Patient Intake Form

Paloma Chiropractic & Massage Therapy

2100 NE Broadway, Suite 125, Portland, OR 97232

Phone: 503-477-8222

Is this visit due to an accident, either Auto, Worker's Comp, or any other serious injury? { } Yes { } No

Patient Information:

Last Name: _____ **Legal First** Name: _____ **MI:**___ **Sex:** M/F

If you don't go by your legal name, what name do you prefer to go by? _____

Date of Birth: ___/___/_____ SSN __ __ __-__ __-__ __ __ __ (Only if needed by Insurance)

Mailing Address: _____ **Apartment/Unit Number**_____

City_____ **State**_____ **Zip** _____

Contact Information:

Phone: (____) _____ **Email Address:** _____

How would you prefer to receive **Appointment Reminders? (Check One)**

{ } **Phone Call** { } **Text Message** { } **Email**

Emergency Contact: _____ Relationship to Patient: _____

Phone: (___) _____ Who referred you to us?: _____

Insurance Policy

As a courtesy, we will check on your benefits and bill your insurance if you have coverage for Massage or Chiropractic Services. Until benefits are confirmed, a 30% payment may be collected at the time of service. Please, be aware that **there is no guarantee of payment by your Insurance** Company and ultimately **you** are responsible for the bill.

Your payment is expected at the time of your visit. We accept all major credit cards in addition to cash or checks.

Missed appointments: a $40 fee may also be charged for missed appointments, or if 24 hour notices is not given for a cancellation.

I have read, understand and agree with the above information:

Signed:_____Printed Name:_____ Date: _____

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NOTICE OF PRIVACY PRACTICES (HIPAA)

We are required by federal and state laws, to maintain the privacy of your health information. We are required to follow the privacy practices as described below. We reserve the right to change this notice in accordance with applicable law. We support your right to the privacy of your health information. You may request a copy of this notice at any time.

- We may share your health information with a physician or other healthcare provider treating you.
- We may use your health information to obtain payment for services from your insurance company.
- You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting an authorization in writing. Without your written authorization, we cannot use or disclose your health information for any reason except those permitted by this notice.
- In the event of your incapacity or in emergency circumstances, we will disclose health information to a family member, friend or other person as necessary only if authorized to do so.
- We will not use your health or personal information (i.e. address & phone #) for marketing purposes.
- We may use or disclose your health information to authorities when we are required to do so by law, including for public health reasons (e.g., disease reporting) if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence victim or the possible victim of other crimes.
- You have the right to review or receive copies of your health information, with limited exceptions.
- You have the right to request that we amend your health information. Such requests must be made in writing and must explain why the information should be amended. We reserve the right to deny your request.

Please know that there is a fee when your records are specifically ordered by an insurance company, lawyer or court subpoena. This fee is paid by them. There is no fee to you or to another healthcare provider for this service. Refusal to sign that you have received this information will not affect your treatment, eligibility for benefits or payment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, or my legal guardian or parent, acknowledge that I have received and read the Notice of Privacy Practices. The notice describes the policies and procedures regarding the use and disclosure of my health information that is created, received or maintained by Paloma Chiropractic & Massage Therapy.

*** Patient _____
Please print

*** Signature _____ Today's Date _____

* Parent or Guardian _____ Relationship _____
Please print Needed if patient is a minor

* Signature _____ Today's Date _____

******FOR OFFICE USE ONLY******

Patient was ***unwilling or unable to sign*** this document: Reason _____

Signed _____ Date _____

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& Massage Therapy
2100 NE Broadway, Suite 125
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(503) 477-8222 Fax: (971) 373-8648

AUTHORIZATION, RELEASE and INFORMED CONSENT for SPINAL MANIPULATION and TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures performed on myself, or the patient named below for whom I am legally responsible. I understand the procedures may include various mode of therapy (modalities) performed by the licensed chiropractic doctor(s) at PALOMA CHIROPRACTIC & MASSAGE THERAPY or any doctor, who now or in the future, may work as a relief doctor when Dr. Paloma may be unavailable.

I have had, or will have, the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures. I understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the areas(s) as needed. I understand and am informed that, as in the practice of medicine, there can also be some risks to treatment in the practice of chiropractic. These risks can include, but are not limited to, the following: fractures; disc injuries; strokes; dislocations; sprains; soreness and physical therapy burns – all of which are very rare occurrences. I understand and comprehend all such risks and complications and by my signature below, I confirm and accept and therefore consent and agree to the treatments and care as deemed necessary and in my best interest by my doctor.

