Patient History

Referred By: _____

Date: _____ First name: _____ Middle: ____ Last: _____

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

Date of Birth: _____ Age: ____ Sex: ____ Email address_____

Phone: (H) _____ (W) _____ (C) _____

Occupation: _____ Employer: _____

Marital Status S___ M____ DP____ W____ D____ Number of Children _____

Contact in case of emergency: _____ Phone: _____

PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential)

Major complaint: _____

Describe what caused it: _____

How long have you had this symptom? _____

Have you had similar symptoms before? Yes ( ) No ( ) When? _____

Frequency (please circle however many apply): daily 3-4x/wk 2-3x/wk 1-2x/wk
constant frequent occasional intermittent after work in the mornings
in the evenings at night all day long

Severity (please circle): slight mild mild-moderate moderate moderate-severe severe

Quality (please circle): stabbing sharp dull sharp/dull numb tingling achy cramping

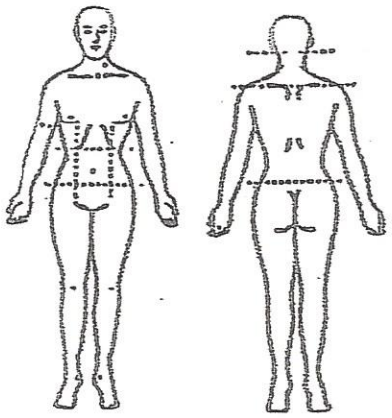
Does it interfere with any activities? (please circle all that apply): sleep lifting sitting standing
walking bending driving self-care bathing holding children exercising stretching
Other activities: _____

Is it worsening? _____

What makes symptom worse? _____

Better? _____

Please mark diagram below:



Was this injury related to: Work accident ( ) auto accident ( )

Have you lost work days? Yes ( ) No ( ) How Many? _____

Sunset Chiropractic Clinic 11507 S.W. Shilo Lane, Portland, OR 97225 (503) 643-2225

Patient Name:_____ **Date**_____

List any significant illnesses:

_____

List all operations:

_____

List any current medications:

_____

_____

Have you seen anybody else for this condition? _____ When? _____ Who? _____

What kind of care did you receive? _____

When did you last see a chiropractor? _____ Dr.: _____

Why did you see this chiropractor? _____

Were you helped? _____

Do you suffer from any allergies?

If so, what are you allergic to? _____

Allergy symptoms: _____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

_____ Temporary Relief (Help the symptoms but do not fix the cause of the problem)

_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US? _____

_____

Family History:

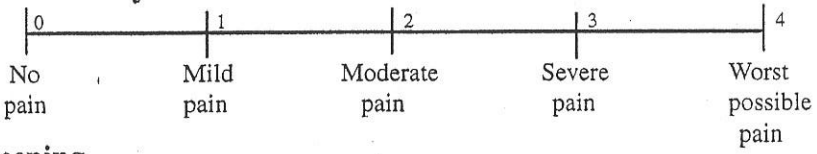
	relationship to you		relationship to you
Diabetes	_____	Alcoholism	_____
Heart disease	_____	Depression	_____
High Blood Pressure	_____	Bleeding Disorder	_____
High Cholesterol	_____	Strokes	_____
Prostate Cancer	_____	Arthritis	_____
Breast Cancer	_____	Thyroid Disease	_____
Other Cancers	_____	Osteoporosis	_____

Functional Rating Index

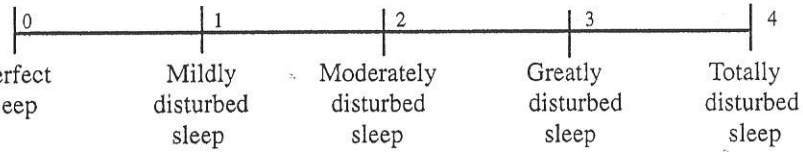
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

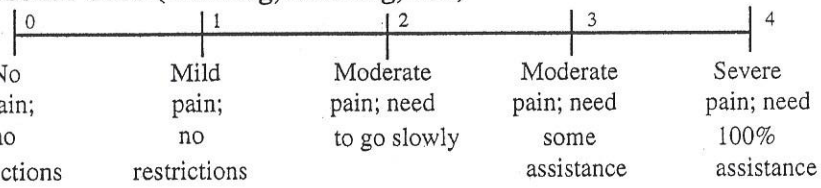
1. Pain Intensity



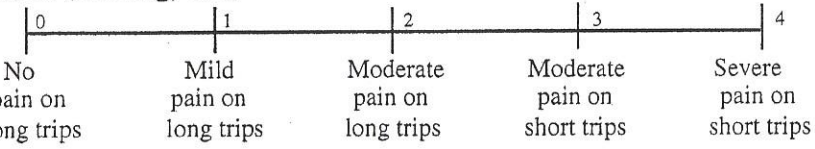
2. Sleeping



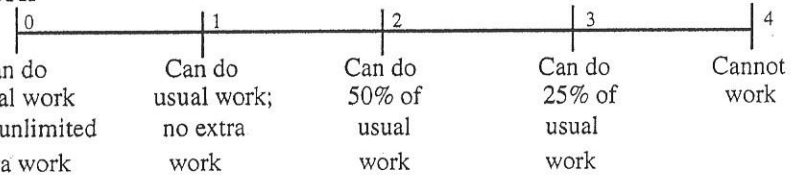
3. Personal Care (washing, dressing, etc.)



