Jade Chiropractic. • 5517 N Commercial Ave. • Portland, OR 97217

Phone: 503-223-0900 • Fax: 503-223-1188 • www.JadeChiropractic.com

NEW PATIENT REGISTRATION

First Name_____ MI:_____ Last Name_____

Address_____
Street Apt# City State Zip

Date of Birth_____ Home Phone # (_____)_____

Cell Phone # (_____)_____

E-mail Address: _____ May we contact you via e-mail? Y / N

Emergency Contact_____ Phone# (_____)_____

Employer_____ Phone# (_____)_____

Occupation_____

Whom may we thank for referring you to our office?_____

Insurance Information

**** If you are not utilizing insurance, please skip this portion and finish the other side of this form ****

Are you the policy holder? Y / N If no, who is the policy holder: Spouse / Parent / Employer / Other

Policy Holder Information – ***If different from above***:

Name (Guarantor)_____
Last First Middle

Date of Birth:_____

Address _____ Phone# (_____)_____
Street Apt# City State Zip

Employer_____ Phone #(_____)_____

Name of Insurance_____ ID#_____Grp#_____

Secondary Policy Holder Name, DOB, SSN and Employer if Different Than Above:

_____

We will also need to make a copy of your insurance card(s)

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Acknowledgment and Understanding

Please initial each item below.

1. _____ I hereby authorize Jade Chiropractic to provide Chiropractic Services for me. I also, hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Jade Chiropractic 5517 N Commercial Ave. Portland, OR 97217

2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Jade Chiropractic.

3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

4. _____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

5. _____ I acknowledge the receipt of a copy of the office 'Notice of Patient Privacy Policy'

Optional below

6. _____ I give permission for Jade Chiropractic to contact my other medical provider regarding my condition, treatments, and prognosis.

Provider name_____ Specialty_____Phone number_____

By signing this application I affirm under penalty that I have given true complete information.

Dated _____

_____

Patient Signature

_____

Guarantor Signature / Relationship to Patient

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

_____ DOB _____

Patient's full name

to any chiropractic treatment deemed advisable , if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of _____ and expires _____.

Signature_____

Dr. Adam Bramble
Dr. Molly Ouellette
Chiropractic Physicians
5517 N. Commercial Ave.
Portland, OR 97217
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Patient name: _____ Date: _____
Date of crash: _____ Time of collision: _____ AM PM
Street (location) where crash occurred: _____City: _____
Which insurance company do you use?: _____
What is the MEDICAL claim number associated with your case?: _____
Name and contact number for your claim adjuster?: _____
If needed Insurance company and claim # of other party_____

Vehicle Model, Make and Year:_____ ❒ Unknown
Was the street wet or dry? ❒ Wet ❒ Dry Were you in your own car?: ❒Yes ❒No
What is the estimated repair cost to your vehicle?: $_____ ❒ Unknown ❒ Estimate not done
How many people were in your vehicle at the time of the crash?: _____

Did the police come to the crash scene? ❒ Yes ❒ No
Did the police make a written report? ❒ Yes ❒ No
Were any photographs taken of the vehicles? ❒ Yes ❒ No If yes, who took them?: _____

Describe How the Crash Happened

_____
_____
_____

Collision Description/Type
Check all that apply to you. Indicate which type of automobile crash you were involved in:

❒Single-vehicle crash ❒ Two-vehicle crash ❒ Three-or-more vehicles
❒ Rear-end crash ❒ Side crash ❒ Rollover
❒Head-on or frontal crash ❒ Hit guard rail, tree, or object ❒ Ran off the road
Other (Describe): _____

At the time of the impact, your vehicle was:
❒ Stopped ❒ Moving at steady speed ❒ Slowing down
❒ Gaining speed ❒ Unknown speed ❒ Other: _____

During and after the crash, your vehicle: ❒ Moved slightly forward ❒ Stayed still
❒ Kept going straight, not hitting anything ❒ Spun around ❒ Hit another car
❒ Was hit by another vehicle ❒ Hit object/curb ❒ Other:_____

Seating Position during the accident :
❒ Driver ❒ Passenger
❒ Rear behind driver ❒ Rear center ❒ Rear behind passenger

Indicate if your body hit something or was hit by any of the following:

❒ Windshield or side window ❒Steering wheel ❒ Side of door
❒ Dashboard ❒ Center console ❒ Glove compartment
❒ Contact with other vehicle (hood) ❒ Frame/Pillar near window ❒ Roof or top part of vehicle
❒ Another person in your vehicle ❒ Other: _____

Check if any of the following parts of your vehicle were damaged in the collision:

❒ Windshield ❒ Seat bent or damaged ❒ Dash or area around knee/foot
❒Steering wheel ❒ Side or rear window broken ❒Other: _____
Describe Damage: _____

All types of collisions: *Indicate those relevant to your case.*	Yes	No
Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard on your car dent inward during the crash?	❒	❒
Did the side door, dash, or interior of your vehicle touch or hit your body during the crash?	❒	❒
Did you strike or did any objects or animals within your vehicle hit you during the crash?	❒	❒
Was the door(s) of your vehicle damaged to a point where you could not open the door?	❒	❒
Did an airbag deploy in your vehicle during the crash? If yes, circle: side airbag / front airbag	❒	❒
Did you have any cuts, bruises, or abrasions from the airbag deploying?	❒	❒
Did your seatbelt system require repairs after the crash?	❒	❒
Was the back of your seat that you were sitting in damaged or bent during the crash?	❒	❒
If a side impact, did the front of the other vehicle strike the door next to where you were sitting?	❒	❒

Were you wearing a seatbelt? If yes, does your seatbelt have a:
❒ Lap and shoulder strap ❒ Automatic shoulder strap with driver needing to manually attach lap belt
❒ Lap belt only
Did you have any cuts, bruises or abrasions from the seatbelts? ❒ Yes ❒ No
Were you holding onto the steering wheel (driver only) at the time of impact? ❒ Yes ❒ No

Bruising after the crash?

