Cascade Chiropractic of southern oregon

745 NE 7th Street
Grants Pass, OR 97526
Phone (541) 472-0500
Fax (541) 471-6285

PATIENT REGISTRATION

PATIENT NAME:_____ DATE OF BIRTH:_____/_____/_____

MAILING ADDRESS:_____ CITY:_____ STATE:_____ZIP:_____

HOME PHONE: (_____)_____-_____ CELL PHONE: (_____)_____-_____ SSN# _____-_____-_____

MALE _____ FEMALE _____ SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____ SEPARATED _____

SPOUSE'S NAME: _____ CHILDREN (NAME & AGES): _____

EMPLOYER _____ PHONE: (_____)_____-_____

OCCUPATION/JOB TITLE: _____

EMERGENCY CONTACT NAME / RELATIONSHIP: _____/_____ PHONE: (_____)_____-_____

SELF PAY: _____ INSURANCE: _____ please provide insurance card and information at check in

CONDITIONS OF SERVICES RENDERED

FINANCIAL AGREEMENT:
I agree, whether I sign as agent or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account with Cascade Chiropractic of Southern Oregon in accordance with the regular rates and terms. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses.

SELF PAY DISCOUNT:
You may request a copy of the current fee schedule at any time. You may take the opportunity to receive a reduction in the charges when payment is received at the time of service. If no payment is make the same day services are performed, normal charges will apply.

ASSIGNMENT OF INSURANCE BENEFITS:
I authorize, whether I sign as agent or as patient, direct payment to Cascade Chiropractic of Southern Oregon of any insurance benefits otherwise payable to or on behalf of the patient for the visit or for these outpatient services at a rate not to exceed Cascade Chiropractic of Southern Oregon's actual charges. I understand that I am financially responsible for charges, deductibles, and co-insurance not covered by insurance.

HEALTH PLAN OBLIGATIONS:
Cascade Chiropractic of Southern Oregon maintains a list of health plans with which it contracts. Cascade Chiropractic of Southern Oregon has no contract, expressed or implied, with any plan that does not appear on that list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by Cascade Chiropractic of Southern Oregon if he/she belongs to a plan, which does not appear on the above- mentioned list.

RELEASE OF INFORMATION:
I authorize Cascade Chiropractic of Southern Oregon to release any information necessary to provide medical treatment to me, and allow Cascade Chiropractic of Southern Oregon to bill and be paid for services they provide. I understand that releasing information for any reason other than those listed above requires a separate authorization by me. I also understand that I have the right to request restrictions on the use of my health information, but Cascade Chiropractic of Southern Oregon is not obligated to honor that request unless required to do so by State or Federal regulations. This consent shall be effective as long as necessary to obtain payment.

The Terms and conditions of this agreement are not binding until the patient receives care and treatment from Cascade Chiropractic of Southern Oregon. The undersigned certifies that he/she had read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

PRINT NAME:_____

SIGNATURE:_____**DATE:**_____
(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

If signed by other than the patient, indicate relationship:_____

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Informed Consent to Chiropractic Treatment

It is prudent for us to obtain your informed consent prior to examination and treatment. The purpose of this information is to inform you, not to alarm you. What you are being asked to sign is simply a confirmation we have discussed the following:

The nature of chiropractic treatment: The doctor will use her hands or a mechanical device upon your body in such a way to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs or therapeutic ultrasound may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in six million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

PRINT NAME:_____

SIGNATURE:_____ **DATE:**_____

PROVIDER SIGNATURE:_____

Parent / Legal Guardian consent

I _____ am the parent / legal guardian of _____ I give my permission and consent to treatment for the patient named above.

SIGNATURE:_____ DATE:_____
(PARENT/CONSERVATOR/GUARDIAN)

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PATIENT ACKNOWLEDGEMENT FORM

RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This office is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to you health information.

