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:_____/_____/_____

SEX: __M__ /___F__ SSN# _____-_____-_____ HEIGHT_____ WEIGHT_____ MARTIAL STATUS: _____

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

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

SPOUSE'S NAME: _____ CHILDREN: _____

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 made 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:**_____

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(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

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

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 your 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:_____

SIGNATURE:_____**DATE:**_____
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Informed Consent

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a mechanical device or instrument. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

Stroke: Stroke means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with stroke or not. Recent evidence suggest that it is not (2008, 2015, 2016, 2019), although the same evidence often suggest that the patient may be entering the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous dissection of the vertebral artery. If we think this is happening, you will be immediately referred to emergency services.

Anecdotal stories suggest that chiropractic adjustments may be associated with strokes that arise from the vertebral artery; this is because the vertebral artery is located inside the neck vertebrae. The adjustment that is suggested to increase the strain on the vertebral artery is called the 'extension-rotation-thrust atlas adjustment" We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes but no one is certain. It is estimated that the incidence of this type of stroke ranges between 1 per every 400,000-3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for a hundred of years before they would statistically be associated with a single patient stroke. If you experience any of the "5 Ds And 3 Ns" (Diplopia, dizziness, drop attacks, dysarthria, dysphagia, ataxia of gait, nausea, numbness and nystagmus) before, during or after an adjustment, tell us immediately, and if we can't be reached, go to the emergency department immediately.

Two other potential problems that are not quantifiable because they are extremely rare and may have no association with chiropractic adjusting are carotid artery injury and spinal dural tear resulting in a leak of cerebral spinal fluid.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction.

Cauda Equina Syndrome: Cauda Equina Syndrome occurs when a low back disc problem puts pressure on the nerves that control bowel, bladder, and sexual function. Representative symptoms include leaky bladder, or leaky bowels, or loss of sensation (numbness) around the pelvic sexual organs (the saddle area), or the inability to start/stop urination or to start/ stop bowel movement. Cauda Equina Syndrome is a medical emergency because the nerves that control these functions can permanently die, and those functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves, and the window to do so may be as short as 12-72 hours, depending. If you have any of these symptoms, tell us immediately, and if we can't be reached, go the emergency department immediately.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movements. Rarely a chiropractic adjustment, traction, massage therapy, etc. may overstretch some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatment for resolution, but there are not long-term effects for the patient.

Rib and other Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. Other fracture locations are extremely rare but possible, especially in those aged over 65 years and/or on steroid drugs.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities and rarely, both heat or ice can burn or irritate the skin. The result is a temporary increase in pain, and there may even be some blistering of the skin. Never put an ice pack directly on the skin, always have an insulating towel between.

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Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell you doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment. Chiropractic is a system of health care delivery, and therefore as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment at this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

Alternatives to chiropractic care include: do nothing, drugs, surgery, acupuncture, massage, etc. Risks from these procedures should be discussed with that particular provider.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

PRINT NAME:_____

SIGNATURE:_____**DATE:**_____

WITNESS 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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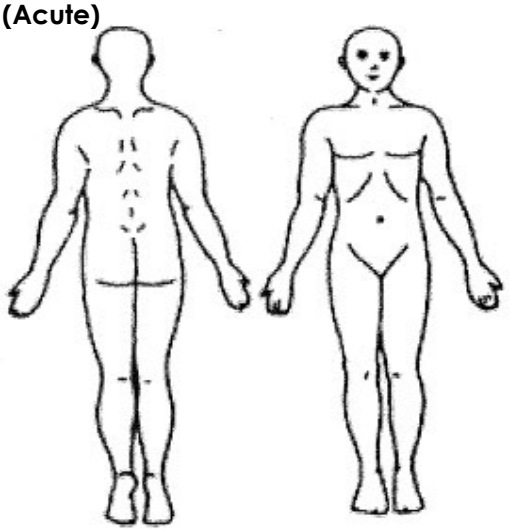
Chief Complaint – HPI (History of Present Illness)

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**

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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**

Please answer every section. Choose the statement that **most closely** describes your present-day situation.

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SECTION 1 - Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

SECTION 2 - Personal Care

- I do not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4 – Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain

SECTION 5 – Sitting

- I can sit in any chair as long as I like.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain straight away.

