Crater Chiropractic Clinic, P.C.

Michael L. Warren D.C. & Michael M. Powell D.C.

3560 National Dr. Ste 100. Medford, OR 97504 (541)734-7333

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. *The information you provide concern past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health*

Name:_____ Date of Birth:_____ Date:_____
Age:_____ Gender:_____ Height:_____ Weight:_____

1. What problems or symptoms are you having?:_____
2. When did your problem(s) begin? SPECIFIC DATE IF POSSIBLE:_____
3. Did your problem(s) begin: Immediately after a specific incident___ Multiple incidents___ Gradually Developed___
4. Describe how your problem(s) began:_____
5. Please describe the character of your current pain (you may choose more than one): Stabbing___ Sharp___ Aches___ Dull___ Soreness___ Weakness___ Throbbing___ Shooting___ Constricting___ Burning___ Tingling___
6. How bad is your pain or ache at the moment? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10 No pain Unbearable pain
7. How often are the complaints present?: Constant (76%-100%)___ Frequent (51%-75%)___ Occasional (26%-50%)___ Intermittent (25% or less)___
8. Is your condition changing?: Worse____ Better____ No Change____
9. What treatment(s) have you received for the present condition?: Surgery____ Medications____ Chiropractic___
10. Have you been treated in the past? Yes__ No__ if yes, by: Chiropractor___ MD___ Therapist___
11. When is the condition worse?: Morning___ Afternoon___ Evening___ Night___
12. When is the condition better?: Morning___ Afternoon___ Evening___ Night___
13. What makes your problem(s) worse?: Nothing___ Laying down___ Walking___ Standing___ Sitting___ Movement/Exercise___ Inactivity___ Ice___ Heat___ Rest___ Other_____
14. What makes your problem(s) better?: Nothing___ Laying down___ Walking___ Standing___ Sitting___ Movement/Exercise___ Inactivity___ Ice___ Heat___ Rest___ Other_____
15. Does the pain radiate to other areas of the body?: Yes___ No___ Location:_____
16. Do you ever experience headaches?: Yes___ No___ How Frequently?_____
17. Have you ever been hospitalized?: Yes___ No___ if yes, when?:_____
18. Have you ever had any surgical procedures performed?: Yes___ No___ if yes, procedure date:_____
19. Are you currently taking any medications (either prescription or over the counter)?: Yes___ No___
20. In the last 5 years have you been in any: Auto accidents? Yes___ No___ Serious falls? Yes___ No___ If yes, when?:_____ Please Describe:_____

21. Do you smoke?: Yes___ No___

22. Do you have annual physicals?: Yes___ No___ Do you have regular dental check-ups?: Yes___ No___

23. When were your last X-rays taken?: Date:_____ By whom?:_____

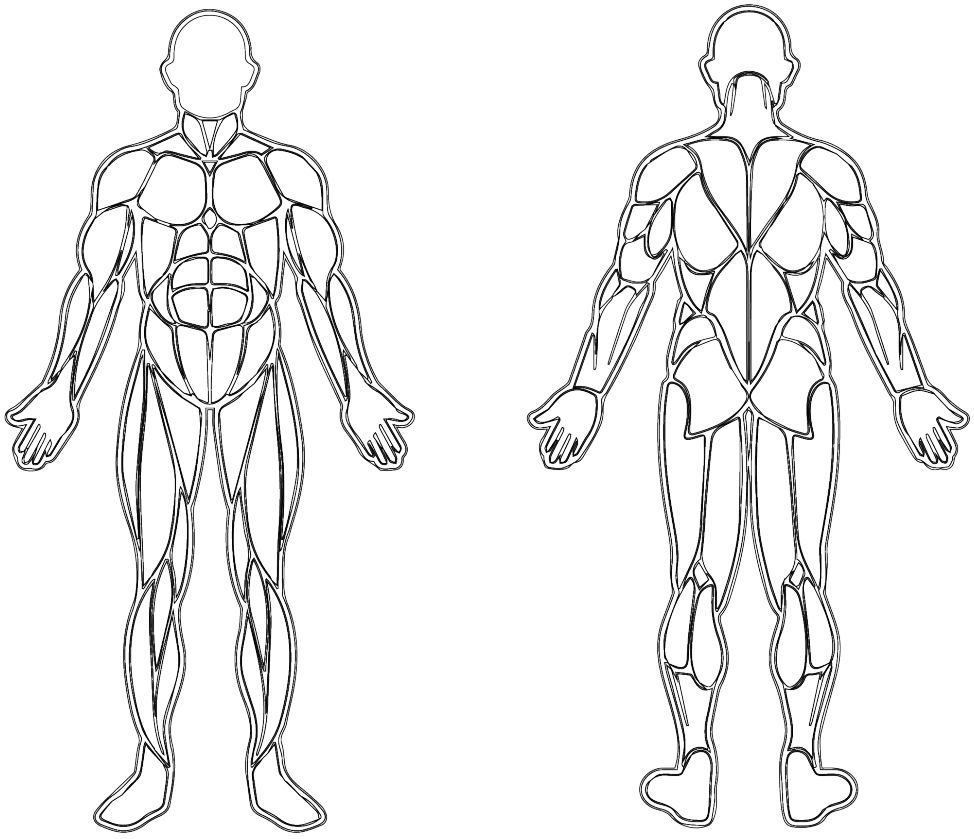
24. If female, are you currently pregnant?: Yes___ No___