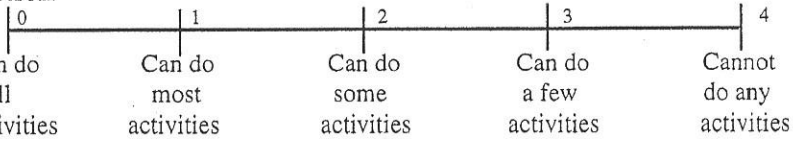
4. Travel (driving, etc.)



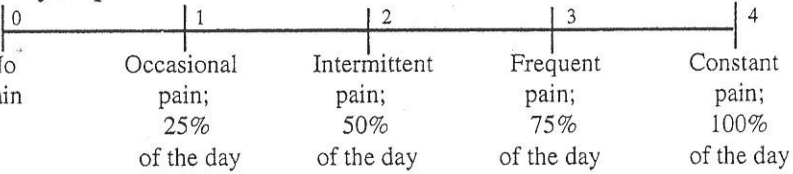
5. Work



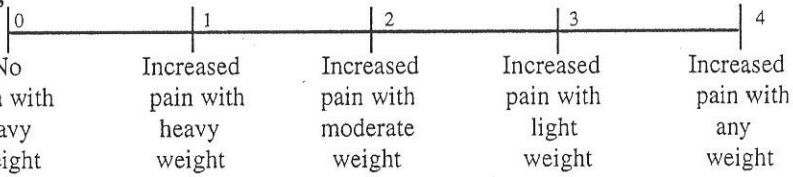
6. Recreation



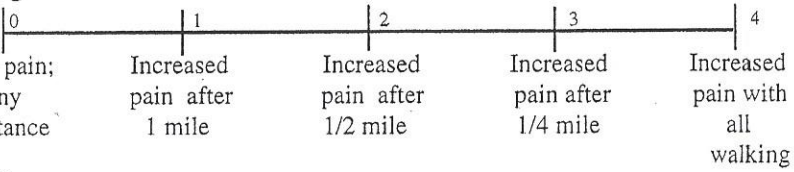
7. Frequency of pain



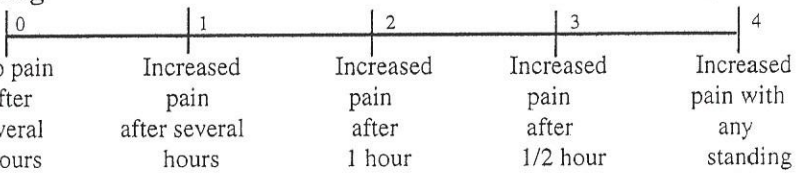
8. Lifting



9. Walking



10. Standing



Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date

Sunset Chiropractic Clinic 11507 S.W. Shilo Lane, Portland, OR 97225 (503) 643-2225

Patient Name:_____ **Date**_____

Please mark (o) for past conditions & (X) for present conditions:

___Fractured Bones
___Auto accidents
(a)____0-1 years ago
(b)____1-5 years ago
(c)____More than 5 years
___Other accidents/Falls
___Knocked unconscious
___Back Curvature
___Mental or Emotional Disorders
___Excessive Gas
___Arthritis
___Diabetes

___Swollen or painful joints
___Head seems too heavy
___Convulsions/Epilepsy
___Skin problems
___Itching
___Bruise easily
___Cancer
___Frequent Colds/Flu
___Nervous /Anxiety
___Tension
___Depressed
___Anemia
___Excess Sweating
___Loss of Balance
___Light bothers eyes
___Allergy
___Sinus Problems
___Light headed upon rising
___Under stress
___Crave sweets or salts
___Trouble sleeping
___Trouble concentrating

___Loss of Memory

___Learning Disability
___Stutter
___Stroke
___Dyslexia
___Hearing problems
___Mood changes
___Wheezing
___Lose temper easily
___High or Low Blood pressure
___Liver trouble
___Headaches
___Numbness, tingling, or pain in arms, hands, fingers
___Kidney stones
___Frequent urination
___Head & Shoulders feel tired
___ Dizziness
___Ringing in ears
___Jaw pain or click (TMJ) R. L.
___Foot trouble
___Chest pain
___Asthma
___Lung problems
___Difficulty breathing
___ Heart Attack
___Fainting
___Pregnant (Now)
___Blurred or double vision
___Numbness, tingling or pain in buttocks, thighs, legs, feet, toes R.L.
___Pain with cough, sneeze or strain at stools
___Hip pain R.L.
___Eating disorders

