Welcome To Overlook Chiropractic Clinic

Personal Information

Referred By: _____

Name:			Date:
Address:		E-mail:	Sex: ❑ F ❑ M
City:	State:		Zip:
Age:	Birth Date:	Marital: M S W D	How many Children?
Cell #:	Home #:		Work #:
Occupation:		Employer:	
Address:	City:	State:	Zip:
Name of Spouse:		Occupation:	
Employer:		Office/Other Phone:	
Emergency Contact:	Phone#:		Other#:

Payment is Expected at the Time of Service

(Please give your insurance card to the receptionist.)

Person Responsible for Payment if not Self Name:	Relationship to Patient:
Address:	Phone #:

Confidential Health History

Have you been treated for any health condition by a physician in the last year? ❑ Yes ❑ No

If yes, please describe: _____

Hobbies:

If any you have experienced any of the following, give approximate dates and briefly describe injury:

Auto Accidents:	Motorcycle Accidents:
Falls/Other Injuries:	Spinal/Neck Injuries:
Broken Bones:	Knocked unconscious:
Surgeries:	Health Problem of Parents:

Do we have your authorization to contact you via Text/E-mail for appointment reminders & communications?
❑ Yes ❑ No

Overlook Chiropractic Clinic
2064 N Killingsworth St. Portland, OR 97217
Phone: 503.719.7742 **Fax:** 503.719.7571 **Web:** www.overlookchiropractic.com

Dr. Michael D. Raeburn DC, CCSP

Please check any of the following that apply to your current/past medical history:

Musculoskeletal

- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Scoliosis
- ☐ Neck pain
- ☐ Back Problems
- ☐ Hip disorder
- ☐ Knee injuries
- ☐ Foot/Ankle Pain
- ☐ Shoulder problems
- ☐ Elbow/wrist pain
- ☐ TMJ Issues
- ☐ Poor Posture

Neurological

- ☐ Anxiety
- ☐ Depression
- ☐ Memory issue
- ☐ Sleeping issues
- ☐ Headache
- ☐ Dizziness
- ☐ Pins & needles
- ☐ Numbness
- ☐ Loss of smell or taste

Head & ENT

- ☐ Changes in head dimension
- ☐ Blurred or double vision
- ☐ Earache
- ☐ Recent hearing loss
- ☐ Ringing in the ears
- ☐ Chronic ear infection
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Migraines
- ☐ Sinus infection
- ☐ Head aches

Cardiovascular

- ☐ Chest pain
- ☐ Palpitations
- ☐ Dizziness
- ☐ Dyspnea
- ☐ Hypertension
- ☐ Hypotension
- ☐ High Cholesterol
- ☐ Excessive Bruising
- ☐ Lower Extremity Edema
- ☐ Asthema
- ☐ Hey Fever

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Heart burn
- ☐ Ulcer
- ☐ Food sensitivities
- ☐ Changes in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in the stool

Endocrine

- ☐ Diabetes
- ☐ Heat or cold intolerance
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Increase size of hands or feet
- ☐ Pancreatic conditions
- ☐ Polyuria
- ☐ Polydipsia
- ☐ Purple striae

Other:

Patient / Guardian Signature: **Date:**

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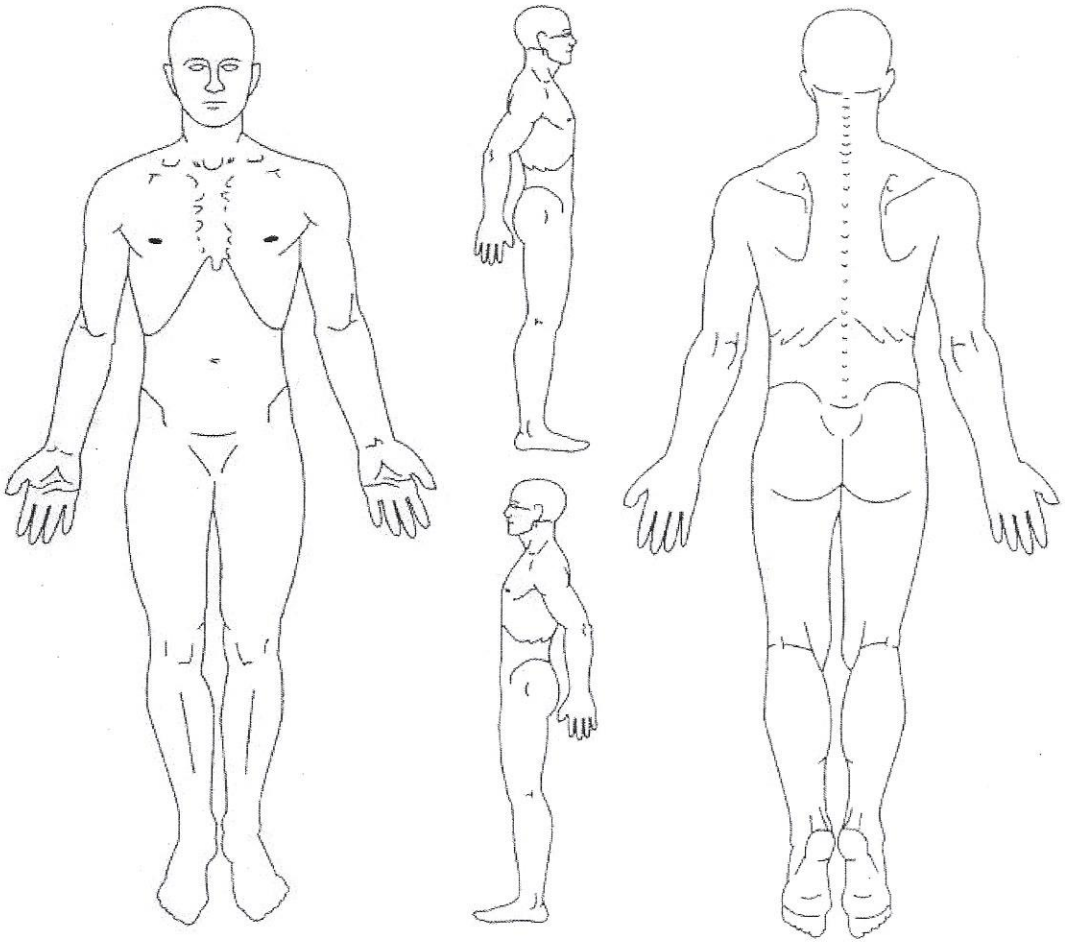
Name: _____ **Date:** _____

