

Welcome!



Your
New Patient
Information

PLEASE PRINT CLEARLY.

Full Name: _____ Gender: M F Age: ____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security#: _____ - _____ - _____ E-mail _____ Home Phone: (____) _____

Marital Status: S M D W # of Children: ____ Work Status: Full time Part-time Retired Cell: (____) _____

Females: Last Menstrual Period: _____ Pregnant? Y N Nursing? Y N

Employer: _____ Occupation: _____ Work Phone: (____) _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Name of Spouse, Parent or Guardian: _____ Age: ____ Birth Date: _____

Spouse's Employer: _____ Spouse's Occupation: _____ Work Phone: (____) _____

In case of an Emergency Contact: _____ Relationship: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Do you have Medicare or Insurance? Y N Drivers license copied by Office Staff Insurance card copied by Office Staff

Who may we thank for referring you? _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care 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. A more detailed account of our policies and procedures concerning the privacy of your PHI is available to you.

1. The patient understands and agrees to allow Portland Chiropractic Wellness Center to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/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 effect the use of those records for the care given prior to the written request to revoke consent but 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 privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Portland Chiropractic Wellness Center 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 privacy official 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 chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

I have received a copy of the Notice of Patient Privacy Policy

Patient's Signature: _____ Date: _____

Spouse's or Guardian's Signature: _____ Date: _____

Medical History Information

Full Name:		Date of Birth:		Age:	Sex:
Medical Care Information					
Do You Have a Family Doctor?:		<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor:			
Address:		City:	State:	ZIP Code:	
Date of Last Visit: / /		Date of Last Exam: / /			
Do You Have a Family Chiropractor?:		<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Chiropractor:			
Address:		City:	State:	ZIP Code:	
Date of Last Visit: / /		Date of Last Exam: / /			
Have you had surgeries in the last 5 Years:		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Last Surgery Date:			
Reason for Surgery:					
Present Illness / Conditions:					
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Scoliosis	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/Hepatitis	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated Joints	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Polio	<input type="checkbox"/> STD'S	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Prostate Trouble	<input type="checkbox"/> Thyroid Trouble	<input type="checkbox"/>
<input type="checkbox"/> Bone Fracture	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>
Other: Rheumatic fever					
Family History of Illness:					
<input type="checkbox"/> AIDS	<input type="checkbox"/> Bone Fracture	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Prostate Trouble	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Thyroid Trouble
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/Hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated Joints	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Polio	<input type="checkbox"/> STD'S	<input type="checkbox"/>
Other:					
Type of Cancer: <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Other:					
Social History:					
Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week?	Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day?	Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day?	Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes Hours per week? (circle one) Light / Moderate / Strenuous		
Misc.:					

Signature: _____

Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

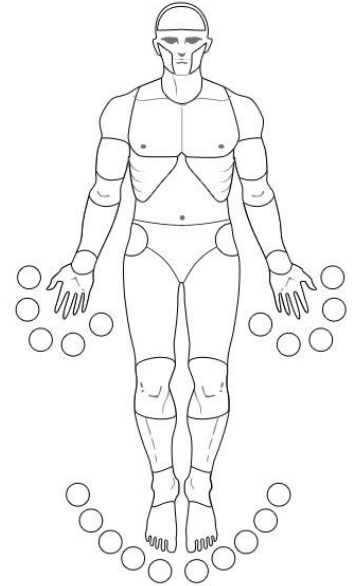
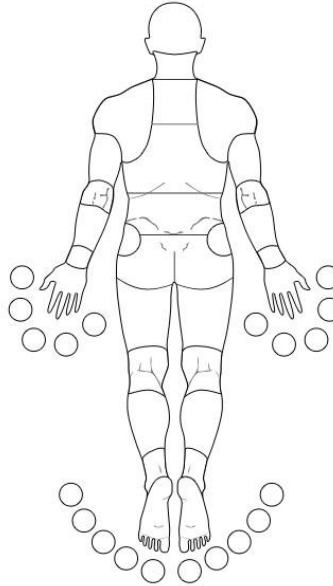
CURRENT COMPLAINTS

Patient's Name: _____

Date: _____

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.

