Columbia Gorge Chiropractic

233 E Hist. Columbia River Hwy
Troutdale, OR 97060

(503) 491-9266

Patient Information:

Date _____
Patient Name _____
SS# _____ Birthdate _____
Address _____
City _____ State _____ Zip _____
Email _____
Cell _____ Home _____
Sex: ☐ Male ☐ Female Age _____
Are you pregnant? _____ Due: _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Divorced ☐ Separated ☐ Partnered
Height: _____ Weight: _____
Number of Children: _____

Spouse Information:

Name _____
SS# _____ Birthdate _____
Phone _____ Work _____
☐ Full Time ☐ Part Time ☐ Homemaker ☐ Unemployed
Occupation _____
Employer/School _____
Employer Address _____
Work Activity: ☐ Sitting ☐ Standing ☐ Heavy Labor
Supervisor Name: _____
Supervisor Phone: _____

How did you hear about us? (Specify)

☐ Current Patient _____
☐ My Doctor _____
☐ The Internet _____
☐ Mailing _____
☐ Other _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Cell _____ Work _____

Insurance Information

Is the patient responsible for this account? ☐ Yes ☐ No
If no, who is responsible for it?
Name _____
Address _____
City _____ State _____ Zip _____
Phone _____
Relationship to Patient _____

Primary Insurance

Insurance Company _____
ID # _____
Group # _____
Subscriber Name _____

Does the patient have additional insurance?
☐ Yes ☐ No

Secondary Insurance

Insurance Company _____
ID # _____
Group # _____
Subscriber Name _____

Accident Information

Is your visit due to an accident? ☐ Yes ☐ No
(If so, please fill out the rest of this section.)
Date of Accident _____
Type: ☐ Auto ☐ Work ☐ Home ☐ Other

Have you reported your accident? ☐ Yes ☐ No

Insurance Company _____
Claim # _____
Attorney Name _____
Attorney Phone _____

Patient signature: _____ Date: _____

For your first visit, please provide your ID and insurance card (if applicable).

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Patient Name: _____

Pain Questionnaire:

Reason(s) for appointment: _____

What is the main area of complaint? _____

When did your symptoms first appear? _____

How did this occur? _____

Is it getting worse? ☐ Yes ☐ No ☐ Unsure

What time of day is the worst? ☐ Morning ☐ Mid-Day ☐ End of Day

What have you done for this condition? _____

What medications are you taking for the pain? _____ How often? _____

Have you had X-Rays, MRI, or other tests for this condition? What tests, when and where?

_____

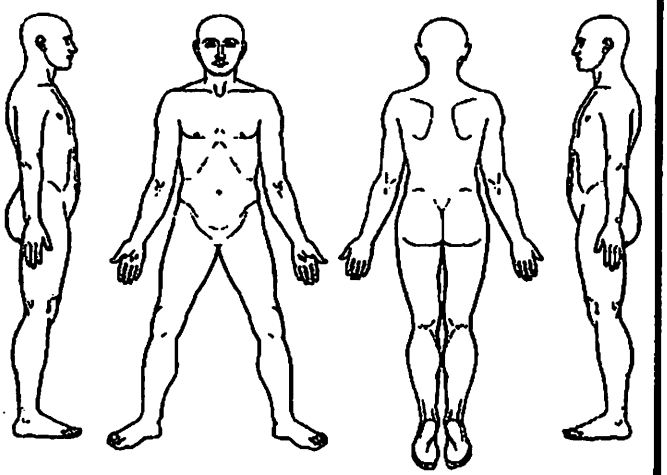
Rate your current pain by circling the corresponding number.

0 = No pain 10 = Pain that would send you to the ER

0 1 2 3 4 5 6 7 8 9 10

Pain level at your best: _____ Worst: _____

Mark on the picture where you have pain, numbness, tingling, etc.



What type of pain is it?

