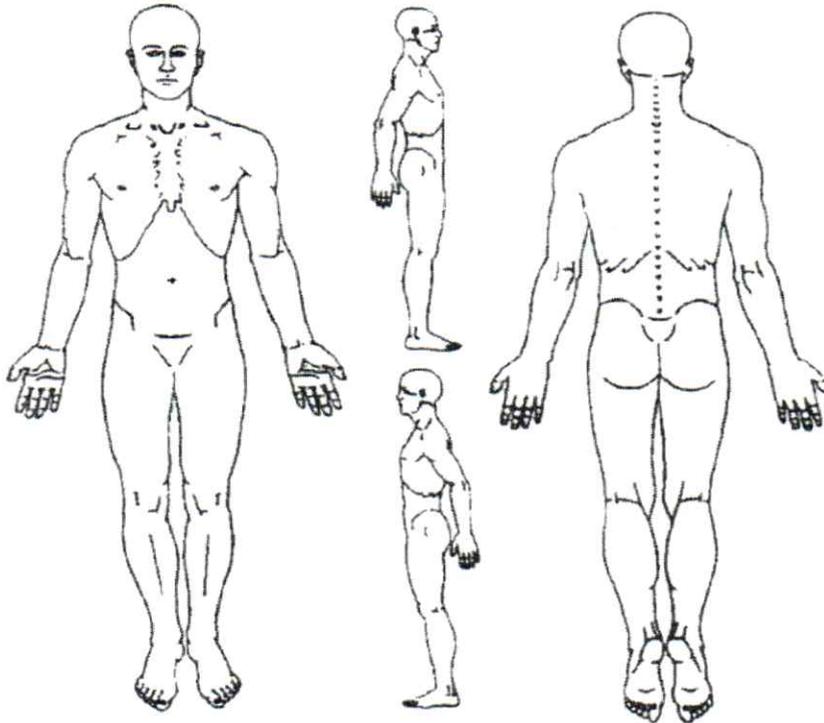
B – BURNS

N – NUMBNESS

P – PINS & NEEDLES

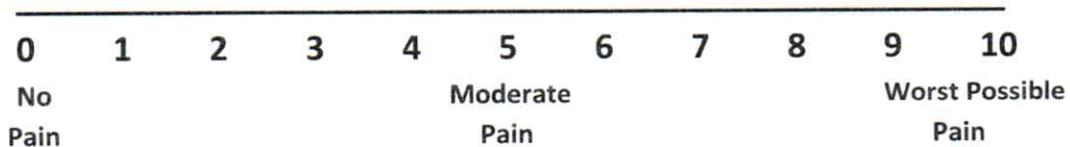
S – STABBING

O - Other



PAIN SCALE

Rate the severity of your pain by marking the following scale.





Roseburg Chiropractic Center

1632 NW Hughwood Ct, Suite 1

Roseburg, OR 97471

(541) 677-9199

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel the movement of the joint. During treatment and examination, the doctors may touch you anywhere that there is a joint of muscle. This may include your neck, shoulders, back, ribs, buttocks, hips and legs. Various ancillary procedures, such as hot and cold packs, electric muscle stimulation, therapeutic ultrasound, decompression therapy, cold laser therapy, or diadulse (electro-magnetic) therapy may also be used; some on bare skin. In regards to electric muscle stimulation, the electrodes (adhesive pads connected by wire to the machine) may need to be used on sensitive parts of the body, such as the buttocks or hips. In the situation, it will be necessary to reach underneath your clothing to apply the electrodes directly to the skin.

Possible risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures to the bone, muscular strain, ligamentous sprain, dislocations of joints, or injuries to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from taking a single aspirin tablet. The risk of cerebro-vascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction to ancillary procedures is also considered "rare".

The availability and nature of other treatment options. Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest.
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers.
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow formation of adhesions, and reduce mobility, which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective, the longer it is postponed.

By signing this consent form, I confirm that I have read the above chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment, I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Signature of patient or patient representative

Date



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Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, we require that you read and sign prior to any treatment.

Full payment of co-pay, co-insurance, deductible or time of service discount is due at time of service. We accept cash, checks and most major credit/debit cards.

Regarding insurance: We may accept assignment of insurance after coverage, eligibility and benefits have been verified. The balance is your responsibility, whether the insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not party to that contract and, in the event we do accept benefits, we require that you pay the portion not covered at the time of visit, i.e. your deductible, co-pay or percentage of co-insurance.

Regarding Medicare: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical coverage. We do accept Medicare assignment. Medicare is billed directly for all patients with Medicare coverage. If you have supplementary insurance, as a courtesy to you, we will bill your secondary insurance. However Medicare only covers a portion of the chiropractic visits. That portion of your bill, which is not covered, as well as any unmet deductible charges, is required at the time of your visit.

Insurance is billed on at least a 30-day cycle as long as you are receiving treatment at this office. If necessary, delinquent accounts will be turned over to an outside collection agency. Any charges incurred will be added to your account. Supports and supplements are to be paid for at the time they are provided.

Usual and customary rates: We are committed to providing the best treatment for our patients; we charge what is usual and customary of our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult patients: Adult patients are responsible for full payment of co-pay, co-insurance, deductible and time of service discount rate at the time of service.

Minor patients: The adult accompanying a minor and/or the parents or guardians are responsible for full payment of co-pay, co-insurance, deductible and time of service discount rate at the time of service.

Missed appointments: Our office policy states that we reserve the right to charge for missed appointments, unless cancelled at least 24 hours in advance, at the rate of \$25 per instance.

Returned checks: All returned checks will incur a \$25.00 fee. This fee includes all bank charges.

Signature of patient or patient representative

Date



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HIPPA Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured, this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit, in writing, any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of these records for care given prior to the written request to revoke consent that would apply to any care given after the request has been presented.
5. For your security, and right to privacy, all staff has been trained in the area of patient record privacy and a compliance officer has been designated to enforce those procedures in our office. We have taken all the precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our compliance officer about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the doctor has a right to refuse to give care.

_____ Please initial here to give consent for our office to leave messages on your answering machine or with family members who may answer the phone when we call for appointment reminders, etc.

Signature of patient or patient representative

Date