FLEXFIT CHIROPRACTIC

P: (541) 265-5550
F: (541) 265-7820
A: 1164 S.W. COAST HWY, SUITE G
NEWPORT, OR 97365

Full Name: ____
Name you prefer to be called: _____________________________________
Birthdate: _____/_____/________ Age: _______ ⬜ Male ⬜ Female

Marital Status:
⬜ Single ⬜ Married ⬜ Divorced ⬜ Separated ⬜ Widowed
Spouse's Name: ____
Children's Names: ____

Address:
Home: ____
City: ________________________________State: ______ Zip: _________
Mailing: ____
City: ________________________________State: ______ Zip: _________

Contact Info:
Cell Phone: ___________________________
Home Phone: __________________________ Work Phone: _______________________
Email Address: ____
Appointment Reminders:
⬜ **Email** **OR** ⬜ **Text** - service provider (AT&T, Verizon, etc.): _________________
Reminder ⬜ **30 min.** ⬜ **1 hr** ⬜ **2 hrs** ⬜ **4 hrs** or ⬜ **1 day** prior to your appt.

Employer: ____
Occupation: ____
Employer's Address: ____
City: ________________________________State: ______ Zip: _________

Referred by: ____

I guarantee this form was completed to the best of my knowledge and understand that it is my responsibility to inform this office if any information changes.

____ ________________
Signature (if patient is a minor, a parent or guardian must sign) **Date**

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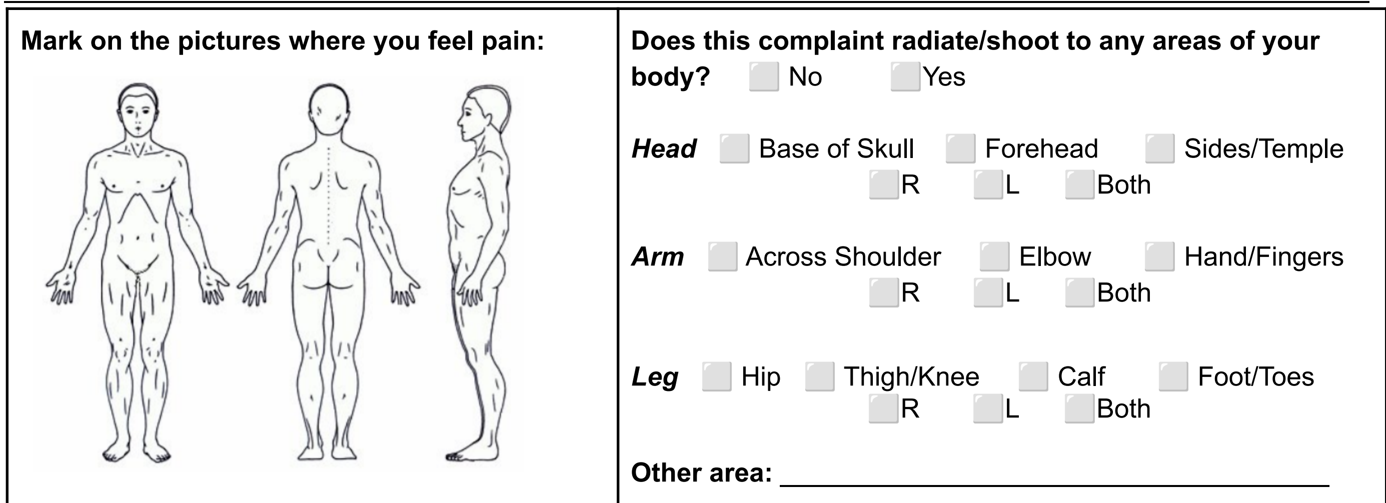
Patient History

Primary area of complaint: ______________________________ **Date of onset:** ____________________

Incident of onset: ____
____
____
____
____



Mark on the pictures where you feel pain:

Does this complaint radiate/shoot to any areas of your body? ☐ No ☐ Yes

Head ☐ Base of Skull ☐ Forehead ☐ Sides/Temple
☐R ☐L ☐Both

Arm ☐ Across Shoulder ☐ Elbow ☐ Hand/Fingers
☐R ☐L ☐Both

Leg ☐ Hip ☐ Thigh/Knee ☐ Calf ☐ Foot/Toes
☐R ☐L ☐Both

Other area: ____________________________________

Current average pain level (on a scale from 0 - 10; 0 = no pain, 10 = worst pain ever): ______________________