☐ Sharp ☐ Dull ☐ Throb ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling

How often is the pain? _____

Is the pain constant or does it come and go? _____

Does your pain interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Painful movements: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Social History: Please check the appropriate box.

Alcohol	Daily	Weekly	Monthly	Never
Diet Food Products				
OTC Stimulants				
Homemade Food				
Soft Drinks				
Water				
Caffeine				
Drugs				
Exercise				
Processed Food				
Tobacco				

Patient signature: _____ Date: _____

For your first visit, please provide your ID and insurance card (if applicable).

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Patient Name: _____

Medical History:

Last Physical Exam: _____ Primary Physician: _____ Physician Phone #: _____

Physician Address: _____

Have you seen any other doctors recently? Explain: _____

Health Conditions: _____

Health History:

Have you had any of the following? Please check the appropriate box.

☐ Allergies	☐ Alcoholism	☐ Anemia
☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Breast Lump	☐ Bronchitis
☐ Bruise Easily	☐ Cancer	☐ Chest Pain
☐ Cold Extremities	☐ Constipation	☐ Cramps
☐ Depression	☐ Diabetes	☐ Digestion Problems
☐ Dizziness	☐ Excessive Menstruation	☐ Eye Pain or Difficulties
☐ Fatigue	☐ Frequent Urination	☐ Headache
☐ Hemorrhoids	☐ Irregular Menstrual Cycle	☐ Hot Flashes
☐ Irregular Heart Beat	☐ Loss of Memory	☐ Kidney Infection
☐ Kidney Stones	☐ Loss of Taste	☐ Loss of Balance
☐ Loss of Smell	☐ Polio	☐ Nosebleeds
☐ Pacemaker	☐ Sciatica	☐ Poor Posture
☐ Prostate Trouble	☐ Sinus Infection	☐ Shortness of Breath
☐ High Blood Pressure	☐ Stroke	☐ Insomnia
☐ Spinal Curvatures	☐ Thyroid Condition	☐ Swelling of Ankles
☐ Swollen Joints	☐ Varicose Veins	☐ Tuberculosis
☐ Ulcers	☐ Sexually Transmitted Disease	☐ HIV/AIDs
☐ Broken Bones	☐ Falls	☐ Head Injuries
☐ Dislocations	☐ Surgeries	☐ Sprain/Strains
☐ Hospitalizations	☐ Loss of Consciousness	☐ Eating Disorder

☐ Family Health History: _____

Medications	Allergies	Vitamins/Herbs/Supplements

Any other concerns or information you would like the doctor to know? _____

Patient signature: _____ Date: _____

For your first visit, please provide your ID and insurance card (if applicable).

Financial Policy

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well. In order to attain the level of achievement we both desire, a care plan must be followed. We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes.

Massage No Show/Missed Appointments: Massage times are reserved especially for you, and if patients do not show up for their appointments, we do not have time to fill the hour with patients who need it. It also takes money from the massage therapist as they are only paid for massage hours. We understand that emergencies come up, so please call our office as soon as possible to notify us and to reschedule your appointments. For all "No Shows" or cancellations with less than 24 hours notice, a $35 missed massage fee will be applied to your account.

In order to file your claims in a timely manner, we need current and accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it does not. Should your our-of-network insurance carrier determine that any or all of our services are ineligible for payment or subject to your deductible, you will be billed directly.

You will receive a statement showing your patient balance if your balance exceeds $5.00. Account balances over 60 days old (after your insurance processes) will be considered "past due". Account balances 90 days old are considered delinquent. Late payment for non-covered services, deductibles, missed massage fees, and co-pays/co-insurances may be subject to a $10 re-billing fee. If it becomes necessary to turn your account over to an outside collection agency or send it to small claims court, a non-negotiable fee of $100 will be added to your account balance. This will ensure that our responsible patients are not penalized to cover costs incurred by those who do not pay on time. If you have any questions about our financial policies, please ask to speak to our billing specialist.

