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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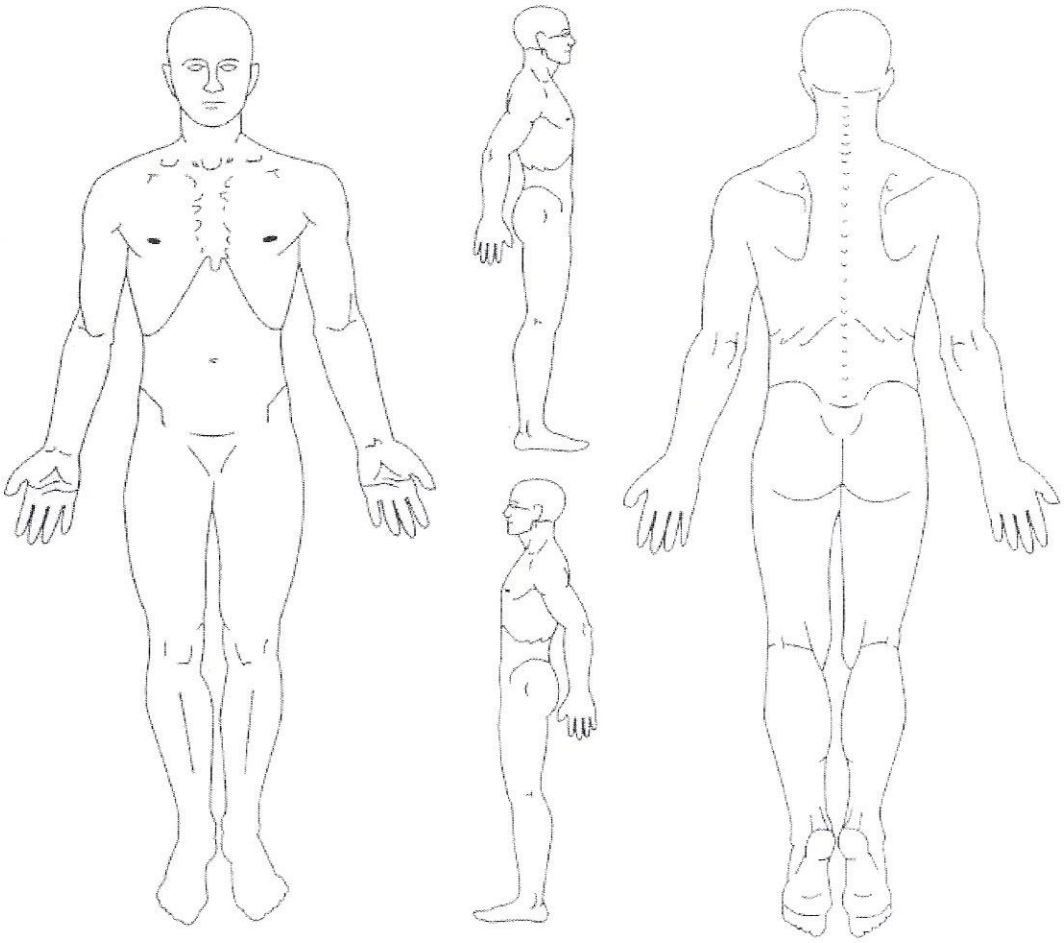
Name: _____ **Date:** _____

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, 9-10 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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Patient Name:_____

Overlook Chiropractic Clinic

Personal Injury Policy

Personal Injury *(auto accident and personal accidents)* is covered for chiropractic care.

If you have been injured in an accident we will bill your insurance carrier for you. If you have PIP or Early Medical coverage on your auto policy your insurance will cover your care here even if you were not at fault. Your carrier will then be reimbursed by the responsible carrier at the time you settle your claim.

If you have an attorney for your claim please advise our office of the name and address so that we may keep their office up to date on your care and billings from this office.

If you do not have PIP or Early Medical coverage on your auto insurance policy and have only third party as insurance this office requires you to have an attorney for your claim. This is to protect our fees and we will wait to be paid at settlement if you have an attorney and we have the appropriate forms and information regarding the accident. If you choose not to have an attorney in this instance, you may either pay for your care as you go or if you have group medical insurance we will bill them for you.

If you are represented by an attorney we will ask you to sign an Attorney Lien Form authorizing your attorney to withhold from your settlement any amounts still due our office at the time of settlement.

It is quite common for insurance companies to require additional information *(from doctor and patient)* before paying for services. Please notify our office *as soon as possible* so we can help you receive your full benefits under your personal injury policy.

Patient's/Guardian's Name: _____ Date:_____

I fully understand that I am directly and fully responsible for all services rendered to me. I further understand that payment for services is not continent on any settlement, judgment or verdict by which I may eventually recover.

Patient's Guardian's Name: _____ Date:_____

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.

Signed by Patient / Guardian **Date**

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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.

_____

Signed by Patient / Guardian **Date**

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INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Oregon Board of Massage Therapists.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped. Any illicit or sexually suggestive remarks or behavior towards the therapist will result in the immediate termination of the treatment.

_____

Printed Name of Patient / Guardian

_____ _____

Signature of Patient / Guardian Date

MASSAGE CANCELLATION POLICY

We ask that you give us **at least 12 hours advance notice** of a cancellation prior to your scheduled appointment time. This allows the opportunity for another person to schedule an appointment. If you are unable to give sufficient notice or if you miss an appointment, you will be subject to a $10 fee. Payment will be expected prior to scheduling your next appointment. In the event of an emergency or illness, we will waive the policy fee. We appreciate your cooperation in this matter and, as always, we will do our very best to accommodate your needs and schedule. This policy is in effect as a courtesy to our massage therapists.

I have read and consent to OCC's cancellation policy for all massage appointments.

_____

Printed Name of Patient / Guardian

_____ _____

Signature of Patient / Guardian Date

Note: Gratuity is always appreciated for our massage therapists, but never required.

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