NW FAMILY WELLNESS CENTER
10365 SE SUNNYSIDE RD. SUITE 210
CLACKAMAS, OR 97015
P: 503.887.7725 F: 503.855.3269

NEW PATIENT REGISTRATION

Today's date_____ How did you hear about the clinic?_____

Name_____
(Last) (First) (M.I.)

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

What is the best # to contact you? Home Work Cell Can we leave a message at this #? Y N

Date of Birth_____ SSN_____-_____-_____ Gender M F

Employer/Occupation_____ Phone #_____

Emergency Contact_____ Phone #_____
(Name) (Relationship)

INSURANCE INFORMATION

Primary Insurance Company_____ Policy Holder Name_____

Policy Holder DOB_____ Policy Holder Employer_____

ID#_____ Group#_____

Secondary Insurance Company_____ Policy Holder Name_____

Policy Holder DOB_____ Policy Holder Employer_____

ID#_____ Group#_____

RESPONSIBLE PARTY INFORMATION
(If patient is a minor)

Name_____ Relationship to Patient_____

Address (if different)_____ City_____ State_____ Zip_____

Contact phone #_____ Date of Birth_____ SSN_____-_____-_____

Employer/Occupation_____ Phone #_____

Patient name_____ DOB_____ Date_____

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NEW PATIENT QUESTIONNAIRE

Male_____ Female_____ Occupation_____

Single___ Married___ Partner___ Divorced___ Separated___ Widowed___ Number of children_____

How would you describe your health?_____

MEDICAL & SURGICAL HISTORY

Please list any previously diagnosed medical problems

_____ _____

_____ _____

Have you ever had any of the following? Please check C if Current Condition or P if Past Condition. Leave blank if you have never experienced the condition.

	C	P		C	P		P	N
Heart Disease			Breast Cancer			Arthritis		
High Blood Pressure			Other Cancer			Cataracts		
Hepatitis/Liver Disease			Broken Bones			Glaucoma		
Positive TB Skin Test			Tuberculosis			Seizures		
High Cholesterol			Depression			Anemia		
Thyroid Disorder			Alcoholism			Pacemaker		

Please list any past surgeries along with the dates of each:

_____ _____

_____ _____

Please list all prescription medications that you are taking:

_____ _____

_____ _____

Please list all non-prescription medications, vitamins or herbs that you are taking:

_____ _____

_____ _____

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Patient name_____ DOB_____ Date_____

HEALTH HABITS

Do you eat a special diet? Yes No If yes, describe_____
_____

Do you exercise regularly? Yes No If yes, how many times per week?_____

What method of exercise do you use?_____

Do you smoke? Yes No If yes, what and how much?_____

Do you chew tobacco? Yes No If yes, what and how much?_____

Do you drink alcohol? Yes No If yes, what and how much?_____

Have you ever smoked? Yes No If yes, when did you stop?_____

DO ANY OF THE FOLLOWING APPLY TO YOU?

Breast lumps or nipple discharge? Yes No

Do a monthly self breast exam? Yes No

WOMEN ONLY

Abnormal vaginal or menstrual bleeding? Yes No

Taking birth control or estrogen? Yes No

Is there a chance you might be pregnant? Yes No If yes, number of weeks _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Is this visit due to a motor vehicle accident? Yes No

Is this visit due to an on-the-job injury? Yes No

Have you ever seen a chiropractor before? Yes No

Have you ever had acupuncture before? Yes No

What was the date of your last physical exam?_____

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Patient name_____ DOB_____ Date_____

CURRENT COMPLAINT(S)

Please describe your current complaint(s) and what are you concerned about today:

_____

_____

_____

_____

Date your current symptoms started:_____

Is the pain? Getting Better Getting Worse Same as the Onset

Have you ever had this condition in the past? Yes No If yes, please explain below:

_____

_____

Have you seen any other healthcare practitioners seen for this condition? Yes No If yes, please list:

_____

Have you had any recent x-rays/images taken? Yes No If yes, of what area(s)?