25. Do you currently have an M.D.?: Yes___ No___ if yes, Name:_____

26. Have you ever been to a chiropractor before?: Yes___ No___ if yes, Name:_____

27. How did you hear about us?:_____

Mark an "X" on the pictures below where you have pain or other symptoms



FRONT *BACK*

Dr's Notes:

_____

_____

_____

Dr's Signature:_____

Michael L. Warren, D.C. Michael M. Powell, D.C.
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Patient's Name:_____ Date of Birth:_____

Do you or your immediate family have a history of:

Cancer: Yes____ No____ Who?_____ Heart Disease: Yes____ No____ Who?_____

Diabetes: Yes____ No____ Who?_____ Multiple Sclerosis: Yes____ No____ Who?_____

High BP: Yes____ No____ Who?_____ Arthritis: Yes____ No____ Who?_____

Fibromyalgia: Yes____ No____ Who?_____ Stroke OR Sensory Loss: Yes____ No____ Who?_____

Hearing OR Vision Loss: Yes____ No____ Who?_____ Neuropathy: Yes____ No____ Who?_____

Anxiety OR Panic Attacks: Yes____ No____ Who?_____ ADD?ADHD: Yes____ No____ Who?_____

Other Important Medical History:_____

_____

Do you exercise regularly (3-5 days/wk)? Yes____ No____ Other:_____

Any pain when exercising? Yes_____ No____ if yes, where?_____

What are your sleep habits like? Good____ Fair____ Poor____

What are your energy levels like during the day? Good____ Fair____ Poor____

Diet Information:

Do you drink soda/energy drinks/Gatorade more than twice a day? Yes____ No____

Do you eat 3 meals a day? Yes____ No____

Are you taking any supplements or dietary supplements? Yes____ No____ Name:_____

_____

How do your symptoms affect the following:

Work:_____

Family Responsibilities:_____

Recreational Activities:_____

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Patient Information

Name:_____ Preferred Name:_____

Address:_____

City, State, Zip:_____

Home Phone:_____ Work:_____ Cell:_____

Email Address:_____

Age:_____ Date of Birth:_____ Sex:_____ Marital Status: M S W D SSN:_____

Employers Name:_____ Occupation:_____

Spouse's Name:_____ Spouse's Employer:_____

If Minor: Legal Guardians Name:_____

Person Responsible for Payment

Name of Person Responsible for Payment:_____ Self__ Spouse__ Other__

Address (if different from above):_____

Home Phone:_____ Work:_____ Cell:_____

Accident or Injury Details

Auto___ On the job___ Other___ Date:_____ AM/PM

Details:_____

_____

Location of accident:_____
if on the job: Did you report the injury to your employer?:___ Did you file a written report with your employer_____

Sign:_____
If the problem for which you are seeing the doctor involves litigation, as may result from an automobile accident or fire, be advised that we do not wait for payment until litigation is settled, but we will accept regular payment on account.

Insurance

Primary Insurance:_____ Policy Number:_____

Name of Insured:_____ Group Number:_____

Secondary Insurance:_____ Policy Number:_____

Name of Insured:_____ Group Number:_____

Sign:_____
I authorize release of information of my medical history to Medicare and/or my insurance companies and assign all benefits for unpaid services to Michael Warren D.C. or Michael Powell D.C.

Informed Consent

Patient Name:_____ **DOB:**_____

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____**, of**_____
Name **City, State**

do hereby give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissues. I understand the the procedures may consist of manipulation/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is to be considered one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise, it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlining physicals defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormalities are detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are extremely rare. I am aware that nerve or brain damage including a stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests have been performed on me to minimize the risk of any complaints from treatment and I freely assume these risks.