Your health insurance does not pay for everything, even some care that your or your healthcare provider have good reason to think you need. We expect your health insurance will not pay for supplements or any chiropractic care deemed "maintenance" or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services. Signing below signifies that you have received and understand this notice.

I authorize Columbia Gorge Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to Columbia Gorge Chiropractic, of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me based in whole or in part upon the charges made for services received.

I hereby appoint Columbia Gorge Chiropractic the authority to cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic for payments due for services rendered on behalf of the undersigned by Columbia Gorge Chiropractic.

If you need to make special arrangements, please ask. We will never deny care to anyone based solely on ability to pay. We will do everything possible to meet your financial needs, including helping you make payment arrangements.

Signature:_____ Date:_____

Patient HIPAA Consent Form

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosure. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in the treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations, such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Authorization for Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various models of physical therapy, electrostimulation of the muscles, ultrasound, and laser therapy.

I further understand that such chiropractic services may be performed by the physician at Columbia Gorge Chiropractic and/or other licensed staff who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Simons and/or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the 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 (CVA), 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 judgement during the course of the procedure which the physician feels are in my best interests at the time, based on the facts then known.

I have read, or have had read to me, the above consent, I have also had the opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intent to 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.

Date:_____ Print Patient Name:_____

Signature:_____

Full name of spouse, family member, emergency contact, or physician who should have access to your medical information as well as the ability to pay your bill on your behalf:_____

AUTO INJURY QUESTIONNAIRE

Please Print

Name_____ **Date**_____

Date of the accident_____ **Time of accident**_____ am/pm

Where were you in the vehicle? (please circle)

Drivers front seat Drivers side rear seat Passenger side front seat Right rear seat

Speed_____ **mph**

Make of vehicle_____ **Model**_____ **Year**_____

vehicle type (Please Circle)

compact car compact passenger truck full-size car mid-sized car
mini van motorcycle passenger truck

Accelerating? (Please Circle) YES or NO

What was your vehicle doing immediately prior to impact? (Please Circle)

Changing lanes
Continuing to drive unaware of the stopped vehicle ahead
Proceeding through the intersection disregarding the stop sign
Stopped for a stop sign
Turing left at an intersection
Other:_____
Continuing to drive unaware of red light
Proceeding through an intersection with the light
Slowing for traffic congestion
Stopped for a traffic light
Turing right at an intersection

What was your vehicles point of impact? (Please Circle)

Front bumper Left front fender Left rear fender Left side Rear bumper
Right front fender Right rear fender Right side Other:_____

Amount of damage to your vehicle $_____

Road condition (Please Circle)

Covered with gravel Covered with leaves or other debris Damp Dry
Icy Mostly dry with the first minutes of rain Muddy Sandy
Snow-covered Wet Other:_____

Visibility (Please Circle)

Excellent, with bright sunlight Excellent, with overcast light Reduced at dawn
Reduced at dusk Reduced at night Reduced due to fog
Reduced due to rain Reduced due to snow Other:_____

Was another vehicle involved? (Please Circle) YES or NO

Number of other vehicles _____

Which vehicle hit the other? (Please Circle)

More than one vehicle hit the patients vehicle
The patients vehicle hit by more than one vehicle
Other:_____
The other vehicle hit the patients vehicle
The patients vehicle hit the other vehicle

Was a police report filled out? (Please Circle) Yes or No

PATIENT AT IMPACT

Air bags deployed (Please Circle) YES or NO

Did you lose consciousness after the injury? (Please Circle) YES or NO

Did you receive emergency care at the scene? (Please Circle) YES or NO

Position of headrest (Please Circle)

Adjusted high
All the way down
Improperly adjusted and offered negligible protection
Properly adjusted
Adjusted low
All the way up
Not equipped with headrest
Other:_____

Type(s) of seats restraint(s), you were wearing if any (Please Circle)

A shoulder harness connected to the door
Lap belts only
Seatbelts with shoulder harness
A shoulder harness only
No seatbelts
Other:_____

Where did you go immediately after the accident? (Please Circle)

Home
To continued with scheduled plans
To the hospital ER by ambulance
A walk-in emergency clinic
To the hospital emergency room
To work
Other:_____

Were you prepared for the impact? (Please Circle) YES or NO

Drivers foot on brake at time of impact? (Please Circle) YES or NO

What was the position of your head and neck prior to impact?