_____

Facility images were taken?_____ Date(s) of procedure?_____

Are your symptoms worse during certain times of the day? Yes No If yes, when?_____

What have you tried at home to help alleviate your symptoms?_____

What makes your symptoms better?_____

What makes your symptoms worse?_____

Do your symptoms interfere with your ability to sleep? Yes No

Do your symptoms wake you up at night? Yes No

How do you sleep? Back Stomach Side Other:_____

Do you feel you sleep with a comfortable pillow?_____

Do you feel you sleep in a comfortable bed?_____

Do you wear: Heel lifts Sole lifts Orthotics Arch supports Negative Heels Platform Shoes

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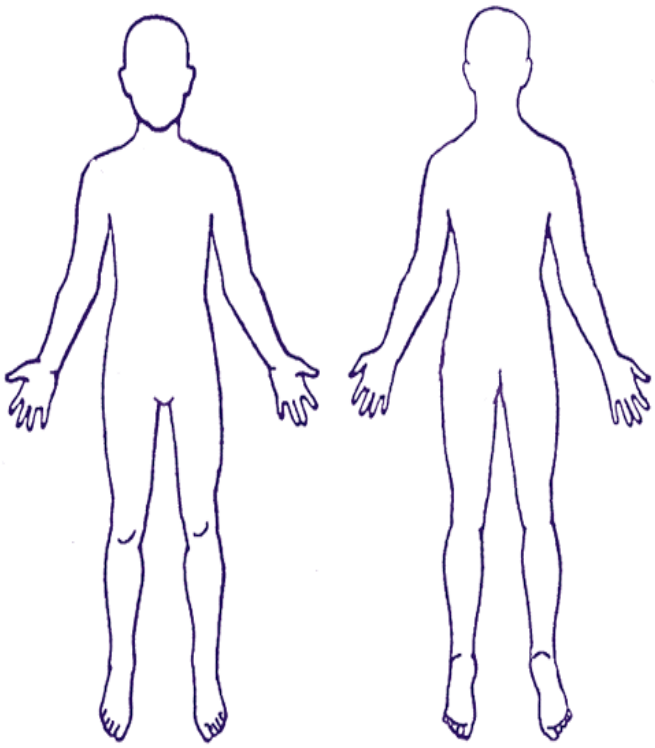
Patient name_____ DOB_____ Date_____

PAIN DRAWING

Tell us where you hurt:
Mark the areas on your body where you feel pain. If your pain radiates, draw an arrow from where it starts to where it stops. Use the symbols listed below.

Ache >>>> Burning XXXX Numbness ==== Stabbing //// Pins/Needles 0000 Throbbing ~~~~



SYMPTOM RATING SCALE

Instructions: Please circle the number that best describes your symptoms in each of the questions below.

What is your symptom intensity **RIGHT NOW**?
0 1 2 3 4 5 6 7 8 9 10
no symptoms unbearable symptoms

What is your **TYPICAL** symptom intensity?
0 1 2 3 4 5 6 7 8 9 10
no symptoms unbearable symptoms

What is your symptom intensity **AT ITS WORST**?
0 1 2 3 4 5 6 7 8 9 10
no symptoms unbearable symptoms

How often are your symptoms present? (Please circle)

0 – 25% 26 – 50% 51 – 75% 76 – 100%

In the past week, how much has your pain interfered with your daily activities?

0 1 2 3 4 5 6 7 8 9 10
no interference unable to carry out activities

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INFORMED CONSENT FOR CHIROPRACTIC, MASSAGE and ACUPUNCTURE

Chiropractic and Massage

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound therapy, heat application, electrotherapy, massage and manual muscle therapy) are considered safe and effective methods of care. However, any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them.

These complications include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are rare. Additional information on side effects is available upon request.