Informed Consent

Patient Name:_____ **DOB:**_____

Treatment Results

- I also understand that there are beneficial effects associated with these treatment procedures including: Decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate that there is no certainty that I will achieve these benefits.
- I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.
- I agree to the performance of these procedures by my doctor and such other persons of the doctors choosing.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications, therapy, prescriptions or over-the-counter medications, exercise and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medications is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or physiological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Surgery: Surgery may be necessary form joint instability or serious disk rupture. Surgical risks may include unsuccessful outcomes, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risk of refusing or neglecting care may include increased pain, scar/adhesion formations, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient:_____

Signature of Witness:_____ **Date and Time:**_____

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HIPPA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND AUTHORIZATION

The Health Insurance Portability and Accountability act of 1996 (HIPPA) requires us to provide you with our Notice of Privacy Practices, which explains our privacy practices and how we may legally use and disclose your protected health information. In order to protect your privacy and confidentiality, we ask that you authorize when, and whom, protected health information can be released.

May we leave a detailed message on your answering machine/voicemail?

Yes No

May we call you at work and leave a message to call the office back?

Yes No

Do we have permission to talk and allow access to your protected health information to family members or other individuals?

Yes No

If yes, please provide the name(s) and relationship(s) of the authorized individuals:

Name:_____ **Relationship:**_____ **Number:**_____

Name:_____ **Relationship:**_____ **Number:**_____

Name:_____ **Relationship:**_____ **Number:**_____

By signing this form, I acknowledge that I have either received a copy of the Crater Chiropractic Clinic's Notice of Privacy Practices or have read the copy of the practices that is posted on the wall and have been given the opportunity to ask questions. A copy of this consent will be kept in my chart for future reference and available for a future copy if needed. There may be a time where the front desk or doctor may be talking to you about your treatment or calling on your insurance and some information may be overhead in the waiting room. We try at all cost to make sure nothing is heard by playing music and speaking low, but there is no guarantee that all spoken words will not be heard. By signing this page, you are stating that you will not accuse Crater Chiropractic Clinic of miss use or violating your health privacy.

Print Name:_____ **Date of Birth:**_____

Signature:_____ **Date:**_____

Relationship (if other than patient):_____

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Financial Policy & Agreement

Thank you for choosing Crater Chiropractic Clinic as your family chiropractor. We are dedicated to your treatment being successful. Please understand that the payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy and your agreement to pay for all services. Fees are due at the time services are rendered.

Insurance

On the day of service, we will submit an insurance claim using the information you have provided us. You may be asked for the estimated patient responsibility portion of fees. Please remember that we can only estimate the amount to be paid by your insurance company, as they make payments based upon their fee schedule. Their fee schedules are not a standard of our profession and may differ from our charges. Our practice is committed to providing the best treatment fees regardless of any insurance companies arbitrary determination of usual and customary rates. While we help you in every way possible to obtain your maximum allowable insurance benefits, the insurance contract is between you and your insurance company, and it's not replace your responsibility for your account. **It is always the responsibility of the patient, not the provider, do you know what is covered and what is excluded from each plan.** Payment plans are not available on remaining patient portion of fees.

ChiroHealth USA Membership

Accounts for which we are not submitting a claim to an insurance company will be placed onto ChiroHealth USA when possible. We have an in-house network plan that private pay will have to join to receive a discount. Payments are due in full for all services rendered on the day of treatments to receive our 30% network discount. If payment is not received on the same day, prices will return to full price. Please make sure to bring payment for all days of treatment.

Minor Patients

Any minor must be accompanied by a parent or legal guardian. The accompanying adult is responsible for full payment of all charges. This office is NOT a party to a General Judgment regarding a Divorce Decree, and office policies remain in force regardless of what the GJ may state until changed in writing.

***Service Charge**

All accounts that have a balance will receive a monthly statement from our office regardless of the date of your appointment or pending insurance claim. This will list the activity on your account. A $5.00 late fee will be applied to late monthly payments on all accounts. We reserve the right to apply a finance charge in the amount of 1.5% per month or 18% annually to all balances over 90 days as allowed by state law. A fee of $20.00 may be assessed to your account for any check returned by your bank.

Communication

Please note that you may be contacted by a member of the staff to confirm appointments, discuss financial issues or review treatment plans with you. This may also include mail that may be pertinent to your account or treatment. By signing this form, you as a patient or guardian, are giving our staff members permission to contact you and leave a voicemail regarding the account on any phone numbers provided, as well as that you understand all information provided above.

Signature:_____ **Date:**_____

Print Name:_____ **DOB:**_____

CRATER CHIROPRACTIC CLINIC, P.C.