Maurice Smith DC – Oregon City Chiropractic
Stephanie Tolonen DC MS CCSP® - Active Oregon Chiropractic
Amy Henry – Licensed Massage Therapist

357 Warner Milne Road
Oregon City, OR 97045
Phone: 503-655-6780
Fax: 503-655-6206

NEW PATIENT INTAKE FORM

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

A message can be left at the 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): _____

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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? _____

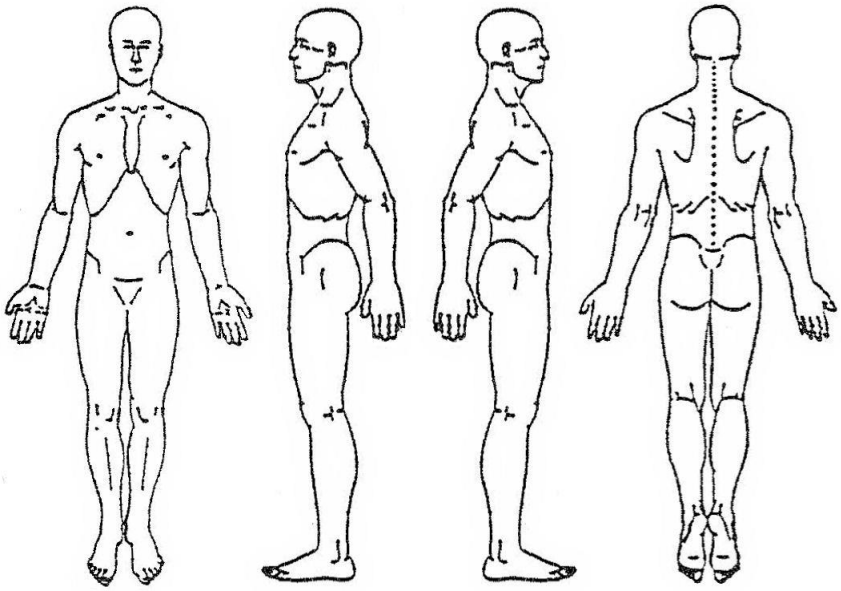
Sleep position? ☐ Side (Left? Right?) ☐ Stomach ☐ Back ☐ Other Handedness: ☐ L ☐ R ☐ Both

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: _____

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HEALTH HISTORY

PRESCRIPTION MEDICATIONS: _____
_____
_____
SUPPLEMENTS, VITAMINS, OVER THE COUNTERS: _____
_____

SURGERIES: _____
_____
_____

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

→FOR OUR FEMALE PATIENTS:
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 - ____ servings per week. Used since: _____. Quit: _____.
☐ C ☐ P - ☐ NA: Alcohol - ____ servings per week. Drank since: _____. Quit: _____.
☐ C ☐ P - ☐ NA: Cannabis - ____ days per week. Medicinal or Recreational? (circle one).

Exercise types and how often: _____

RECREATIONAL ACTIVITIES AND HOBBIES: _____
_____

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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

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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 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.

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 understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with my chiropractic physician because it may affect care.

_____ 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, Oregon City Chiropractic/Active Oregon Chiropractic/Amy Henry reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

_____ I authorize Oregon City Chiropractic/Active Oregon Chiropractic/Amy Henry to provide chiropractic/massage therapy services to me and understand that there is no guarantee of warranty for a specific cure or result.

By signing this application, I affirm under penalty that I have given true and complete information on all documentation submitted.

Print Patient Name: _____

Print Name and Relationship of Personal Representation / Legal Guardian: _____
_____

Signature: _____ Date: _____

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Patient Financial Responsibility

To Our Patients:

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will check your benefits and bill your insurance carrier on your behalf, but confirmation of benefits is not a guarantee of payment nor a guarantee of how your insurance will process the services. It is your responsibility to know your insurance benefits such as deductible, copayment, co-insurance, prior authorization or referral requirements, or any other type of benefit limitation for the services. The member services phone number is usually on the back of your insurance card. Please be aware some insurance policies are now processing chiropractic care in a variety of innovative ways. There may be a co-pay/coinsurance for office visits/exams, plus a co-pay/co-insurance for spinal manipulations, plus co-insurance for modalities such as ultrasound and electric muscle stimulation, plus co-insurance for extra-spinal manipulation such as TMJ. If your deductible applies for these benefits and has not been met, all amounts allowed will be your financial responsibility. You are ultimately responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue care past your approved period, you will be responsible for the account balance in full. If you do not have insurance benefits for chiropractic care, or if you choose to self-pay in full, we do offer courtesy discounts for payments at time of service.

Please read the following carefully and initial each statement:

_____ I confirm that I have read the above statements and agree to the financial responsibility of my account with Oregon City Chiropractic/Active Oregon Chiropractic/Amy Henry.

_____ 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 Oregon City Chiropractic/Active Oregon Chiropractic/Amy Henry. 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 Oregon City Chiropractic/Active Oregon Chiropractic/Amy Henry, address above.

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

_____ I authorize Oregon City Chiropractic/Active Oregon Chiropractic/Amy Henry to release any/all pertinent medical records if and or when this request is received from another provider office via fax, phone, or other communication.

By signing this application, I affirm under penalty that I have given true and complete information on all documentation submitted.

Signature: _____ Date: _____

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Authorizations for Use and Release of PHI

Consent for the Purposes of Treatment, Payment, and Healthcare Operations:

I, _____ consent to Oregon City Chiropractic/Active Oregon Chiropractic/Amy Henry's use and disclosure of my Protected Health Information ("PHI") for the purposes of providing treatment to me, for purposes relating to payment of services rendered to me, and for general healthcare operations. Healthcare operations shall include, but are not limited to, quality assessment activities, credentialing, business management, and other operation activities. I understand that my diagnosis and treatment are conditioned upon my consent as evidence by my signature on this document. For purposes of this consent "PHI" means any information, including my demographic information, created or received by the offices listed above, 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 that I have the right to request a restriction on the use and disclosure of my PHI, but that the offices listed above are not required to agree to these restrictions; however if agreeded apon these restrictions become binding. I have been given the opportunity to review the Notice of Privecy Practices prior to signing this document. The Notice of Privecy Practices describes my rights and the practice's duties regaurding the types of uses and discolosures of my PHI. This document is posted in the office and a paper copy is availible by request at any time, but at this time a waive that right. I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or Oregon City Chiropractic/Active Oregon Chiropractic/Amy Henry has acted in reliance on this consent.

Authorization to Release PHI to Individuals:

Certain information cannot be released without prior authorization. To release the information listed below to anyone (spouse, family, friend, etc.) please fill in the information below. By signing, I authorize Oregon City Chiropractic/Active Oregon Chiropractic/Amy Henry to release the information I have checked below to the person(s) I have listed. I DO NOT authorize the release of anything I have not signed.

Check all boxes you wish to be release to the individuals listed below:

☐ Appointment history ☐ Treatment plans/history ☐ Insurance/Billing ☐ Payment history

Authorized Individuals:

Name/Relationship: _____Name/Relationship: _____

Name/Relationship: _____Name/Relationship: _____

Signature: _____ Date: _____

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