



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

Mailing: _____

City: _____ State: _____ Zip: _____

Home: _____

City: _____ State: _____ Zip: _____

Contact Info

Cell Phone: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____

Occupation: _____

Appointment Reminders

We send text/email reminders for appointments and occasional updates.

If you would like to **opt out** of electronic communication from our office, check this box:

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)

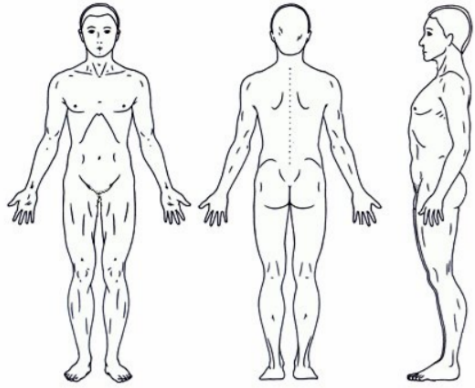
Date



Patient History

Primary area of complaint: _____ Date of onset: _____

What caused your symptoms to start or worsen? _____

<p>Mark on the pictures where you feel pain:</p> 	<p>Does this complaint radiate/shoot to any areas of your body? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Head <input type="checkbox"/> Base of Skull <input type="checkbox"/> Forehead <input type="checkbox"/> Sides/Temple <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both</p> <p>Arm <input type="checkbox"/> Across Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Hand/Fingers <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both</p> <p>Leg <input type="checkbox"/> Hip <input type="checkbox"/> Thigh/Knee <input type="checkbox"/> Calf <input type="checkbox"/> Foot/Toes <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both</p> <p>Other area: _____</p>
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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? _____

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): _____



Health and Social History

Personal History of: heart disease, diabetes, cancer, high blood pressure, stroke? None

Other/please explain: _____

Family History of: heart disease, diabetes, cancer, high blood pressure, stroke? None

Who & what? _____

Surgical History None What & when: _____

Previous injuries or trauma (ex: motor vehicle accident) None

What & when: _____

Are you pregnant, or is there a chance you may be pregnant? No

Please explain/due date: _____

Medications (we can take a copy of a list) None

List medications, vitamins, supplements, etc., and what condition it is for: _____

Recreational use of controlled substances None

Please explain: _____

Tobacco use None

Please explain: _____

Occupation: _____

Recreational activities/exercise habits: _____

Have you been to a chiropractor before? No

When & where? _____

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Patient Name (print): _____ **Date:** _____

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



Review of Systems

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

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Patient Name (print): _____

Date: _____

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



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): _____



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): _____



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 judgment 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): _____