Disclosure of Your Health Care Information

We may disclose your health information to: Your insurance provider, medical consultations, State Worker' Compensation, emergencies, for judicial and administrative proceedings, to law enforcement officials, coroner or medical examiners, and for public safety.

Your Health Information Rights

You have the right to request restriction on certain uses and disclosures of your health information. Please be advised, however that this clinic is not required to agree to the restriction that you request.

You have the right to have your health information received and communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon request.

You have the right to inspect and request a copy of your health information.

You have the right to request that this clinic amend your protected health information. Please be advised however, that this clinic is not required to agree to mend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by this clinic.

You have a right to receive a paper copy of the Notice of Privacy Practices at any time upon request.

Complaints

Complaints about your Privacy rights or how this clinic has handled your health information should be directed to Dr. Reeser by calling this office at (541) 472-0500. If Dr. Reeser is not available, you may make an appointment for a personal conference in person or by telephone within two business days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to

DHHS, Office of Civil Rights
200 Independence Avenue, SW
Room 509F HHH Building
Washington, DC 20201

PRINT NAME:_____

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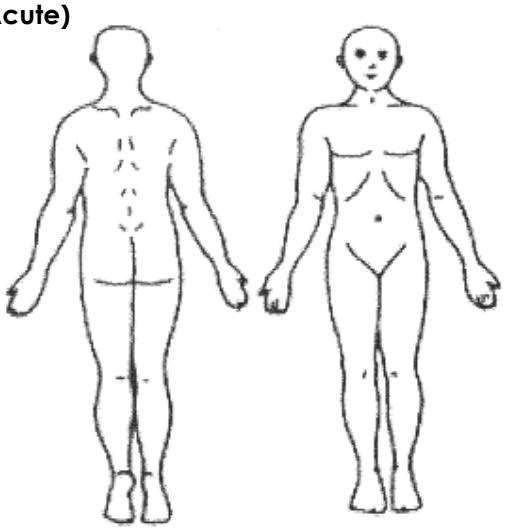
Chief Complaint – HPI (History of Present Illness)

Chief Complaint: _____ **please label the diagram**:
Key: A=Ache B=Burning N = Numbness S=Stabbing

☐ **New** ☐ **Chronic** ☐ **Recurrence (Acute)** ☐ **Exacerbation (Acute)**



Mechanism of Onset:

☐ **Etiology Unknown** ☐ **Overexertion** ☐ **Repetitive Use** ☐ **Slept Wrong** ☐ **Slip or Fall**
☐ **Auto** ☐ **Work Related**

Current Symptoms: ☐ **Pain** ☐ **Numbness** ☐ **Stiffness** ☐ **Weakness**

Location: **Left / Right / Bilateral** _____

Duration: **When did it start:**_____

Timing: ☐ **Constant** ☐ **Intermittent**
Worse: ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Night** ☐ **with Activity**

Quality: ☐ **Burning** ☐ **Diffuse** ☐ **Dull/Aching** ☐ **Localized** ☐ **Radiating** ☐ **Sharp** ☐ **Shooting**
☐ **Stabbing** ☐ **Throbbing** ☐ **Tightness** ☐ **Tingling** ☐ **Other** _____

Assoc Signs and Symptoms: ☐ **Stiffness** ☐ **Sleep Disturbance** ☐ **Irritability/Mood Swing** ☐ **Localized Tingling**
☐ **Nausea** ☐ **Ringing in Ears** ☐ **Blurred Vision** ☐ **Depression** ☐ **Dizziness**

Level of Pain Due to Symptoms (Resting): *0= no pain 10= severe pain*

0 1 2 3 4 5 6 7 8 9 10

Level of Pain Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

Modifying Factors:

Symptoms Better With:

☐ **nothing helps**	☐ **activity**	☐ **bending**	☐ **applying cold**	☐ **applying heat**
☐ **massage**	☐ **movement**	☐ **OTC meds**	☐ **Rx meds**	☐ **rest**
☐ **stretching**	☐ **sitting**	☐ **standing**	☐ **twisting**	☐ **walking**

