Chiropractic Care Centers, P.C.
25700 SW Argyle Avenue, Unit C.
Wilsonville, OR 97070-5799
(503) 582-9805

WELCOME

The doctors and staff of **Chiropractic Care Centers** welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

INSURANCE

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

PATIENT IDENTIFICATION

_____
Name

_____
Street

_____
City, State and Zip

_____
Social Security #

Male ( ) Female ( )

Email:_____

How did you hear about us? _____

Name or Nickname I prefer to be called
in this office _____

Telephone : Home_____
Work: _____
Cell: _____

Place you would like to be reached at first:_____

_____
Occupation

_____ _____
Date of Birth Age

Contact in case of emergency:
Name:_____Relationship:_____Telephone # _____

Name of Parent of Minor Patient (If applicable) _____

Primary Insurance_____ Group/Subscriber/ID#_____

ACCEPTANCE AS PATIENT

I understand and agree that the doctors of **Chiropractic Care Centers** have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Date _____ Signature _____

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In our office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Your Early Years: (birth to 17yrs) *Current research has shown that many of the health challenges that occur in our adult life have their beginnings during our childhood years, some starting as early as birth.*

(Y) Yes (N) No

Did you have any serious falls as a child? _____ Were you vaccinated? _____
Were you involved in any car accidents as a child? _____ As a child, did you receive regular chiropractic care?___
Were you active in youth sports? _____ Did you have any surgery as a child? _____
Did you wear braces/head gear/retainer or other?_____ Date of most recent auto accident/ injury:_____
Did you use any medications (antibiotics, inhalers, aspirin, etc.) on an on-going basis? Y N

Adult Years: (18+yrs)

Did/ do you smoke? Y / N How much_____ How long _____ Did/ do you play any adult sports? _____ Did/ do you drink alcohol? Y / N How often _____ how Much? _____
Did/ do you participate in any extreme sports? _____
Have you been in any accidents? ____ What year? _____
On a scale from 1-10 describe your stress level. (1=none/ 10 Extreme) *Occupational* 1 2 3 4 5 6 7 8 9 10
Personal 1 2 3 4 5 6 7 8 9 10

Do you?
Belong to health club: _____
Take vitamins: _____
Drink bottled water: _____

Please Circle: Describe your

Diet	*Excellent*	*Good*	*Poor*
Exercise	*Excellent*	*Good*	*Poor*
Sleep	*Excellent*	*Good*	*Poor*
General	*Excellent*	*Good*	*Poor*
Health	*Excellent*	*Good*	*Poor*

Reasons for consulting office: Please briefly describe the *chief area of complaint* ***If you have no symptoms or complaints and are interested in Wellness services, please let us know.***

Intensity Scale-1=low 10=unbearable

1._____Date of Onset_____ ***1 2 3 4 5 6 7 8 9 10***
2._____ Date of Onset _____ _____***1 2 3 4 5 6 7 8 9 10***
3._____ Date of Onset _____ ***1 2 3 4 5 6 7 8 9 10***

How often is the pain present? Δ Intermittent (25% or less) Δ Occasional (26-50%) Δ Frequent (51-80%) ΔConstant (81-100%)
Since your problem began, is your pain? Δ Getting better Δ Staying the same Δ Getting worse
How did your problem begin? Δ Auto accident Δ Work related Δ Other type of accident Δ Gradual Onset Δ Sudden Onset Δ No Specific reason please explain : _____
What makes it worse? Δ Walking Δ Standing Δ Sitting Δ Stairs Δ Driving Δ Working Δ Moving/Exercise Δ Sneezing/Coughing Δ Other:_____ What makes it better: _____
_____ *Medications currently taking(*OTC/Prescription)*:*_____
Were you treated for this condition previously? _Yes _No If yes, by whom? Δ Chiropractor Δ MD Δ Physical Therapist Δ Other_____List dates, types of treatments and results: _____
_____
Does your problem affect your ability to work or affect your routine daily activities? Δ No effect Δ Limited restrictions but can function Δ Needs some assistance with daily activities Δ Cannot work Δ Cannot function without assistance Δ Totally disabled --- List all Surgeries: _____
Previous Chiropractor: Δ Yes Δ No Dr._____Time under care_____ Last Visit_____
Reason for interrupting care:_____
Other Doctors seen for this problem: Δ MD/specialist_____ Δ Physical Therapist Δ Other _____

List dates, types of treatments and results: _____

Check off any of the following symptoms you have ever had even if you think they are not related to your problem:

MUSCULO-SKELETAL
- ❒Neck Pain
- ❒Arm Pain
- ❒Shoulder Pain
- ❒Hand/Wrist Pain
- ❒Mid Back pain
- ❒Low Back Pain
- ❒Upper Leg/Hip Pain
- ❒Lower Leg/Hip Pain
- ❒Ankle/Foot Pain
- ❒Walking Problems
- ❒Joint Pain/Stiffness/Swelling
- ❒Arthritis
- ❒Jaw Pain/TMJ
- ❒Scoliosis

NERVOUS SYSTEM
- ❒Nervous
- ❒Numbness
- ❒Paralysis
- ❒Dizziness
- ❒Forgetfulness
- ❒Confusion/Depression
- ❒Fainting
- ❒Convulsions
- ❒Cold/Tingling limbs
- ❒High stress

GENERAL
- ❒Fatigue
- ❒Allergies
- ❒Fever
- ❒Headaches
- ❒Diabetes
- ❒Cancer
- ❒Skin Conditions

