COLUMBIA GORGE
CHIROPRACTIC
& AUTO INJURY

NAME: _____ **DOB:** _____

Sex: □ M □ F □ Other

Address: _____ City: _____ State: _____ Zip: _____

Tel. #: _____ Email: _____

Do you give permission for our office to update your general medical practitioner with the progress of your condition? □ **YES** □ **NO**

Name of General Medical Doctor: _____

Is this related to a motor vehicle collision or work injury? □ **YES** □ **NO**

May we send you EMAIL and TEXT the day before scheduled appointments? □ **YES** □ **NO**
PLEASE CIRCLE WHICH METHOD YOU PREFER

ASSIGNMENT AND RELEASE

Scheduling an appointment reserves this time especially for you and no one else.

Our office requires **24 HRS. Notice** to cancel an appointment.

If 24 HRS. notice is not given, a charge of $50 for massage appointments and $35 for chiropractic appointments will be billed to your account.

I acknowledge that if I no show or do not provide the required 24 hours notice 3 or more times that I may be required to schedule same day appointments moving forward. Excessive no shows beyond 3 visits may result in being discharged from the clinic as a patient.

I clearly understand and agree that all services provided will be charged directly to me and that I am personally responsible for payment. I agree to allow Columbia Gorge Chiropractic and/or provider to bill my insurance company as a courtesy and permit the release of medical records necessary to process my claims. I authorize Columbia Gorge Chiropractic, to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I authorize payments to be made directly to Pivot Health INC DBA Columbia Gorge Chiropractic and/or provider for treatment rendered. I may receive an additional bill for services not covered by my insurance.

I understand that my deductible, co-insurance and co-pays are due at the time of service.

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

Parent or guardian signature needed if patient under 18 mm / dd / yyyy

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NAME: _____ **DOB:** _____

Height: _____ **Weight:** _____

For clinic use only
BP:
HR:
T:

Please describe your complaints below, starting with the most SEVERE.

Most SEVERE PROBLEM: When it started:

(Check ONE) □**Headache** □**Neck** □**Mid back** □**Low back** □**Other?** _____

a) Rank Severity **0-10** ***(0** NONE - **10** WORSE)* **right now**? _____, and at **worse?** _____
b) **Describe** Problem (Check): □**DULL** □**SHARP** □**NUMBNESS** □**TINGLING** □**Other?**_____
c) How frequent does it occur? □**DAILY** □ **3X WK** □**2X WK** □**1X WK** □**OTHER?** _____
d) Is it □**CONSTANT 100%?** or □**COME & GO?** What **%** of the day is it present? □**25%** □**50%** □**75%**
e) Any **radiation** into extremities? (arms or legs) □ **YES** □**NO** (if yes) Where? _____

Rate your **CURRENT** physical ability to complete the following activities.

From 0-10 (0= WITHOUT pain or restriction, 10= SEVERE pain or restrictions):

Working (/10) **Sleeping (/10)** **Showering (/10)** **Dressing (/10)** **Lifting (/10)**
Walking (/10) **Sitting (/10)** **Standing (/10)** **Bending (/10)**

PROBLEM 2 (IF ANY): When it started: _____

(Check ONE) □**Headache** □**Neck** □**Mid back** □**Low back** □**Other?** _____

a) Rank Severity **0-10** ***(0** NONE - **10** WORSE)* **right now**? _____, and at **worse?** _____
b) **Describe** Problem (Check): □**DULL** □**SHARP** □**NUMBNESS** □**TINGLING** □**Other?**_____
c) How frequent does it occur? □**DAILY** □ **3X WK** □**2X WK** □**1X WK** □**OTHER?** _____
d) Is it □**CONSTANT 100%?** or □**COME & GO?** What **%** of the day is it present? □**25%** □**50%** □**75%**
e) Any **radiation** into extremities? (arms or legs) □ **YES** □**NO** (if yes) Where? _____

PROBLEM 3 (IF ANY): When it started: _____

(Check ONE) □**Headache** □**Neck** □**Mid back** □**Low back** □**Other?** _____

a) Rank Severity **0-10** ***(0** NONE - **10** WORSE)* **right now**? _____, and at **worse?** _____
b) **Describe** Problem (Check): □**DULL** □**SHARP** □**NUMBNESS** □**TINGLING** □**Other?**_____
c) How frequent does it occur? □**DAILY** □ **3X WK** □**2X WK** □**1X WK** □**OTHER?** _____
d) Is it □**CONSTANT 100%?** or □**COME & GO?** What **%** of the day is it present? □**25%** □**50%** □**75%**
e) Any **radiation** into extremities? (arms or legs) □ **YES** □**NO** (if yes) Where? _____