1. Where is your primary discomfort?

   _____

2. Write a number over the parts of the body where you feel pain (at its worst) on a scale of 1- 10.
   For reference, 1-2 slight, 3-4 mild, 5-6 moderate, 7-8 severe, 9-19 very severe.

3. Please label your complaints with a letter describing the quality of the discomfort.
   S= Spasm NT=Numbness/Tingling B=Burning D=Dull O=Throbbing A=Aching W=Weakness
   X=Popping/Clicking H=Tight R=Sharp



Complaint improved with...

- ❑ Rest
- ❑ Medication
- ❑ Walking
- ❑ Stretching
- ❑ Lying down
- ❑ Exercising
- ❑ Other

_____

Complaint aggravated with...

- ❑ Bending
- ❑ Twisting
- ❑ Lifting
- ❑ Sitting
- ❑ Driving
- ❑ Lying down
- ❑ Coughing/sneezing
- ❑ Other

_____

4. On the scale below please circle the frequency you experience your complaint.

Occasional	Intermittent	Frequent	Constant

5. Would you describe the onset of your symptoms as ❑ gradual or ❑ sudden?
6. When did your present complaints occur? _____
7. Was this the result of an accident or work injury? ❑Y ❑N
8. Since the problems began, have they been ❑ better ❑ worse or ❑ the same?
9. Are they worse at ❑ in the morning ❑ in the afternoon or ❑ in the evening?
10. Have you had this condition or similar conditions in the past? ❑Y ❑N If so, when? _____
11. Has anyone treated you for this condition? ❑Y ❑N If yes, what treatment did you receive?

    _____
12. Name, location & date of previous care: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I,_____, (patient's name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Overlook Chiropractic Clinic, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the practice.

Signature: _____ **Date:** _____

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Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques and adjustments used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stoke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no specific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
d) There are infrequent reported cases of burns or skin irritation in associating with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have thoroughly read this consent and I have discussed, or have been offered the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustments), the treatment options and recommendations for my condition, and the contents of this Consent.

Having been informed of the risks, I hereby give my consent to the chiropractic treatment recommended to me by my chiropractor including any spinal adjustments. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

_____ _____

Name **Date**

_____

Signature

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Notice to Our Patients with Group Insurance:

We bill insurance as a courtesy to our patients. We deal with hundreds of insurance policies each year and it is impossible for us to know all the details of each one. Accordingly, you are responsible for any charges less any amount we may receive from your insurance carrier. We check these details in office, but please be sure to review your policy and to learn their limitations. If you have specific questions or concerns, we would be more than happy to look into them for you. Based on our own research, we are able to give you an estimated cost for copayments, co-insurances, and deductible costs. This estimated payment is expected at the time of service. If financial hardship arrangements are necessary, they must be made prior to the appointment. All balances must be paid by you or your insurance company within 45 days of your time of service. An interest charge of 1.5% per month will be charged to all accounts not paid within 45 days and if collection should be required for any past due sum, the patient understands and agrees to be responsible for all collection cost and attorney fees, if legal action is initiated.

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING SHOULD OCCUR

- → Treatment goes over my yearly maximum
- → My insurance company denies any treatment
- → I am not eligible for insurance.
- → I prevent or delay payment by not complying with requests for insurance forms or signatures.
- → I received my insurance check and did not send it to this office.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Furthermore, I understand that OCC will prepare any necessary reports and forms to assist me in making collection from the insurance company. I have read and understand my obligations in acceptance of my insurance policy as payment.

Patient / Guardian Signature:	**Date:**

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