Percent of time you experience symptoms: ☐0-25% ☐26-50% ☐51-75% ☐76-99% ☐Constant

Symptoms are worse in the: ☐Morning ☐Afternoon ☐Night ☐Not specific

Since the problem started, it is: ☐ About the Same ☐ Getting Better ☐Getting Worse

Aggravated by: ☐Sitting ☐Lying down ☐Bending ☐Coughing ☐Lifting ☐Walking Other: _________

Alleviated by: ☐Ice ☐Heat ☐Rest ☐Movement ☐Stretching ☐Meds Other: ______________

For this CURRENT condition, have you sought care anywhere else? (MD, massage, PT, ER, etc.)
Where/when? ____

Had any diagnostic testing of this area? ☐X-rays ☐MRI ☐ CT Other: _______________
Where and when? ____

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand that it is my responsibility to inform this office of any changes in my health.

Patient Name (print): ____ **Date**: ___________________

Patient Signature (or guardian signature for minor children): ____

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Health and Social History

Personal History of: heart disease, diabetes, cancer, high blood pressure, stroke? Other: ______________
____

Family History of: heart disease, diabetes, cancer, high blood pressure, stroke? Other: _________________
Who/What?____

Surgical History (what and when):____
____

Previous injuries or trauma, ex: motor vehicle accident: ____
____

Medications (we can take a copy of a list):
List medications, vitamins, supplements, etc., and what condition it is for: _______________________________
____
____

Recreational use of controlled substances: ⬜no ⬜yes, please explain: ________________________

Tobacco use: ⬜no ⬜yes, please explain: ____

Occupation: ____

Recreational activities/Exercise habits: ____
____

Have you been to a chiropractor before? ⬜Yes ⬜No
When and where? ____

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Review of Systems

Spinal Nerve	Associated Organs/Glands	Symptoms Please check off any symptoms you are currently experiencing:	
C1 C2 C3 C4 C5 C6 C7 C8	*Parotid Gland · Scalp Base of Skull · Eyes Lacrimal Gland · Sinuses Inner, Middle, & Outer Ear Nose · Mouth Intracranial Blood Vessels Sympathetic Nervous System · Neck Muscles Diaphragm · Shoulders Elbows · Arms · Wrists Hands & Fingers · Tonsils Vocal Cords · Esophagus Heart · Lungs · Chest Thyroid*	☐ Dizziness & Vertigo	☐ Stiff Neck
		☐ Vision Problems	☐ Arm Pain
		☐ Sinus Pain	☐ TMJ Pain
		☐ Ear Pain	☐ Hand Numbness
		☐ Allergies	☐ Low Grip Strength
		☐ Chronic Cough	☐ Headache
		☐ Poor Immunity	☐ Blood Pressure Issues
		☐ Fainting	☐ Thyroid Dysfunction
		☐ Fever	☐ Seizures
		☐ Chronic Fatigue	☐ Poor Concentration
		☐ Tinnitus	☐ Insomnia
T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12	*Arms · Wrists · Esophagus Chest · Heart · Lungs Trachea · Larynx Diaphragm · Stomach Gallbladder · Liver Pancreas · Small Intestine Spleen · Kidneys Appendix · Adrenals Colon · Buttocks · Uterus Ovaries · Testes*	☐ Trouble Breathing	☐ Shoulder Pain
		☐ Indigestion/Heartburn	☐ Mid-Back Pain
		☐ Ulcers	☐ Rib Pain
		☐ Reflux & GERD	☐ Kidney Stones
		☐ Congestion	☐ Skin Conditions
		☐ Trouble Swallowing	☐ Rashes
		☐ Asthma	☐ Eczema
		☐ Bronchitis	☐ Liver Conditions
		☐ Gas & Bloating	☐ Blood Sugar Issues
L1 L2 L3 L4 L5	*Large Intestine · Colon · Thighs · Buttocks · Groin · Knees · Legs · Feet · Reproductive Organs*	☐ Irritable Bowel	☐ Low Back Pain
		☐ Constipation	☐ Hip Pain
		☐ Diarrhea	☐ Thigh Pain
		☐ Bladder Issues	☐ Numbness in Legs
		☐ Bed Wetting	☐ Tingling in Legs
		☐ Painful Urination	☐ Prostate Dysfunction
S1 S2 S3 S4 S5	*Buttocks · Groin · Legs Ankles · Feet · Toes · Prostate Gland · Bladder Reproductive Organs*	☐ Leg Cramping	☐ Pelvic Pain
		☐ Restless Legs	☐ Knee Pain
		☐ Poor Circulation	☐ Ankle Pain
		☐ Sciatica	☐ Foot Pain