I authorize payment of insurance benefits directly to PALOMA CHIROPRACTIC & MASSAGE THERAPY. I understand and agree to allow PALOMA CHIROPRACTIC & MASSAGE THERAPY to use my Confidential Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care through communication with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of my chiropractic care, regardless of any insurance coverage. I understand that any insurance I may have, may not cover all procedures performed. I also understand that the Federal Government has deemed it mandatory to notify my doctor, or any other party or insurance company who may be responsible for reimbursement for my treatment.

I have read and understand the ways in which my Patient Health information may be used and agree to these policies and procedures.

I have read, or have had read to me, the above informed consent, authorization and release. I have had or will have an opportunity to ask any and all questions about the content and by signing below, I agree to the above named treatment and procedures. I expect this consent to cover the entire course of treatment for my present condition(s) and for future conditions for which I may seek treatment by PALOMA CHIROPRACTIC & MASSAGE THERAPY.

Patient Name: _____
Please Print

Signature of:

Patient: _____ Date: ____/____/____

Parent or Guardian: _____ Relationship: _____

Name of Parent or Guardian: _____
Please Print

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Massage Therapy Consent Form

I understand that the massage I receive is provided for the basic purpose of relieving muscular tension, relieving pain and facilitating range of motion and relaxation. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the license massage therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form I confirm my consent to treatment. In addition, I intend this consent to cover the treatment discussed with me and such additional treatment as performed by my massage therapist from time to time to deal with my physical condition for which I have sought massage therapy. I understand that at any time I may withdraw my consent and massage therapy will be stopped.

Client name: _____

Date:_____

Client/Guardian Signature: _____

Licensed Massage Therapist_____

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Name:_____ Age:_____ Birth Date:_____ Sex: M F

Daytime phone:_____ Evening /Cell phone_____

Reasons for seeking chiropractic care today:

1._____

2._____

3._____

Circle the description of your current pain: Sharp, stabbing or shooting; Dull ache; Weakness; Numbness; Throbbing or gnawing; Burning; Tingling; Grip constricting

Circle the frequency of the previous complaints:

Constant (76-100% of time) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

How strong is your pain or ache: 0 1 2 3 4 5 6 7 8 9 10 (Circle one)

Since your problem began, is the pain: Increasing? Decreasing? Not changing? (Circle one)

On what date did your problem begin or how long has it been a problem?_____

Describe how your problem began:_____

_____

_____

What treatment have you received for this problem?:_____

Were you previously treated for a different occurrence of the same condition? YES NO

If YES, by whom: DC, MD, Massage Therapist, Physical Therapist or Other?_____

(Circle the appropriate answer to the following questions)

What makes your problem better? Nothing Lying down Walking Standing Sitting Moving Not moving

What makes your problem worse? Nothing Lying down Walking Standing Sitting Moving Not moving

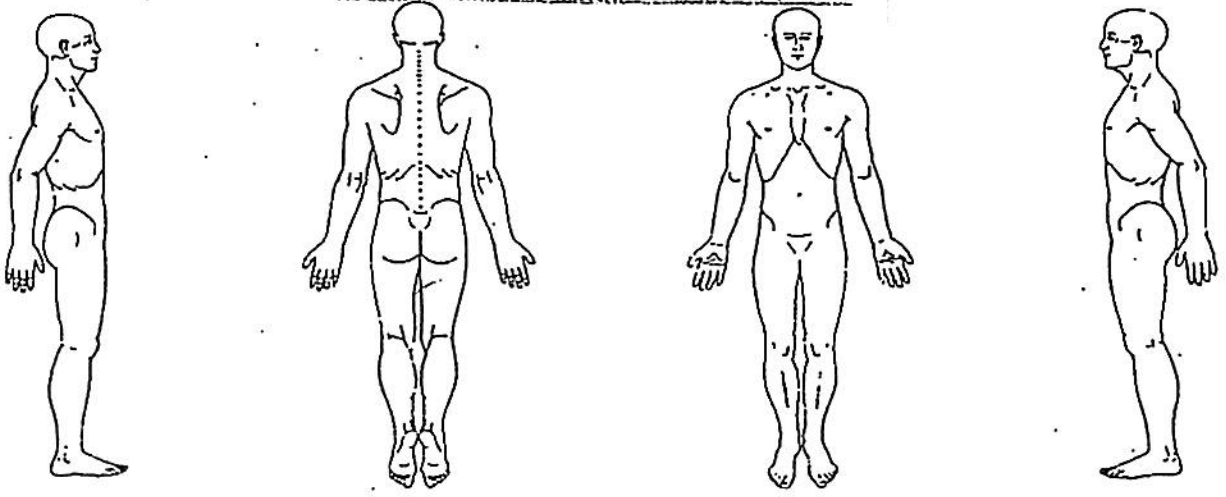
How would you grade your general stress level? None Minimum Moderate A Great Deal

