HEALTHY LIVING
CHIROPRACTIC & WELLNESS CENTER

KATANAH GROSSMAN, DC, CCSP®
10001 SE SUNNYSIDE ROAD, SUITE 220 CLACKAMAS, OR 97015
P: 503.908.0881 F: 503.908.0891

New Patient Health History Form

Patient Data

First Name_____ Last Name_____ Date_____
Name you prefer to be called (if different from above):_____
E-mail address_____
How did you hear about us?_____
Who can we thank for referring you?_____

Mailing Address

Address_____ City_____ State_____ Zip_____
Phone (Home)_____ Work_____ Cell_____
Age____ Birth Date_____ SSN#_____ Number of Children _____
Occupation_____ Employer_____
Marital Status_____ Emergency Contact_____ Phone_____

Insurance Information

Name of party responsible for payment _____Phone_____
Do you have health insurance? __No __Yes
Name of company_____ ID#_____ Group#_____
Do you have secondary health insurance? __No __Yes
Name of company_____ ID#_____ Group#_____
***If an auto accident, please provide:**
Insurance Company Name_____ Contact person_____
Phone_____ Claim #:_____

Signatures

Name of insured _____

Patient's signature _____Date_____

Spouse's or guardian's signature _____Date_____

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Name:_____ DOB:_____ Date:_____

Medical History

Have you been treated for any conditions in the last year? __No __Yes
If yes, please describe_____
Date of last physical exam_____ Is there a chance that you are pregnant? __No __Yes
Have you had X-rays taken? __No __Yes If yes, where?_____
What medications are you taking and for what conditions (Please list dosage and amounts, etc.)
_____
What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency)
_____

Have you ever:	**No**	**Yes**	**Briefly explain**
Broken bones?	___	___	
Been hospitalized?	___	___	
Been in an auto accident?	___	___	
Had sprains/strains?	___	___	
Had surgery?	___	___	
Do you have a pacemaker?	___	___	

Family History

Family Members – Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc)

Current Complaints

Nature of Injury ___Automobile* ___Work ___Other
Please describe:_____
_____
What are you concerned about today?_____
_____
_____
Date of Injury _____ Date symptoms appeared_____
Have you ever had same condition? ___No ___Yes If yes, when? _____
List of other practitioners seen for this injury/condition_____
Have you ever been under chiropractic care? ___No ___Yes Have you ever received acupuncture? ___No___Yes
If yes, please describe_____
Do you experience pain every day? __No __Yes
Do your symptoms interfere with daily life? __No __Yes Explain_____
Does pain wake you up at night? __No __Yes
Are your symptoms worse during certain times of the day? __No __Yes Explain_____
Do changes in weather affect your symptoms? __No __Yes

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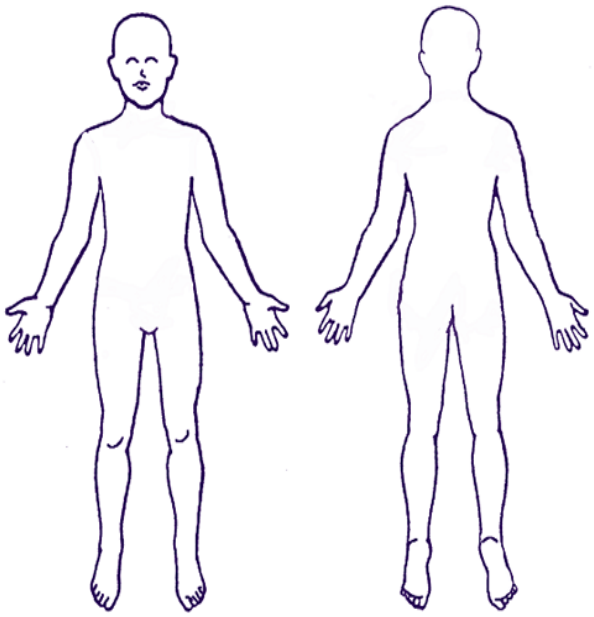
Name:_____ DOB:_____ Date:_____

TELL US WHERE YOU'RE HURT:
MARK THE AREAS ON YOUR BODY WHERE YOU FEEL PAIN. IF YOUR PAIN RADIATES, DRAW AN ARROW FROM WHERE IT STARTS TO WHERE IT STOPS. USE THE SYMBOLS LISTED BELOW.

ACHE >>>> BURNING XXXX NUMBNESS ====

STABBING //// PINS/NEEDLES 0000 THROBBING ~~~~



SYMPTOM RATING SCALE

INSTRUCTIONS: Please circle the number that best describes your symptoms in each of the questions below.

WHAT IS YOUR SYMPTOM INTENSITY **RIGHT NOW**?
0 1 2 3 4 5 6 7 8 9 10
no symptoms unbearable symptoms

WHAT IS YOUR **TYPICAL** SYMPTOM INTENSITY?
0 1 2 3 4 5 6 7 8 9 10
no symptoms unbearable symptoms

WHAT IS YOUR SYMPTOM INTENSITY **AT ITS WORST**?
0 1 2 3 4 5 6 7 8 9 10
no symptoms unbearable symptoms

HOW OFTEN ARE YOUR SYMPTOMS PRESENT? (PLEASE CIRCLE)

0-25% 26-50% 51-75% 76-100%

IN THE PAST WEEK, HOW MUCH HAS YOUR PAIN INTERFERED WITH YOUR DAILY ACTIVITIES?