Any previous treatment for this problem: _____

Employment:

Occupation/Job Title: _____ **Work:** _____ **hrs / day or week**

Description of Work: _____
Job Classification: ☐ **Sedentary** (<5lbs) ☐ **Light** (5-20lbs) ☐ **Moderate** (20-50lbs) ☐ **Heavy** (>50 lbs)
Lifting Frequency: ☐ **Constant** (67-100%/day) ☐ **Frequent** (33-66%/day) ☐ **Occasional** (0-32%/day)
Lifting Postures: ☐ **with Arms** ☐ **High Near** ☐ **from Knee** ☐ **Off Posture** ☐ **from Torso**

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Choose 5 daily activities and circle the level of impairment

examples: Bending, Care –Infirm Family, Carrying Groceries, Change Posn–Sit-Stand, Climb Stairs, Driving, Extended Computer Use, Feeding, Household Chores, Kneeling, Lift Children, Lifting, Pet Care, Reading (Concentration), Self Care, Self Care–Bathing, Self Care, Dressing, Self Care–Shaving, Sexual Activities, Sleep, Static Sitting, Static Standing, Walking, Yard Work.

(fill in the blanks)

Level of Impairment Due to Symptoms: *0=no impairment* *10=complete impairment*

0 1 2 3 4 5 6 7 8 9 10

____

Level of Impairment Due to Symptoms: *0=no impairment* *10=complete impairment*

0 1 2 3 4 5 6 7 8 9 10

____

Level of Impairment Due to Symptoms: *0=no impairment* *10=complete impairment*

0 1 2 3 4 5 6 7 8 9 10

____

Level of Impairment Due to Symptoms: *0=no impairment* *10=complete impairment*

0 1 2 3 4 5 6 7 8 9 10

____

Level of Impairment Due to Symptoms: *0=no impairment* *10=complete impairment*

0 1 2 3 4 5 6 7 8 9 10

____

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***Medical History*.** **CIRCLE all CURRENT conditions.**

ADD	anxiety	hypertension	rheumatoid arthritis (RA)
asthma	depression	high cholesterol	osteoarthritis
anemia	dementia	liver disease	seizures
scoliosis	stroke	lung disease	shingles
diabetes	eczema	kidney disease	thyroid problems
cancer	osteoporosis	STD's (unspecified)	other:

Surgery (ies): **Write the DATE of the Procedure immediately afterward.**

angioplasty	cosmetic	hysterectomy	pacemaker insertion
appendectomy	D & C	joint reconstruction	rotator cuff
caesarian section	dental surgery	joint replacement	spinal fusion
cardiac catheterization	gall bladder	knee repair	tonsilectomy
carpal tunnel repair	hemorrhoidectomy	laminectomy	breast enhancement
coronary artery bypass	hernia repair	mastectomy	other:

Family Medical History: **List any specific conditions past or present**

Social History:

Alcohol: Never Social Consumption only Beer Liquor Wine ____ glasses; Day Week Month

Diet (please mark all that apply): High Fat High Fiber High Protein High Salt
Low Calorie Low Carb Low Fiber Low Salt Low Sugar

Education (please mark the highest level completed):
Junior Highschool Votech In High School Did Not Finish High School
High School Diploma Post High School Classes Assoc/Technical Degree
In College College Degree In Graduate School Graduate Degree Doctorate

Tobacco: Never Smoked Live with a smoker Quit smoking/tobacco-start date _____
Smoke; # _____ per Day Week Month
Chew; #_____cans per Day Week Year end date_____

Marijuana: Never Smoked Live with a smoker
Smoke; # _____ per Day Week Month Oral consumption_____

Drugs: Deny any illegal drug use Have used drugs for _____ Have not used drugs since _____

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Current Medications/Supplements:

Medication/Supplements	Dosage	For What Condition?	How long have you been taking this?

