PATIENT INTAKE QUESTIONNAIRE

PATIENT INFORMATION

Date _____

Legal Name _____

Preferred Name _____

Pronouns _____

Gender (circle any and all that apply):

Man Woman Transgender NB/GNC Agender Other

Decline to answer

Date of birth_____ **SSN** _____

Relationship status: ☐ Single ☐ Partnered ☐ Married

☐ Other ☐ Divorced ☐ Widowed ☐ Decline to answer

Partner's name:_____

Partner's phone:_____

Emergency contact:_____

Relationship:_____ Phone: _____

Home address_____

City/State/Zip_____

Cell phone_____

Home phone_____

Work phone_____

E-mail address _____

Preferred contact #: ☐ Cell ☐ Home ☐ Work

May we leave confidential information on your voicemail? **Y / N**

Occupation_____

Employer _____

Whom may we thank for referring you to our office?

_____

Were you referred to our clinic, or to a specific chiropractor?

☐ Clinic ☐ C. Wright ☐ K. Lange ☐ C. Gullikson ☐ M. S-Gonzales

PATIENT CONDITION

Current Symptoms

List the present symptoms you are having _____

_____

Have you ever had a similar problem before? ☐ No ☐ Yes When? _____

Did this injury occur while at work? ☐ No ☐ Yes Due to an auto accident? ☐ No ☐ Yes

Please explain in detail when and how your symptoms began: _____

_____

_____

What have you done to get relief? _____

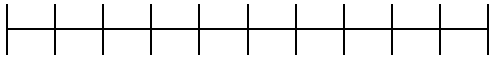
Since your symptoms began, are they? ☐ Better ☐ Worse ☐ Same Have you had previous treatment for this? ☐ No ☐ Yes

If yes, when?_____ By whom? _____

What was done? _____

Current Pain Level

On a scale of 0-10, with 0 being pain-free and able to function well, and 10 being constant excruciating pain, where do you rate your pain?

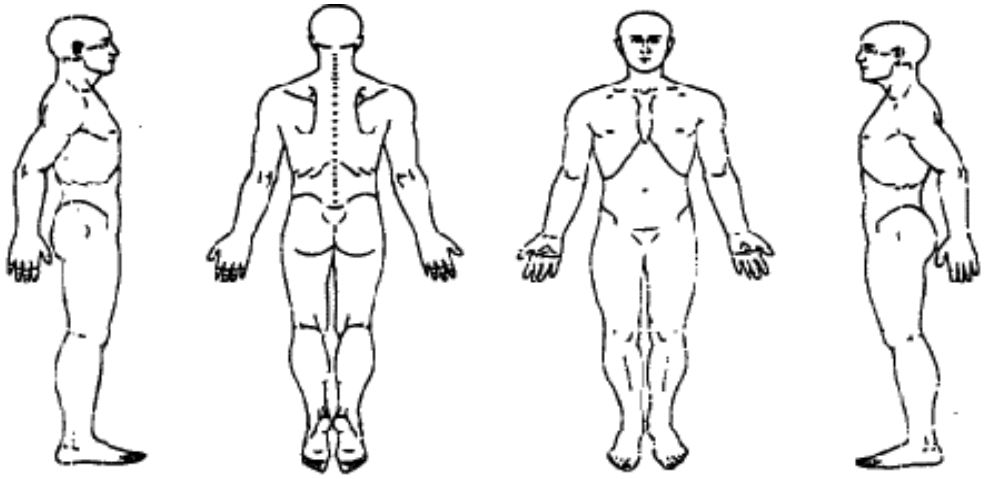


0 1 2 3 4 5 6 7 8 9 10

What makes your condition worse?_____

What makes your condition better?_____

Please mark your areas of pain on the figures below. Shade and code area(s) of complaint. Use codes: P = pain; N = numb; S = spasm



HEALTH HISTORY

Do you have a primary care physician? ☐ No ☐ Yes If yes, who? _____

Have you received previous chiropractic care? ☐ No ☐ Yes If yes, by whom?_____

For what conditions? _____

Have you had any past significant injuries? (list with approximate year) _____

_____

Have you been involved in any past motor vehicle accidents? ☐ No ☐ Yes When?_____