Level of physical work activity: Sedentary (50% or more of day) Light labor Moderate labor Heavy labor

General physical activity: No exercise Light exercise Strenuous exercise; Regularly or Seldom

Do your complaints affect your ability to work or be active? No effect Need some help with everyday tasks Very hard to function without help Cannot function without help Some physical restrictions Totally disabled

Mark an X on the following pictures where you have pain or other symptoms.



Please Sign: _____ Today's Date: _____

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Please check any of the following you have had in the last six months:

GENERAL:
- ☐ Unusual fatigue
- ☐ Always warm or cold
- ☐ Unusual weakness
- ☐ Chills, fever, itching
- ☐ Unable to fall or stay asleep
- ☐ Marked weight changes
- ☐ Night sweats
- ☐ Easy bleeding
- ☐ Frequent colds

HEAD:
- ☐ Frequent headaches
- ☐ Dizziness or vertigo
- ☐ Loss of balance
- ☐ Fainting Spells

EYES:
- ☐ Wear glasses
- ☐ Wear contact lenses
- ☐ Blurry vision
- ☐ Eye pain
- ☐ Double vision
- ☐ Seeing spots
- ☐ Blind spots

EARS:
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Ear infection or discharge
- ☐ Earache
- ☐ Mastoid problems
- ☐ Had ears lanced

NOSE:
- ☐ Frequent bleeding
- ☐ Stopped up
- ☐ Sinus problems
- ☐ Post-nasal drip
- ☐ Unusual discharge
- ☐ Excessive sneezing

THROAT MOUTH:
- ☐ Dentures: upper lower
- ☐ Sore mouth, tongue or lips
- ☐ Hoarseness
- ☐ Frequent sore throat
- ☐ Bleeding gums

NECK:
- ☐ Stiffness or pain
- ☐ Swelling or goiter

HEART:
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular or stopped beats
- ☐ Racing, fluttering or pounding
- ☐ Chest pain on exertion
- ☐ Heart murmur
- ☐ Need to sit up to breathe at night
- ☐ Swollen feet or ankles

LUNGS:
- ☐ Shortness of breath
- ☐ Pleurisy
- ☐ Persistent cough
- ☐ Cough up blood, pus, mucous
- ☐ Unsatisfactory breathing
- ☐ Wheezing
- ☐ Chest pain

STOMACH & INTESTINAL:
- ☐ Appetite poor
- ☐ Difficulty swallowing
- ☐ Frequent indigestion
- ☐ Heartburn
- ☐ Belching
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Loose Bowel movements (BM)
- ☐ Black stools
- ☐ Change in bowel habits
- ☐ Jaundice
- ☐ Hemorrhoids of piles
- ☐ Abdominal pains / stomach aches
- ☐ Intolerance to some foods
- ☐ Bright blood in stool
- ☐ Frequent use of antacids
- ☐ Frequent gas problems
- ☐ Anal itching
- ☐ Frequent use of laxatives
- ☐ Bowel (BM) frequency:_____

URINARY:
- ☐ Pain or burning on urination
- ☐ Night time frequency:_____times
- ☐ Slow starting or stopping
- ☐ Slow urine stream
- ☐ Leakage with cough, sneeze, etc
- ☐ Discharge
- ☐ Kidney stones
- ☐ Bloody or dark urine

BONES, JOINTS, MUSCLES:
- ☐ Painful or stiff joints
- ☐ Swollen joints
- ☐ Back pain
- ☐ Pain in legs or feet
- ☐ Cramps (thigh, calves, back, other)
- ☐ Varicose veins
- ☐ Muscle weakness or soreness

SKIN (where, etc):
- ☐ Rash, hives or itching:_____
- ☐ Easily bruise
- ☐ Change in mole or wart
- ☐ Dryness
- ☐ Excessive moisture
- ☐ Chronic soreness, not healing well