1. Headaches
2. Neck
3. Upper Back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin



Primary Complaint	
Location <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center	
Pain Ratings <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)	
Frequency <input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%	
Pain Type <input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Burning	
Severity <input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe	
What makes it better? <input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing	
What makes it worse? <input type="checkbox"/> Movements <input type="checkbox"/> Bending <input type="checkbox"/> Twisting <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Movements <input type="checkbox"/> Neck flexion <input type="checkbox"/> Sneezing <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Chewing <input type="checkbox"/> Yawning <input type="checkbox"/> Opening Mouth <input type="checkbox"/> Closing Mouth <input type="checkbox"/> Range of Motion <input type="checkbox"/> Pushing/Pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Watching T.V. <input type="checkbox"/> Reading <input type="checkbox"/> Working <input type="checkbox"/> Driving <input type="checkbox"/> Housework <input type="checkbox"/> Bright Lights <input type="checkbox"/> Loud Noises	
Does the pain radiate to any other locations?	Upper Body <input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of Head <input type="checkbox"/> Right Side of Head <input type="checkbox"/> Left Side of Head <input type="checkbox"/> Neck <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> Face <input type="checkbox"/> Right Jaw <input type="checkbox"/> Left Jaw <input type="checkbox"/> Right Upper Back <input type="checkbox"/> Left Upper Back <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs
	Mid Body <input type="checkbox"/> Right Mid Back <input type="checkbox"/> Left Mid Back <input type="checkbox"/> Right Lower Back <input type="checkbox"/> Left Lower Back <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Groin <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Forearm <input type="checkbox"/> Left Forearm <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Hand <input type="checkbox"/> Right Fingers <input type="checkbox"/> Left Fingers
	Lower Body <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes
Described as <input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing	
At it's worst <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate	
Associated with <input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing Ears <input type="checkbox"/> Bright Light <input type="checkbox"/> Sensitivity <input type="checkbox"/> Loss of Balance	
Comments	

Secondary Complaint	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain Type	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Burning
Severity	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Movements <input type="checkbox"/> Bending <input type="checkbox"/> Twisting <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Movements <input type="checkbox"/> Neck flexion <input type="checkbox"/> Sneezing <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Chewing <input type="checkbox"/> Yawning <input type="checkbox"/> Opening Mouth <input type="checkbox"/> Closing Mouth <input type="checkbox"/> Range of Motion <input type="checkbox"/> Pushing/Pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Bright Lights <input type="checkbox"/> Loud Noises <input type="checkbox"/> Watching T.V. <input type="checkbox"/> Reading <input type="checkbox"/> Working <input type="checkbox"/> Driving <input type="checkbox"/> Housework
Does the pain radiate to any other locations?	Upper Body
	Mid Body
	Lower Body
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
Associated with	<input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing Ears <input type="checkbox"/> Bright Light <input type="checkbox"/> Sensitivity <input type="checkbox"/> Loss of Balance
Comments	

Other Complaint	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain Type	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Burning
Severity	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Movements <input type="checkbox"/> Bending <input type="checkbox"/> Twisting <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Movements <input type="checkbox"/> Neck flexion <input type="checkbox"/> Sneezing <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Chewing <input type="checkbox"/> Yawning <input type="checkbox"/> Opening Mouth <input type="checkbox"/> Closing Mouth <input type="checkbox"/> Range of Motion <input type="checkbox"/> Pushing/Pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Bright Lights <input type="checkbox"/> Loud Noises <input type="checkbox"/> Watching T.V. <input type="checkbox"/> Reading <input type="checkbox"/> Working <input type="checkbox"/> Driving <input type="checkbox"/> Housework
Does the pain radiate to any other locations?	Upper Body
	Mid Body
	Lower Body
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
Associated with	<input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing Ears <input type="checkbox"/> Bright Light <input type="checkbox"/> Sensitivity <input type="checkbox"/> Loss of Balance
Comments	

Patient's Signature

Patient name: _____ Signature: _____ Date: _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Unable to work at all*
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Need help with all my personal care*
3. Does your pain interfere with your traveling?
Travel anywhere I like 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Only travel to see doctors*
4. Does your pain affect your ability to sit or stand?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Cannot sit /stand at all*
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Cannot do at all*
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Cannot do at all*
7. Does your pain affect your ability to walk or run?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Cannot walk/run at all*
8. Has your income declined since your pain began?
No decline 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Lost all income*
9. Do you have to take pain medication every day to control your pain?
No medication needed 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *On pain medication throughout the day*
10. Does your pain force you to see doctors much more often than before your pain began?
Never see doctors 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *See doctors weekly*
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Never see them*
12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Total interference*
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Need help all the time*
14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Severe depression / tension*
15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 *Severe problems*