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Please be as thorough as possible with your past health history

HEALTH HISTORY

NAME: _____ **DOB:** _____

PAST HEALTH:

1. Do **YOU currently (C)** or **have you ever in the past (P),** suffered from any of the following?

Asthma : C / P
Aneurysm: C / P
Autoimmune disease: C / P
Bleeding disorder: C / P
Cancer: C / P
Depression: C / P
Diabetes: C / P
Emphysema/COPD: C / P
Genetic disorder: C / P
Heart disease/attack: C / P
High blood pressure: C / P
High Cholesterol: C / P
HIV/AIDS: C / P
Liver disease: C / P
Osteoporosis: C / P
Rheumatoid arthritis: C / P
Skin condition: C / P
Stroke: C / P
Tuberculosis: C / P
Other: _____

2. Do you have any **INJURIES/ TRAUMAS? (please included dates of injury)** **□YES □NO**
   EXPLAIN: _____

3. Previous **SURGERIES**? **(please included dates of surgeries)** **□ YES □NO**
   EXPLAIN: _____

4. Do you take any **MEDICATIONS/VITAMINS?** **□ YES □NO**
   EXPLAIN: _____

5. Do you have any **ALLERGIES?** **□YES □NO**
   EXPLAIN: _____

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FAMILY HISTORY:

Have any of your IMMEDIATE BLOOD RELATIVES suffered from any of the following? If YES, please identify (mother, father, sister, grandparent, etc.)

Autoimmune disease: _____ **High Blood pressure:**_____

Bleeding disorder:_____ **Neurologic Disorders:**_____

Cancer:_____**type:**_____ **Heart Disease/attack:** _____

Diabetes:_____ **Osteoporosis:**_____

High cholesterol:_____ **Stroke:**_____

ANY deceased blood relatives? □**YES** □**NO** If (YES), Age & Cause? _____

PERSONAL HISTORY:

1. Your **HABITS:**
    a. How many alcoholic drinks do you consume per week? _____
    b. **Tobacco usage:** □ Current □ Former □ Never
    c. **Recreational Drugs:** □ Current □ Former □ Never

2. Do you **EXERCISE** regularly**?** □ **YES** □**NO** What **Type/Frequency**? _____

3. Have you ever been treated by a chiropractor before? □ **YES** □**NO** (if yes) When was your last adjustment? _____

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PROTECTED HEALTH INFORMATION DISCLOSURE

PLEASE REVIEW CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) AND GIVES CONSENT TO TREATMENT. PLEASE INITIAL ALL SECTIONS AND SIGN BELOW

NAME: _____ **DOB:** _____

INT. _____ I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to Columbia Gorge Chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors, LMT's, and locum providers see fit. **I hereby authorize Columbia Gorge Chiropractic to release all information necessary to any insurance company, attorney, or adjuster for claim reimbursement of charges incurred by me.** I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. My questions (if any) were answered to my satisfaction. I intend this consent to cover the course of treatment for my present condition and for any future conditions for which I seek treatment.

TREATMENT CONSENT & FINANCIAL POLICY

INT. _____ All procedures and treatment interventions [nutraceuticals, soft tissue manipulation (including massage, suction cups, instrument assisted), exercises, spinal manipulation, physical therapy modalities (elec/tric stimulation and ultrasound are a few examples), etc.] carry with them both risks and benefits. Risks include but are not limited to: injury, fracture, burns, worsening of condition, adverse reactions, stroke and/or death. Not receiving or accepting treatment recommendations also carries inherent risks including but not limited to: possible worsening of condition or disease progression, which may result in reduced quality of life and/or premature death. If uncomfortable with a recommended treatment or procedure, there may be alternative treatments available. You are encouraged to ask questions if you would like additional information. No guarantees can be assured regarding the outcomes of any treatment(s) or procedure(s) recommended or performed.

INT. _____ Fees are charged for professional services, and full payment with cash, check, or credit card is due at the time these services are rendered. **You are responsible for payment of office fees, treatments, imaging, and lab tests regardless of insurance coverage.** As a courtesy, we provide insurance billing service. However, each insurance plan offers different levels of reimbursement and/or coverage for services. Many "preventative approaches" to healthcare are not covered by insurance plans. **Any expense not covered by your insurance plan is your responsibility to pay in full**. **Deductible, copays, and non-covered services must be paid at time of service. If patient is a minor, the parent/ guardian signing below is assuming financial responsibility.**

Signature of Patient: _____ **Date:** _____

Parent or guardian must sign for anyone under the age of 18