MOOD:
- ☐ Generally happy
- ☐ Lack of memory
- ☐ Cry often
- ☐ Depressed
- ☐ Irritable
- ☐ Worry a lot
- ☐ Upset easily
- ☐ Tense or under stress
- ☐ Shy or sensitive
- ☐ Work or family problems
- ☐ Frightening thoughts/dreams
- ☐ Desire psychiatric help
- ☐ Suicidal thoughts

SEXUAL:
- ☐ Satisfactory Yes No
- ☐ Frequent Yes No
- ☐ Performance problems
- ☐ Painful intercourse
- ☐ Other:_____

MENSTRUAL:

Starting age:_____

Last period:_____

Ave. length of period:_____

Last PAP date:_____

Result of PAP:_____

Do you use: pads tampons

- ☐ Bleeding between periods
- ☐ Unusual discharge
- ☐ Excessive menstrual bleeding
- ☐ Birth control pills:_____
- ☐ Hot Flashes
- ☐ Post menopausal bleeding
- ☐ Vaginal dryness
- ☐ Female hormones:_____

PREGNANCIES: (Number of)
- ☐ Live births:_____
- ☐ Miscarriages:_____
- ☐ Abortions:_____
- ☐ C-sections:_____
- ☐ Premature births:_____
- ☐ Complications:_____

NEUROLOGIC (location, etc):
- ☐ Chronic pain:_____
- ☐ Numbness:_____
- ☐ Burning:_____
- ☐ Tingling:_____
- ☐ Loss of feeling:_____
- ☐ Paralysis:_____
- ☐ Trembling:_____
- ☐ Fainting:_____
- ☐ Seizures:_____
- ☐ Poor balance:_____

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FAMILY HISTORY:
Please list major diseases of parents or siblings (i.e. heart disease, cancer, diabetes, Kidney disease, etc.)
1._____ 4._____
2._____ 5._____
3._____ 6._____

HABITS:
Do you smoke now or have you smoked in the past? YES NO How many packs per day?_____
How many years did you smoke?_____ If you have quit, how long ago?_____

Do you consume alcohol? YES NO Amount & frequency:_____

Have you ever used street drugs? YES NO What type?_____

CANCER SCREENING HISTORY: please list date of your last...
Pap smear _____ Breast exam _____ Mammogram _____ Prostate exam _____ Complete physical _____

PERSONAL PAST ILLNESS HISTORY: (please check & include dates if known)

☐ Rheumatic fever	☐ Venereal disease	☐ Cancer	☐ Head injury (unconsciousness)
☐ Scarlet fever	☐ 3-day measles	☐ Mental illness	☐ Back injury
☐ Heart disease	☐ Thyroid disease	☐ Diphtheria	☐ Lung condition
☐ Heart murmur	☐ Eye disease	☐ Tropical disease	☐ Frequent colds
☐ High blood pressure	☐ Arthritis	☐ Asthma	☐ Whooping cough
☐ Stomach/Duodenal ulcer	☐ Rheumatism	☐ Hay fever	☐ Migraines
☐ Anemia	☐ Hepatitis	☐ Deformity	☐ Radiation treatments
☐ Bladder infection	☐ Liver disease	☐ Skin trouble	☐ Intestinal disease
☐ Kidney disease	☐ Epilepsy	☐ Drinking problem	☐ Nervous system disease
☐ Tuberculosis	☐ Diabetes	☐ Extensive burns	☐ Sprain / dislocation
☐ Pneumonia	☐ Gout	☐ Other:_____	

SURGERIES: (include dates if known)
1._____ 4._____
2._____ 5._____
3._____ 6._____

CURRENT MEDICATIONS: (prescriptions & OTC medications, strengths and dosage amounts)
1._____ 4._____ 7._____
2._____ 5._____ 8._____
3._____ 6._____ 9._____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO
If YES, list the medications and the type of reaction you had.
1._____ 3._____
2._____ 4._____

SOCIAL HISTORY:
Occupation:_____ Hours worked per week:_____
Birthplace:_____ Other locations lived in: 1._____
2._____ 3._____
4._____ 5._____

Number of hours you usually sleep per night:_____ Is it restful sleep? YES NO
Average number of cups of the following: (please circle one) Coffee Tea Soft drinks # per day: _____
Your present weight: _____ Height: _____

DO YOU HAVE ANY CONCERNS NOT LISTED PREVIOUSLY ON THESE PAGES? (If so please list)
1._____ 3._____
2._____ 4._____

Signature:_____ Today's date: _____