Current Primary Care Health Provider: _____

Please label- CURRENT or PAST HISTORY for each item

Constitutional: ***please*** **indicate CURRENT or PAST HISTORY**

☐ **fatigue** ☐ **fever** ☐ **malaise** ☐ **loss of appetite**
☐ **unexplained weight gain** ☐ **unexplained weight gain** ☐ **other:**

Head: ***please*** **indicate CURRENT or PAST HISTORY**

☐ **head injury** ☐ **headache** ☐ **other:**

Eyes: ***please*** **indicate CURRENT or PAST HISTORY**

☐ **wear vision correction** ☐ **sensitivity to light** ☐ **changes in vision** ☐ **blurred vision**
☐ **double vision** ☐ **cataracts** ☐ **glaucoma** ☐ **other:**

Ears: ***please*** **indicate CURRENT or PAST HISTORY**

☐ **ear pain** ☐ **ear drainage** ☐ **hearing loss** ☐ **tinnitus** ☐ **dizziness** ☐ **other:**

Nose: ***please*** **indicate CURRENT or PAST HISTORY**

☐ **frequent nose bleeds** ☐ **postnasal drip** ☐ **loss of sense of smell** ☐ **snoring** ☐ **sinus infections** ☐ **other:**

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Cardiovascular: ***please*** **indicate CURRENT or PAST HISTORY**

☐ angina (chest pain or discomfort) ☐ high blood pressure ☐ low blood pressure ☐ heart problems
☐ heart murmur ☐ palpitations ☐ claudication (leg pain/ache) ☐ swelling of the legs
☐ varicose veins ☐ other:

Respiratory: ***please*** **indicate CURRENT or PAST HISTORY**

☐ asthma ☐ chronic cough ☐ coughing up blood ☐ sputum production ☐ other:

Gastrointestinal: ***please*** **indicate CURRENT or PAST HISTORY**

☐ belching ☐ heartburn ☐ difficulty swallowing ☐ vomiting ☐ vomiting blood
☐ abdominal pain ☐ constipation ☐ diarrhea ☐ hemorrhoids ☐ other:

Female: ***please*** **indicate CURRENT or PAST HISTORY**

☐ breast lumps/pain ☐ frequent urination ☐ burning urination ☐ urine retention
☐ hormone therapy ☐ pregnancy ☐ other:

Male: ***please*** **indicate CURRENT or PAST HISTORY**

☐ frequent urination ☐ burning urination ☐ urine retention
☐ erectile dysfunction ☐ prostate problems ☐ other:

Musculoskeletal: ***please*** **indicate CURRENT or PAST HISTORY write DATE immediately after**

☐ fracture ☐ fall (severe) ☐ motor vehicle accident ☐ worker's comp ☐ other:

Neurological: ***please*** **indicate CURRENT or PAST HISTORY**

☐ difficulty concentrating ☐ dizziness ☐ loss of consciousness ☐ slurred speech ☐ TIA
☐ stroke ☐ tremor ☐ seizures ☐ other:

Psychiatric: ***please*** **indicate CURRENT or PAST HISTORY**

☐ anxiety ☐ depression ☐ bi-polar disorder ☐ insomnia
☐ behavioral change ☐ memory loss ☐ other:

Endocrine: ***please*** **indicate CURRENT or PAST HISTORY**

☐ cold intolerance ☐ excessive hunger ☐ goiter ☐ unusual hair growth
☐ diabetes ☐ excessive thirst ☐ hair loss ☐ voice changes
☐ excessive appetite ☐ abnormal frequency of urination ☐ heat intolerance ☐ other:

Hematologic/Lymphatic: ***please*** **indicate CURRENT or PAST HISTORY**

☐ bruising easily ☐ anemia ☐ fatigue ☐ lymph node swelling
☐ blood clotting problem ☐ blood transfusion ☐ other: