Welcome!

PORTLAND CHIROPRACTIC WELLNESS CENTER

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?: ☐ No ☐ Yes, Name of Doctor:			
Address:	City:	State:	ZIP Code:
Date of Last Visit: / /	Date of Last Exam: / /		
Do You Have a Family Chiropractor?: ☐ No ☐ 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: ☐ Yes ☐ No	If yes, Last Surgery Date:		
Reason for Surgery:			

Present Illness /Conditions:

☐ AIDS	☐ Cancer	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Scoliosis	
☐ Allergies	☐ Cirrhosis/Hepatitis	☐ Heart Problem	☐ Multiple Sclerosis	☐ Sinus Trouble	☐ Ulcer
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Pacemaker	☐ Spinal Disc Disease	☐
☐ Arthritis	☐ Dislocated Joints	☐ HIV/ARC	☐ Polio	☐ STD'S	☐
☐ Asthma	☐ Diverticulitis	☐ Kidney Trouble	☐ Prostate Trouble	☐ Thyroid Trouble	☐
☐ Bone Fracture	☐ Epilepsy	☐ Low Blood Pressure	☐ Rheumatic Fever	☐ Tuberculosis	☐

Other: Rheumatic fever

Family History of Illness:

☐ AIDS	☐ Bone Fracture	☐ Diverticulitis	☐ Kidney Trouble	☐ Prostate Trouble	
☐ Allergies	☐ Cancer	☐ Epilepsy	☐ Low Blood Pressure	☐ Scoliosis	☐ Thyroid Trouble
☐ Anemia	☐ Cirrhosis/Hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Sinus Trouble	☐ Tuberculosis
☐ Arthritis	☐ Diabetes	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ Ulcer
☐ Asthma	☐ Dislocated Joints	☐ High Blood Pressure	☐ Polio	☐ STD'S	☐

Other:

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ 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: _____

Patient Signature: _____

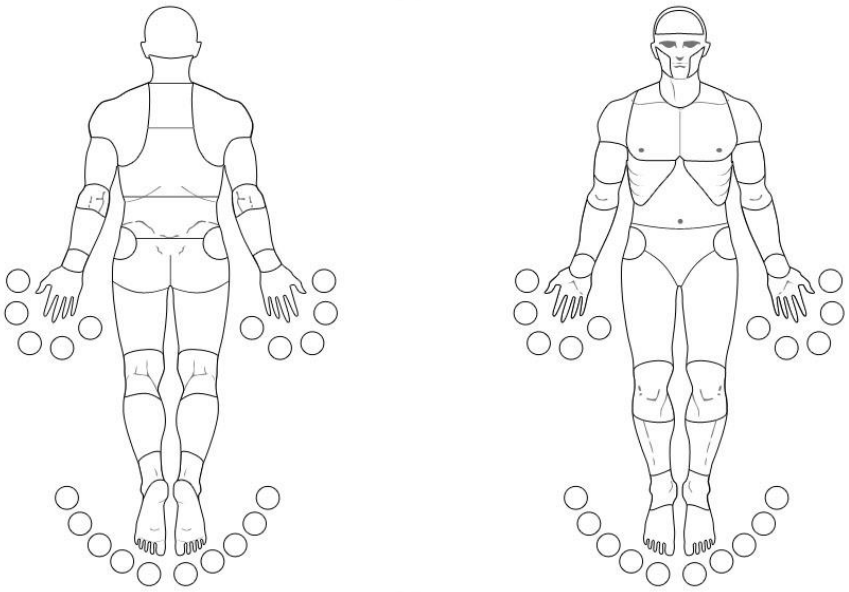
Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow. (If you need additional forms please ask.)

What is / are your Areas of Complaint

1._____

2._____

3._____



1. Area of Complaint		
Location		☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain Type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning
Severity		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it feel better?		☐ Chiropractic care ☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?		☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Walking ☐ Neck movement ☐ Sneezing ☐ Coughing ☐ Sitting ☐ Standing ☐ Laying ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth ☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving ☐ Housework ☐ Bright lights ☐ Loud Noises
Does the pain radiate to any other locations?	Upper Body	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left Jaw ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐ Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐ Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐ Right Arm ☐ Left Arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as		☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Burning
At it's worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Associated with		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
How do you think this happened?		

2.Area of Complaint		
Location		☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain Type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning
Severity		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it feel better?		☐ Chiropractic care ☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?		☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Walking ☐ Neck movement ☐ Sneezing ☐ Coughing ☐ Sitting ☐ Standing ☐ Laying down ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth ☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Bright lights ☐ Loud Noises ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving ☐ Housework
Does the pain radiate to any other locations?	Upper Body	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left Jaw ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐ Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐ Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐ Right Arm ☐ Left Arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as		☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Burning
At it's worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Associated with		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
How do you think this happened?		

3.Area of Complaint		
Location		☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain Type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning
Severity		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it feel better?		☐ Chiropractic care ☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?		☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Walking ☐ Neck movement ☐ Sneezing ☐ Coughing ☐ Sitting ☐ Standing ☐ Laying down ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth ☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Bright lights ☐ Loud Noises ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving ☐ Housework
Does the pain radiate to any other locations?	Upper Body	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left Jaw ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐ Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐ Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐ Right Arm ☐ Left Arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as		☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Burning
At it's worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Associated with		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
How do you think this happened?		

Patient signature_____