If yes, were you injured? ☐ No ☐ Yes If yes, please describe: _____

_____

What significant illnesses have you had?_____

_____

Have you had any surgeries? (list with approximate year)_____

_____

What medications are you currently using? _____

Do you exercise regularly? ☐ No ☐ Yes Describe _____

Describe your diet:_____

_____

_____

Mark any family illnesses: ☐ diabetes ☐ stroke ☐ cancer ☐ heart disease ☐ high blood pressure ☐ unknown

Do you have, or have you had, any of the following?

☐ Stroke	☐ High blood pressure	☐ Numbness
☐ Heart trouble	☐ Cancer	☐ Diabetes
☐ Recent Weight Loss	☐ Bruising tendencies	

Is there anything else that you think the doctor should know?_____

_____

OFFICE POLICIES

❖ Financial Policy and Cancellations

If you are accepted as a patient, you are expected to pay at the time of service unless other arrangements are approved. If you are unable to keep your appointment, please give us 24 hours notice, otherwise we reserve the right to charge $70 for the time reserved. If you are more than 10 minutes late for your appointment, we reserve the right to reschedule your appointment. Please note that reminder calls are given as a courtesy but are not responsible for ensuring that you make your scheduled appointment. I have read, understand and agree to the Hands On Wellness financial policy as provided to me.

Patient Signature X _____ **Date** _____

❖ Insurance:

If you have insurance, this office will gladly prepare medical claims forms, but we cannot render services on the assumption that our charges will be paid by an insurance company. You are responsible for payment whether or not paid by insurance.

Assignment of Benefits & Power of Attorney to Cash Checks:

I, the undersigned, do hereby authorize payment directly to this office, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. If these payments are made out to me, I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize Dr. Cynthia Wright, Dr. Kelly Lange, Dr. Caressa Gullikson or Dr. Salgado-Gonzales to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

Patient Signature X _____ **Date** _____

❖ Consent to Treat Minor Child:

The information I have given to this office pertaining to_____is truthful and complete to the best of my knowledge. I authorize Dr. Wright, Dr. Lange, Dr. Gullikson, Dr. Salgado-Gonazales and staff to administer such procedures and treatment, as they deem necessary to my (son), (daughter), (ward in my legal custody). The doctor has no implied guarantee of cure.

Parent or Guardian's name _____Date _____

Relationship to Minor Child _____

Witnessed by_____Date _____

Parent/Guardian Signature X _____**Date** _____

Cynthia Wright, D.C. ♦ Kelly Lange, D.C. ♦ Caressa Gullikson, D.C. ♦ Miguel Salgado-Gonzales, D.C.
108 E Hersey Street #2A, Ashland, OR 97520
PH: (541) 482-3492 ♦ FAX: (541) 482-4203 ♦ www.ashlandhands.com

PRIVACY POLICY STATEMENT

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship.
This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways.

- Information we receive from you
- Information we receive from other healthcare providers
- Information we receive from third party payers

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship, we will likely use and disclose health information by submitting the authorization in writing. Disclosures will be made to any personal representation you choose to have your protected health information.

You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing
This office will not use your health information for marketing communication without your written authorization. This office may send birthday cards, newsletters and appointment reminders, by telephone correspondence, post cards or letters.

Disclosure
This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of your healthcare information that this office has disclosed.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. Upon written request you have the right to amend your Protected Health Information.
5. You have the right to receive all notices in writing.

If you have any questions, complaints or want more information, contact our Office Manager:

Telephone: 541-482-3492
Fax: 541-482-4203
Address: 108 E Hersey Street #2A, Ashland, OR 97520

You may submit a written complaint to the U.S.A. Department of Health and Human services.

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Policy for Healthcare Services in this office. A copy of the Privacy Policies can be obtained upon request.

Patient Signature X _____ Date_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc., on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
Printed name of patient

_____ _____
Signature of patient Date

_____ _____
Signature of representative (if patient is minor or has a guardian) Date

_____ _____
Witness to patients' signature Date

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