Acupuncture

Techniques within the Licensed Acupuncturist's scope of practice include acupuncture, moxibustion, cupping and bleeding, electrical stimulation, Tuina (Chinese massage), Shiatsu/Sotai (Japanese massage), reflexology, dermal friction (gua sha), infrared heating lamps, Chinese herbal medicine, the use of vitamins, minerals, supplements and nutritional counseling. Any herbs prescribed may need to be prepared and that once prepared, should be consumed according to the instructions provided to the patient orally and in writing. A member of NW Family Wellness Center should be notified immediately of any unanticipated or unpleasant effects associated with the consumption of herbs or other supplemental products.

Acupuncture is a considered a safe method of treatment, but it may have some side effects, including bruising, scarring, swelling, and numbness or tingling near the needling sites that may last a few days. Unusual risks of acupuncture include: dizziness, fainting, nerve damage, organ puncture such as lung puncture or pneumothorax, spontaneous miscarriage, and burning due to moxa or infrared heat therapy. Because of any possible side effects of acupuncture related to pregnancy, the acupuncturist(s) associated with NW Family Wellness Center must be informed prior to treatment if there is a possibility of pregnancy. Infection is another possible risk, although the acupuncturist(s) at NW Family Wellness Center use sterile, disposable needles and maintain a clean and safe environment. While this document describes the major risks of treatment, other side effects and risks may occur. Results of treatment are not guaranteed.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Signature: _____ **Date:**_____

Printed Name: _____**DOB:**_____

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CLINIC ACCOUNT POLICY

- Payment is expected as the time of service.
- As a service to you, we will bill your insurance company. If we can document your coverage, we will ask you to pay your co-pay, percentage, deductible or non-covered service fee as the time of each visit.
- If your insurance policy requires a referral for chiropractic care, you are responsible for obtaining this referral prior to your visits. Any care that is not covered by the referral is your financial responsibility.
- We make every effort to get accurate information from your insurance company. At times, however, insurance companies give us inaccurate information. For this reason, we periodically review our accounts and may have to inform you of a balance due.
- Information received from the insurance company **IS NOT A GUARANTEE OF BENEFITS**. You are responsible for all charges incurred in this office.
- If you have had a personal injury (automobile accident), we will bill your personal injury protection carrier (your auto insurance). The insurance company may not cover 100% of the billings and you are responsible for any difference. We will keep you updated on the payment activity on your account and ask that you keep us updated on any new information you may receive regarding your account.
- Personal injury accounts (automobile accidents) require that certain paperwork be filed by you with your insurance company in order for us to bill for services rendered. If you choose not to fill out this paperwork, you must pay that the time of service for your care and be reimbursed by an insurance company involved.
- Patients paying cash at the time of service may receive a 25% cash discount off our retail pricing. This discount is the approximate cost to us of billing an insurance company for services rendered. We pass these savings on to you; however, **WE WILL DO NO BILLING FOR THESE SERVICES**. If, at a later date, you ask that insurance billings be done, the amount of the discount will be added back to your account prior to any billing being done.
- If at any time you would like a copy of your fee schedule, please do not hesitate to ask.
- We require 24 hour notice if you need to cancel your appointment. You will be charged a $30.00 fee for any appointment missed without letting us know in advance.

I have read and understand the above account policy.

Signature:_____ **Date:**_____

Printed Name_____ **DOB:**_____

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HIPPA Notice-Privacy Disclosure and Policies

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Safeguards in place include:
· Limited access to facilities where information is stored.
· Policies and procedures for handling information.
· Requirements for third parties to contractually comply with privacy laws.
· All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Public Interaction
Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc.. It is our preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

Consultations
We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information
· From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
· From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)

Records Release
Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply
Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have NW Family Wellness Center maintain my records confidentially in accordance with the law. I agree to inform NW Family Wellness Center if I need any special arrangements pertaining to this issue.

Signature_____ **Date** _____

Printed Name_____**DOB:**_____