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Patient Signature (or guardian signature for minor children): ______________________________________

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Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Doctors of Chiropractic at FlexFit Chiropractic, LLC and/or other licensed Doctors of Chiropractic who may treat me now or in the future at this office. I have/had an opportunity to discuss with office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

Patient Name (print): ______________________________________ **Date**: ____________________

Patient Signature (or guardian signature for minor children): __________________________________

If x-rays are taken of you (or of your minor dependents), do you authorize FlexFit Chiropractic, LLC to use the images for, but not limited to; patient education, handouts, and posters?
Note: All images would be ***anonymous****. No name will ever be associated with them or referenced when images are used.*

⬜ Yes ⬜ No

Patient Signature (or guardian signature for minor children): ___________________________________

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Financial Policy

Please review carefully and sign in agreement

- **FULL PAYMENT OR CO-PAYMENT IS REQUIRED AT TIME OF SERVICE** unless 100% coverage is expected, such as in the case of an auto accident or workers' compensation injury.

- Group or individual insurance patients will pay copay and/or deductible at the time of service. **We use all information available to us to calculate the amount due at time of service. Upon receiving insurance payment, an adjustment may need to be made which could result in a balance due. Health insurance policies are an arrangement between you and your insurance company. We recommend that *you* verify your insurance benefits with your insurance company.**

- Medicare patients will pay at the time of service. We will bill Medicare if you have requested us to. Medicare will bill any secondary insurance you may have. If they are going to pay, they will reimburse you directly.

- Patients may take advantage of the Time of Service Payment Credit *as long as payment is made at the time of service*.

- Auto claims will be billed to *your* auto insurance. Should the insurance carrier deny payment and/or the medical services are not paid within a reasonable amount of time, the bill will then become delinquent and immediate payment by the patient will be expected.

- Workers' compensation claims will be billed to your employer's insurance carrier. Denied claims are the responsibility of the patient.

- Delinquent accounts will be referred to a collection agency at the discretion of FlexFit Chiropractic, LLC. If any legal action is initiated by FlexFit Chiropractic, LLC or by its agents for collection, the non-prevailing party promises and agrees to pay reasonable attorney fees and costs as set by the court having jurisdiction.

I hereby authorize assignment of my insurance benefits directly to this office for services rendered in this office.

Patient Name (print): ___________________________________ **Date**: _______________

Patient Signature (or guardian signature for minor children): __________________________

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Patient Privacy Notice

We care about your privacy.
This notice describes how your medical information may be used and disclosed.
Please review carefully and sign below indicating that you understand this notice.

In the course of your care as a patient at FlexFit Chiropractic, LLC, we may use or disclose personal and health related information about you in the following ways:

- **Your protected health information**, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment, or such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- **You have a right to request restrictions** on our use of your protected health information for treatment, payment, and operations purposes. Such requests are not automatic and require the agreement of this office.
- **Your name, address, phone number**, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, reactivation or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder or other health related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide you care.
- If we are ordered by the courts or another appropriate agency.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. Requests to inspect, copy, or amend your health related information should be provided to us in writing.

This office utilizes an “open” adjusting and physical therapy environment for ongoing patient care. Open adjusting or physical therapy involves several patients being seen in the same room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is **not** the environment used for taking patient histories, providing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive, as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, other arrangements will be made for you. Closed circuit monitors are also used for your security which are monitored by our front desk.

- **Your signature indicates your authorization of this activity.** You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you choose not to authorize this information use, your decision will have no adverse effect on your care from our doctors or therapists or your relationship with our staff.
- **You may refuse to sign this privacy notice.** You may also revoke your authorization at any time. Revocation must be in writing delivered by U.S. Mail Certified Return Receipt Requested to 1164 SW Coast Hwy, Suite G, Newport, OR 97365. Revocation will not apply to situations where actions have been taken previously relying on the authorization.
- **If you have a complaint regarding our privacy notice**, our privacy practices, security, or any aspect of our privacy activities, or if you would like further information about our privacy policies and practices, please contact our Security and Privacy Officer in writing at the address listed above. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created.

Patient Name (print): ____________________________________ **Date**: ____________________

Patient Signature (or guardian signature for minor children): ___________________________________