Day Chiropractic Patient Information Form

(503) 760-7572
www.DayChiropractic.com
3758 SE 122nd Avenue
Portland, OR 97236

Some Pages Are DOUBLE Sided

Today's Date: _____ Patient ID # _____

Legal Name: Last: _____ First: _____ M.I.:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____ Date of Birth: _____ Age: _____ Sex: M / F

Who referred you to our office?_____

Are You Employed? Full Time Part Time None Employer: _____

Are You A Student? Full Time Part Time None School: _____

SS#: _____ Driver's License: _____ State: _____

Are you: Married Single Divorced Separated Widowed Other: _____

Names and ages of family members:_____

_____

Emergency Contact:_____

Signature: _____ Parent/Guardian: _____
(if patient is a minor)

How do you plan to pay for today's visit? Cash Check MC/VISA

Do you have Group Health Insurance? Yes No If "Yes," please provide the following information & present you insurance card to the receptionist so a photocopy of your information can be made. Thank you.

Insurance Company: _____

Insurance Company Address: _____

Phone Number: _____

Name of Insured's Name: _____ Insured's SS#: _____

Policy or Group #: _____Insured's Employer: _____

Does this health insurance cover Chiropractic treatments? _____

Thank You!

Day Chiropractic Patient Health History Form

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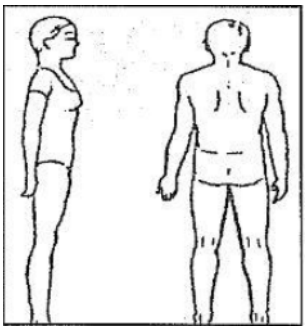
Patient Name: _____ **Today's Date:** _____

Please list your current health concerns below and rate them on a scale from 0-10. O being no pain, 10 being severe pain.

Health Concern	0-10

Please indicate on figures below where you are experiencing your greatest troubles.



Extra Notes:

_____
_____
_____
_____
_____
_____
_____
_____

Misalignments of the spine (subluxation) are caused by trauma, bad posture, and repetitive motion(s).

Please list any and all auto accidents (motorcycle, etc.) no matter *how* small or *how* long ago.

Month/Year	Rear end	Head on	T-bone	Driver	Passenger	Back L/R	Did you receive treatment?			
							E.R.	M.D.	P.T.	Chiro.
							E.R.	M.D.	P.T.	Chiro.
							E.R.	M.D.	P.T.	Chiro.
							E.R.	M.D.	P.T.	Chiro.

Please list any worker's compensation incidents, recreational accidents, or injuries at home.

Month/Year	Type (as above)	Details

Subluxations often occur during the birthing process.

How were you born?

	Vaginally		
	Vaginally w/assist: vacuum, forceps,etc.		
	Caesarian		Unknown

Complication Details

General Health Status

	Good	Fair	Poor
Health as child			
Health as adult			

Please think back on your childhood years and fill in charts below as appropriate.

	Yes	No	Details (Year, treatment)
Serious Illness(s)			
Notable Injuries			
Other			

(PLEASE COMPLETE BOTH SIDES OF SHEET)

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Please list all minor and major surgeries.

Month/Year	Procedure	Details

Are you taking any medications at this point? (Please include over-the-counter.)

Name	Frequency	Dosage	How many mnths	Purpose

Please list current/most recent information for the following:

	Name	City	Current status of relationship
Medical Doctor			
Dentist			
Chiropractor			
Other			

Vertebral subluxation can cause the following syptoms; which of these, if any, do you experience?

Symptom	Frequency	Months/Years	Type (sharp, dull, throbbing, burning, aching, stabbing)	When is it worst?
Neck Stiffness				
Headaches				
Shoulder Pain				
Arm/hand Pain				
High B.P.				
Allergies				
Asthma				
Ribs				
Low back				
Upper back				
Mid back				
Hip/Groin				
Legs				
Dizziness				
Other				

Patient Signature: _____ **Today's Date:** _____

David A. Day, D.C., P.C.
Chiropractor

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Patient Consent Form

Patient Name: _____ Date: _____

According to state and federal laws, consent is required for the following patient care items. By initialing each item below, I consent to the following items initialed.

_____ **Open Room Environment.** The treatment room is where education, learning, and healing take place. I understand and consent to participating in the open room environment. I also understand that if at any time I wish to speak to the doctor in private, I can schedule a private consultation appointment.

_____ **Marketing.** Marketing is considered to be "a communication about a product or service the purpose of which is to encourage recipients of the communication to purchase or use the product or service." I understand that Day Chiropractic may have additional services that I may wish to know about. I consent to Day Chiropractic contacting me about such services. Day Chiropractic will only use your information for in-house services and never release your information to another entity for marketing purposes without your consent.

_____ **Testimonials.** I understand that Day Chiropractic will not use my personal testimony for any purpose without my prior consent. If Day Chiropractic wishes to use information concerning my experience in treatment at Day Chiropractic, I will be asked to sign a separate consent and release form.

_____ **Pre-Enrollment Underwriting.** I understand that if I apply for new insurance coverage and the insurance company wants to review my personal health information, Day Chiropractic will not release information without my written authorization. I understand that I am responsible for all fees incurred for treatment not covered by my insurance.

_____ **Employment Determinations.** I understand that if a pre-employment physical is conducted, Day Chiropractic will not release information to the employer without my consent.

_____ **Appointment Reminders and Correspondence.** I consent to Day Chiropractic contacting or corresponding with me concerning my treatment and to use my name and/or photo for internal purposed such as patient appreciation, bulletin boards, sign-in sheets, postcards, etc.

Patient Signature: _____

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Terms of Acceptance

Patient Name: _____ **Date:** _____

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer a diagnoses or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression for the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____
Print Name

_____ _____
Signature **Date**

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Auto Accident Questionnaire

The purpose of this questionnaire is to confirm as much information as possible about your accident and injury. Please complete each question below to the best of your ability.

Name: _____ Date: _____ Patient ID #: _____

Date of accident: _____ Time: _____ AM/PM

Location: _____ City & State: _____

Were you the driver or a passenger? _____

Was anyone else in the car with you? Yes No If yes, please list other passengers: _____

_____

Please circle your answers below:

Was the vehicle: Stopped Moving Turning R/L Waiting to Turn R/L

What direction was your vehicle headed? North South East West

What direction was the other vehicle headed? North South East West

Were you aware of the impending accident? Yes No

Was your foot on the brake at the time of impact? Yes No

Were you wearing a seat belt? Yes No **Type:** Lap Shoulder Both

Upon impact, which way was your body thrown? _____

Were you knocked unconscious? Yes No

Please describe the accident: _____

_____

_____

Hospitalized? Yes No **If yes, which hospital?** _____ **How did you get there?** _____

Have you been treated by another doctor since the accident? Yes No

If yes, name, & address: _____

Have you lost any time from work since the accident? Yes No

If yes, date time loss began and ended: _____

Your occupation: _____

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Name: _____ Date: _____ Patient ID #: _____

Have you ever had any complaints in the area of injury before? Yes No

If yes, please explain: _____

_____

Name of Insurance Company of the car you were in: _____

Insured's Name & Address: _____

Policy Number: _____ Claim Number: _____

Did you report the accident to the insurance company yet? Yes No

Have they sent you the "Application for Benefits" and medical authorization yet? Yes No

If yes, have you completed and returned those forms? Yes No

Other vehicles Insurance Company: _____

Insured's Name: _____

Policy Number: _____ Claim Number: _____

Have you hired any Attorney for this accident? Yes No

Attorney's Name: _____

Address: _____

Phone: _____