0 1 2 3 4 5 6 7 8 9 10
no interference unable to carry out activitie

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Name:_____ DOB:_____ Date:_____

Health Problems and Concerns: Please circle and indicate if you have experienced any of the following, add "C" if currently experiencing the issue:

Allergies	Excessive Menstruation	Poor Posture
Alcoholism	Eye Pain	Prostate Trouble
Anemia	Fatigue	Sciatica
Arteriosclerosis	Frequent Urination	Shortness of Breath
Arthritis	Headache	Sinus Infection
Asthma	Hemorrhoids	Sleep Problems
Back Pain	High Blood Pressure	Spinal Curvatures
Breast Lump	Hot Flashes	Stroke
Bronchitis	Irregular Heart Beat	Swelling of Ankles
Bruise Easily	Irregular Menstrual Cycle	Swollen Joints
Cancer	Kidney Infection	Thyroid Condition
Chest Pain	Kidney Stones	Tuberculosis
Cold Extremities	Loss of Memory	Ulcers
Constipation	Loss of Balance	Varicose Veins
Cramps	Loss of Smell	Venereal Disease
Depression	Nosebleeds	Dizziness
Diabetes	Pacemaker	
Digestion Problems	Polio	

Life Choices: Please mark an "x" in the box that best fits your lifestyle

	Daily	Weekly	Occasionally	Never
Alcohol				
Tobacco				
Caffeine				

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INFORMED CONSENT FOR CHIROPRACTIC, ACUPUNCTURE, AND MASSAGE

Chiropractic and Massage

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound therapy, heat application, electrotherapy, and manual muscle therapy) are considered safe and effective methods of care. However, any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them.

These complications include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are rare. Additional information on side effects is available upon request.

Acupuncture

Techniques within the Licensed Acupuncturist's scope of practice include acupuncture, moxibustion, cupping and bleeding, electrical stimulation, Tuina (Chinese massage), Shiatsu/Sotai (Japanese massage), reflexology, dermal friction (gua sha), infrared heating lamps, Chinese herbal medicine, the use of vitamins, minerals, supplements and nutritional counseling. Any herbs prescribed may need to be prepared and that once prepared, should be consumed according to the instructions provided to the patient orally and in writing. A member of Healthy Living Chiropractic & Wellness Center should be notified immediately of any unanticipated or unpleasant effects associated with the consumption of herbs or other supplemental products.

Acupuncture is considered a safe method of treatment, but it may have some side effects, including bruising, scarring, swelling, and numbness or tingling near the needling sites that may last a few days. Unusual risks of acupuncture include: dizziness, fainting, nerve damage, organ puncture such as lung puncture or pneumothorax, spontaneous miscarriage, and burning due to moxa or infrared heat therapy. Because of any possible side effects of acupuncture related to pregnancy, the acupuncturist(s) associated with Healthy Living Chiropractic & Wellness Center must be informed prior to treatment if there is a possibility of pregnancy. Infection is another possible risk, although the acupuncturists at Healthy Living Chiropractic & Wellness Center use sterile, disposable needles and maintain a clean and safe environment. While this document describes the major risks of treatment, other side effects and risks may occur. Results of treatment are not guaranteed.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient Name: _____ DOB:_____

Patient Signature: _____

Date: _____

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CLINIC ACCOUNT POLICY

- Payment is expected at the time of service.
- As a service to you, we will bill your insurance company. If we can document your coverage, we will ask you to pay your co-pay, percentage, deductible or non-covered service fee at the time of each visit.
- If your insurance policy requires a referral for chiropractic care, **YOU** are responsible for obtaining this referral prior to your visits. Any care that is not covered by the referral is your financial responsibility.
- We make every effort to get accurate information from your insurance company. At times, however, insurance companies give us inaccurate information. For this reason, we periodically review our accounts and may have to inform you of a balance due.
- Information received from the insurance company **IS NOT A GUARANTEE OF BENEFITS.** You are responsible for all charges incurred in this office.
- If you have had a personal injury (automobile accident), we will bill your personal injury protection carrier (your auto insurance). The insurance company may not cover 100% of the billings and you are responsible for any difference. We will keep you updated on the payment activity on your account and ask that you keep us updated on any new information you may receive regarding your account.
- Personal injury accounts (automobile accidents) require that certain paperwork be filed by you with your insurance company in order for us to bill for services rendered. If you choose not to fill out this paperwork, you must pay at the time of service for your care and be reimbursed by any insurance company involved.
- Patients paying at the time of service may receive a 20% discount. This discount is the approximate cost to us of billing an insurance company for services rendered. We pass these savings on to you; however, **WE WILL DO NO BILLING FOR THESE SERVICES**. If, at a later date, you ask that insurance billings be done, the amount of the discount will be added back to your account prior to any billing being done.
- If at any time you would like a copy of your fee schedule, please do not hesitate to ask.
- We do not allow same day cancellations for you appointment. Please contact us the day before your appointment to avoid a $35.00 last minute cancellation fee. _____Initial

I have read and understand the above account policy.

Patient Name:_____ DOB:_____

Patient Signature:_____

Date:_____