GASTRO-INTESTINAL
- ❒Poor/Excessive Appetite
- ❒Excessive Thirst
- ❒Frequent Nausea
- ❒Vomiting
- ❒Diarrhea
- ❒Hemorrhoids
- ❒Liver Problems
- ❒Gall Bladder Problems
- ❒Weight Trouble (Loss/Gain)
- ❒Abdominal Cramps
- ❒Gas/Bloating After Meals
- ❒Heartburn
- ❒Colitis
- ❒Digestive Problems

GENITO-URINARY
- ❒Bladder/Kidney Trouble
- ❒Painful/Excessive Urination
- ❒Discolored Urine

C-V-R
- ❒Chest Pain
- ❒Short Breath
- ❒Blood Pressure Problem
- ❒Irregular Heartbeat
- ❒Heart Disease
- ❒Lung Congestion
- ❒Respiratory Condition
- ❒Varicose Veins
- ❒Ankle Swelling
- ❒Stroke

EENT
- ❒Vision Problems
- ❒Dental Problems
- ❒Sore Throat
- ❒Earaches
- ❒Hearing Difficulty
- ❒Stuffed Nose

FEMALES ONLY: **ARE YOU PREGNANT? Yes /months_____ No** When was your last period? _____

❒Menstrual Irregularity ❒Menstrual Cramps ❒Vaginal Pain/Infection ❒Breast Pain/Lumps

Family Health Profile: *At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:*

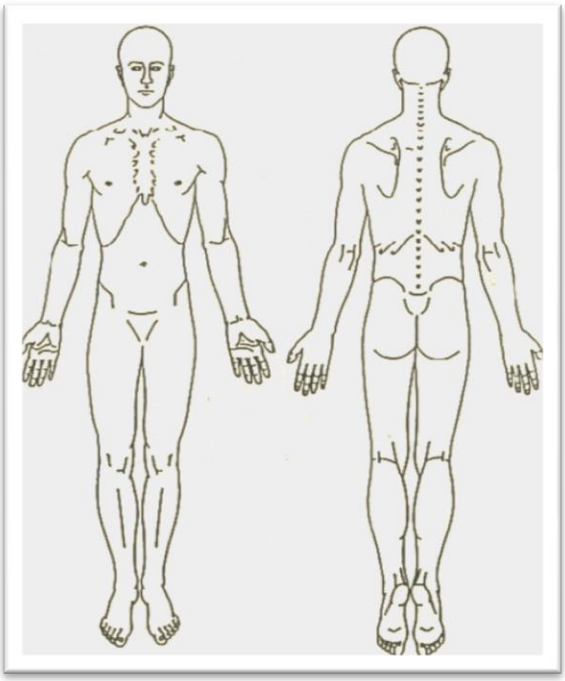
Mother _____ Sister _____ Brother_____

Father _____Spouse _____ Child _____

Using the letters below please mark on these figures the area and type of altered sensation you are experiencing.

P = Pain **T** = Tingling **S** = Stiffness

B = Burning **N** = Numbness **M** = Muscle Spasm



Doctors Notes:_____

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_____

Name: _____

Signature: _____

Date: _____ **DOB:** _____

Patient Accepted: ❒ YES ❒ NO ❒ Referred

Doctor's Signature: _____Date_____

I have reviewed the information contained on this form with the patient

To better serve you as a patient, we want to get to know you better. Thank you for taking the time to tell us a little bit more about you.

PATIENT NAME: _____ DATE: _____ D.O.B: _____

Please indicate beside the below activity whether you engage in it:

OFTEN = "O" SOMETIMES = "S"

Social History

_____ Horseback riding
_____ Bowling
_____ Golf
_____ Volleyball
_____ Baseball/softball
_____ Handball
_____ Racquetball
_____ Basketball
_____ Walking (mile or less)
_____ Walking (more than mile)
_____ Jogging (mile or less) (mile or more)
_____ Dancing
_____ Scuba diving
_____ Back packing
_____ Swimming
_____ Aerobics
_____ Resistance training
_____ Free weights
_____ Exercise machines

_____ Tennis
_____ Gymnastics
_____ Skiing
_____ Water skiing
_____ Hunting
_____ Fishing
_____ Lawn mowing
_____ Weed eater use
_____ Snow shoveling
_____ Gardening
_____ Child care
_____ Girl/Boy Scouts
_____ Cycling
_____ Climbing stairs
_____ Alcohol _____ per day_____ per week
_____ Yoga
_____ Medication
_____ Tobacco
_____ Football

Other:_____
_____
_____
_____
_____

Family History

Please indicate if any of the following is currently or has contributed to some stress or personal lifestyle changes within the past three years.

_____ Marriage
_____ Birth of a child
_____ Divorce
_____ Death of spouse
_____ Marital separation
_____ Death of a family member or friend
_____ Handicapped household member
_____ Caregiver to family member
_____ Spousal abuse

_____ Dependence problems
_____ Alcohol
_____ Drugs
_____ Change in jobs
_____ Loss of job
_____ Retirement
_____ Change in living conditions
_____ Change in residence
_____ Change in financial status

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Informed Consent

The primary treatment used by doctors of chiropractic is the spinal adjustment.

The doctor will use his/her hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click." You may feel or sense movement.

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. These complications are extremely rare occurrences.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctors of Chiropractic Care Centers and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment recommended. Having been informed of the risks, I hereby give the doctors of Chiropractic Care Centers consent to treatment.

_____ _____

Patient name (print) Date

_____

Patient Signature