

Day Chiropractic Patient Information Form

(503) 760-7572

www.DayChiropractic.com



3758 SE 122nd Avenue
Portland, OR 97236

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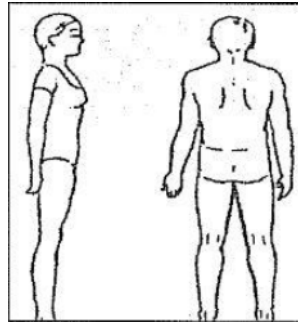
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Patient Name: _____ **Today's Date:** _____

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

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

Health Concern	0-10



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.

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?

Complication Details

General Health Status

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

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 symptoms; 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

Day Chiropractic

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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 purposes such as patient appreciation, bulletin boards, sign-in sheets, postcards, etc.

Patient Signature: _____



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Chiropractor

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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