Down
Down and to the right
Down and to the left
Level and to the left
Level and to the right
Straight ahead
Up
Other:_____

OTHER VEHICLE

Other vehicle type (Please Circle)

compact car
compact passenger truck
full-size car
mid-sized car
mini van
motorcycle
passenger truck

Make of vehicle_____ **Model**_____ **Year**_____

Accelerating? (Please Circle) YES or NO

What was the other vehicle doing immediately prior to impact? (Please Circle)

Changing lanes
Continuing to drive unaware of the stopped vehicle ahead
Proceeding through the intersection disregarding the stop sign
Stopped for a stop sign
Turing left at an intersection
Continuing to drive unaware of red light
Proceeding through an intersection with the light
Slowing for traffic congestion
Stopped for a traffic light
Turing right at an intersection
Other:_____

What was the other vehicles point of impact? (Please Circle)

Front bumper
Left front fender
Left rear fender
Left side
Rear bumper
Right front fender
Right rear fender
Right side
Other:_____

Amount of damage to the other vehicle $_____

CIRCLE THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

Headaches	Neck Pain	Sleeping Problems	Loss of Concentration
Chest Pain	Dizziness	Mid-Back Pain	Foggy Thoughts
Depression	Ears Ring	Low Back Pain	Sensitive to Motion
Jaw Pain or Click	Stomach Upset	Nervousness	Light Sensitivity
Pain Shoots Down Legs	Neck Stiffness	Fatigue	Pins and Needles in Legs
Pain Shoots Down Arms	Pins & Needles in Arms	Loss of Coordination	Other:
Blurry Vision			

Name of hospital & location_____
Were you admitted? (Please Circle) YES or NO **For how long?**_____
Emergency room only? (Please Circle) YES or NO

Treatment received_____

Was any other doctor consulted after your accident? (Please Circle) YES or NO

If so, what was the doctor's name?_____ **(Please Circle)** DC MD DO DDS
What was the diagnosis?_____
What treatment was given?_____
How often did you see the doctor?_____
Have you ever had any complaints in the involved area before? (Please Circle) YES or NO
If so, what were the complaints?_____
Before the injury, were you capable of working on an equal basis with others your age?(Please Circle)
YES or NO
Are your work activities restricted as a result of this accident? (Pleas Circle) YES or NO
Have you lost any days of work?(Please Circle) YES or NO
Dates_____

Were you struck from __**behind** __**right side** ___**left side** ___**front** ___**auto parked**

You were heading___**North**___**East**___**South** ___**West on**_____**(street or hwy)**

Other vehicle was headed___**North**___**East**___**South**___**West on**_____**(street or hwy)**

Were there any witnesses?(Pleas Circle) YES or NO
Names_____
Have you made settlement with the insurance company in any way? ___yes___no

Did you have any physical complaints BEFORE THE ACCIDENT? ___yes___no
Please Describe_____
Have you ever been involved in an accident before?___yes___no
If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:_____
_____
_____
_____

Insurance companies involved_____
Have you been contacted by an insurance adjuster or representative regarding this claim?__yes___no

Your auto insurance company at the time of the accident?_____

Policy#_____**Were you given a claim#**_____**yes**_____**no**

Claim#_____**Adjuster's name handling your File**_____
Driver of vehicle in which you were injured (if applicable)

Name_____ **Insurance Company**_____
Policy #_____

Patient Signature_____ **Date**_____