SECTION 6 – Standing

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 30 minutes without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

SECTION 7 – Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal night's sleep is reduced by less than 1/4.
- Because of pain my normal night's sleep is reduced by less than 1/2.
- Because of pain, my normal night's sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of my pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life, and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

SECTION 9 – Travel

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling, which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing degree of pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

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Medical history:		***Surgeries: (write date)***	
ADHD: _____	Hypertension: _____	Appendectomy: _____	Tonsillectomy: _____
Asthma: _____	High cholesterol: _____	Caesarian section: _____	Joint reconstruction:
Anemia: _____	Liver disease: _____	Carpal tunnel repair: _____	_____
Anxiety/Depression: _____	Lung disease: _____	Cosmetic: _____	Joint replacement:
Diabetes: _____	Kidney disease: _____	Coronary artery bypass: _____	_____
Cancer: _____	Sexually transmitted infection:	D & C: _____	Spine surgery:
Dementia: _____	_____	Dental surgery: _____	_____
Stroke: _____	Seizures: _____	Gallbladder: _____	Rotator cuff: _____
Osteoporosis: _____	Shingles: _____	Hemorrhoidectomy: _____	Mastectomy: _____
Osteoarthritis: _____	Thyroid problems: _____	Hysterectomy: _____	Breast enhancement:
Rheumatoid arthritis: _____	**Other:** _____	Hernia repair: _____	_____
			Other:

Alcohol:	***Education (please mark the highest level completed):***	***Tobacco:***
Never: _____	Did not finish High School: _____	Never smoked: _____
Social consumption only: _____	High School: _____	Live with a smoker: _____
Excessive use: _____	Assoc/Technical Degree: _____	Smoke: _____
	Undergrad Degree: _____	#_____per day/week
Diet:	Graduate Degree: _____	Chew: _____
High fat: _____	Doctorate: _____	#_____cans per day/week
High fiber: _____		Quit smoking: _____
High protein: _____	***Cannabis/ CBD*: (please circle type)**	Start/end date: _____
High salt: _____	Oral consumption: _____	
Low calorie: _____	Smoke: _____	***Recreational Drugs:***
Low carb: _____	#_____per day/week	No drug use: _____
Low fiber: _____		Current use: _____
Low salt: _____		Have not used since: _____
Low sugar: _____		

Current Medications/Supplements:

Are you on any blood thinner's? _____

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

Current Primary Care Health Provider: _____

Family Medical History:

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Please label- CURRENT or PAST HISTORY for each item

***please* indicate (C) CURRENT or (P) PAST HISTORY**

Constitutional:

Fatigue _____
Malaise _____
Unexplained weight loss/gain _____
Other: _____

Head:
Head injury: _____
Headache: _____
Other: _____

Eyes:
Wear vision correction: _____
Double vision: _____
Sensitivity to light: _____
Cataracts: _____
Changes in vision: _____
Glaucoma: _____
Blurred vision: _____
Other: _____

Ears:
Ear pain: _____
Hearing loss: _____
Tinnitus: _____
Dizziness: _____
Other: _____

Nose:
Frequent nose bleeds: _____
Loss of sense of smell: _____
Sinus infections: _____
Other: _____

Cardiovascular:
Angina: _____
Heart murmur: _____
Palpitations: _____
High blood pressure: _____
Low blood pressure: _____
Claudication: _____
Swelling of the legs: _____
Other: _____

Respiratory:
Asthma: _____
Chronic cough: _____
Other: _____

***Gastrointestinal*:**
Abdominal pain: _____
Heartburn: _____
Vomiting: _____
Hemorrhoids: _____
Constipation: _____
Diarrhea: _____
Other: _____

***Female*:**
Pregnancy: _____
Breast lumps/pain: _____
Hormone therapy: _____
Frequent urination: _____
Burning urination: _____
Urine retention: _____
Other: _____

***Male*:**
Prostate problems: _____
Frequent urination: _____
Burning urination: _____
Urine retention: _____
Erectile dysfunction: _____
Other: _____

***Musculoskeletal*:**
Fracture: _____
Fall (severe): _____
Motor vehicle accident: _____
Worker's comp: _____
Other: _____

***Neurological*:**
Difficulty concentrating: _____
Stroke: _____
TIA: _____
Dizziness: _____
Tremor: _____
Slurred speech: _____
Other: _____

***Psychiatric*:**
Anxiety: _____
Depression: _____
Bi-polar: _____
Memory loss: _____
Other: _____

***Endocrine*:**
Cold intolerance: _____
Heat intolerance: _____
Diabetes: _____
Excessive appetite: _____
Excessive thirst: _____
Abnormal frequency of urination: _____
Goiter: _____
Hair loss: _____
Unusual hair growth: _____
Voice changes: _____
Other: _____

***Hematologic/Lymphatic*:**
Bruising easily: _____
Anemia: _____
Fatigue: _____
Lymph node swelling: _____
Blood clotting problem: _____
Blood transfusion: _____
Other: _____