___Sexually transmitted Disease

___Gall Bladder trouble
___Digestive problems
___Varicose Veins

___Belching/bloating after meals
___Heartburn
___Ulcers
___Diarrhea/Constipation
___Colon Trouble
___Hemorrhoids
___Prostate problems
___Impotence

____ Joint replacement

____ Discharge
____ Menstrual problems/PMS
____ Menopausal problems
____ Breast lumps, soreness
____ Frequent urination
____ Bedwetting
____ Ear infections
____ Hepatitis
____ AIDS/HIV
____ Tremors
____ Alcoholism
____ Smoking
____ Pacemaker

Any other comments or conditions please list below: _____

_____

_____

Sunset Chiropractic Clinic 11507 SW Shilo Ln, Ste E, Portland, OR 97225 (503) 643-2225

Patient Billing Policy

Sunset Chiropractic Clinic provides chiropractic and rehabilitative services for acute care, chronic care (usually covered by health insurance) as well as maintenance care (not covered by health insurance). While it is our general policy at Sunset Chiropractic to bill your insurance company as a courtesy to you, we'd like to clarify our billing policy for your information.

For patients that receive chiropractic and rehabilitation services for acute and chronic care, we need to follow a complex set of clinical guidelines & administrative procedures. For example:

- Obtain your insurance information and verify your coverage
- We usually need to provide more intense therapy (i.e. traction, muscle stretching & strengthening, upper & lower extremity adjusting, etc.) which requires you to spend more time with the doctor.
- Complete insurance authorization forms
- Submitting each claim to your insurance company and often re-submitting the claims
- Tracking and posting payments from the insurance company
- Often times waiting weeks, sometimes months to receive reimbursement
- And depending upon the type of insurance, reimbursed a percentage of the billed amount

As a result of the above, the prevailing reasonable and customary rate for the services we provide can range from $ 50 to $ 175 per session. Depending upon your type of insurance, we will be reimbursed a percentage of this amount.

The fees for patients that receive services for maintenance care are $40 to $100. Maintenance care usually begins after the first 12-36 visits and in most cases is not covered by insurance. This type of care usually requires less time, less intense therapy and may provide a discount from our standard fee schedule because there are no administrative costs (example, printing insurance claims, folding and stuffing evelopes, postage fees, etc. that are involved with collecting the fee). Also, we do not have to call insurance company representatives, engage in written correspondence with the insurance company and wait weeks, months or even longer to receive payment.

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and the insurance company and all services rendered to you are ultimately your responsibility. We hope this clarifies our billing policy. If you have any further questions, please don't hestitate to ask.

I have read, agree to, and understand the Sunset Chiropractic billing policy

_____

Patient signature

_____ _____

Patient Name Printed Date

Sunset Chiropractic Clinic 11507 S.W. Shilo Lane. Portland, OR 97225 (503) 643-2225

Sunset Chiropractic Clinic
11507 SW Shilo Ln, Suite E • Portland, Oregon 97225
Telephone: 503.643.2225 • Facsimile: 503.520.0514

INFORMED CONSENT FOR CHIROPRACTIC FUNCTIONAL NEUROLOGY TREATMENT

I _____ consent to the performance of chiropractic functional
(Responsible party's name)

neurology treatments and any other associated procedures: physical examinations, tests, diagnostic x-ray, physical medicine, physical therapy procedures, massage therapy etc., on me by the doctors of chiropractic and/or the chiropractic assistants within Sunset Chiropractic Clinic.

**I understand, as with any health care procedures, that certain complications may arise during chiropractic functional neurology treatment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horners' syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the treating doctor to be able to anticipate all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) at Sunset Chiropractic Clinic, and/or with office personnel, the nature and purpose, as well as, risks of chiropractic functional neurology treatments and other recommended procedures. Alternatives to these procedures have been discussed with me and I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic functional neurology treatments. By signing below, I state that I have been informed and weighed the risks involved in chiropractic functional neurology procedures at this health care clinic. I have decided, freely and voluntarily, that it is in my best interest to receive chiropractic functional neurology care. I give my consent to that treatment. This consent will cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.
SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
PRINT PATIENT NAME

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

_____ _____
WITNESS SIGNATURE DOCTOR SIGNATURE

Sunset Chiropractic Clinic

11507 SW Shilo Ln, Suite E · Portland, Oregon 97225

Telephone: 503-643-2225 · *Facsimile: 503-520-0514*

Acknowledgment of Privacy Practices and Permission to Leave Messages

Patient Name: _____ Date of Birth: _____

I acknowledge that I have received and/or reviewed a copy of Sunset Chiropractic Clinic Notice of Privacy Practices

I give permission to communicate messages in the following manner:

_____ You may leave a message on my answering machine located at this number _____

_____ You may leave a message on my cell phone _____

_____ You may leave a message with my spouse, _____ at this number _____

_____ You may leave a message with another person, _____ at this number _____

_____ You may email me regarding my medical care at _____

I give permission to communicate messages about the following via phone or email:

_____ X-rays, and other test results

_____ Billing or insurance matters

_____ _____

Patient Name **Date**