Did your body have any bruising (areas that were visibly black, red and/or blue) after the crash? ❒Yes ❒ No
If yes, indicate where bruising was located on your body: _____

Awareness and body position descriptions: *Check all areas that apply to you.*

❒ You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
❒ You were aware of the impending crash and relaxed before the collision.
❒ You were aware of the impending crash and braced yourself.
❒ Your body, torso and head were facing straight ahead.
❒ You had your head and/or torso turned at the time of collision:
❒Turned to the left, ❒Turned to the right
Describe how far you were turned/twisted and why you were turned/what were you doing?
_____
How soon did you first notice any pain or soreness after the crash? _____

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Patient Name:_____Date_____

Chief Complaint:
Pain in: □ Head □ Neck □ Arm □ Mid back □ Low back □ Buttock □ Leg
Other_____

History of Present Illness:
When did your pain begin?_____
How did your pain begin? □ No Apparent Reason
□ Bending □ Lifting □ Fall □ Motor Vehicle Accident
□ Other_____
Have you had a similar episode before? □ Yes □ No
Has your pain: □ Improved □ Worsened □ No Change
Is your pain: □ Constant □ Frequent (51-75%)
□ Occasional (26-50%) □ Intermittent (25% or less)
Have you seen another healthcare provider for this problem? □ Yes, diagnosis_____ □ No

Treatment for Your Current Problem:
OTC's: □ Advil / Motrin □ Tylenol □ Aleve
Other_____ Result_____
Steroids: □ Cortisone Pills □ Cortisone Injection
Other_____ Result_____
Other Meds /Results:_____
Injections: □ Epidural □ Facet □ Other_____
Spinal Surgery: □ Yr /Procedure? Result_____
Phys Ther: □ Yr/Procedure/Result_____
Chiropractic: □ Yr/Procedure/Result_____
Other: □ Yr/Procedure/Result_____

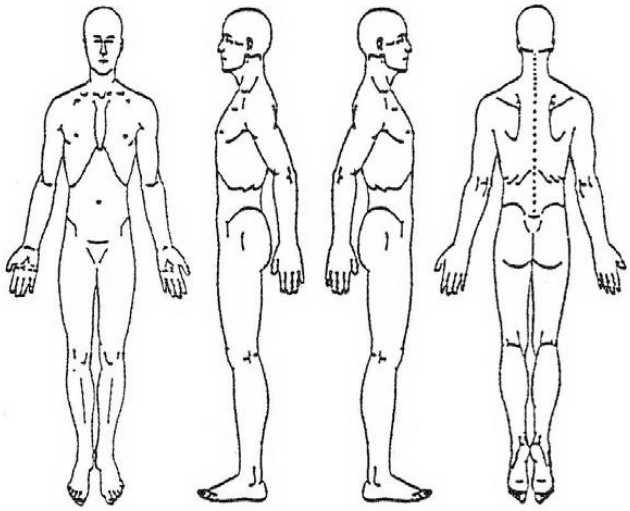
How do the following affect your pain?

	Worse	Better	Same
Cough/Sneeze:	□	□	□
Sitting:	□	□	□
Standing:	□	□	□
Walking:	□	□	□
Lying down:	□	□	□
Sit to Stand:	□	□	□
Turning Head:	□	□	□
Bending:	□	□	□
Lifting:	□	□	□
Morning:	□	□	□
Nighttime:	□	□	□

Date of Test: Test/Results
[ ] X-Ray_____
[ ] MRI_____
[ ] CT_____
[ ] Lab_____
[ ] Other_____
[ ] Physical/ Ob-GYN_____

Pain Level: (Please Circle)
Current - None 0 1 2 3 4 5 6 7 8 9 10 Most Severe
Worst - None 0 1 2 3 4 5 6 7 8 9 10 Most Severe

Please Fill Out the Pain Drawing Below:
>>>> Ache ZZZZ Numbness XXXX Burning
0000 Pins and Needles //// Stabbing



FOR PROVIDER USE ONLY

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Patient Name:_____Date:_____

Known Allergies:_____

Known Diseases:_____

Family Medical History: □ Heart Disease □ Cancer
□ Auto-Immune □ Abnormal Bleeding □ Diabetes
□ Muscle Disease □ Scoliosis □ Arthritis □ RA
□ Other_____
Living Parents? Mother □ Yes □ No; Age_____
(□ Adopted) Father □ Yes □ No; Age_____

Current Work Status:
□ Regular Duty □ Limited/Light Duty Since_____
□ Off Work Since_____

Lifestyle Habits: Tobacco use: □ never □ prior
□ current _____ (Pks/Day) □ Sleep_____(Hrs/Day)
□ Alcohol_____(Drs/Day) □Caffeine_____(Drs/Day)
Do You Regularly Exercise?
□ Yes; Frequency_____ Duration_____
□ No; Last Regular Exercise_____
□ My Condition Currently Prevents Me from Exercising

Past Medical History:
□ Cancer □ Arthritis □ Alcoholism □ Kidney Disease
□ Diabetes □ Seizures □ Lung Disease □ Thyroid
□ Ulcers □ Glaucoma □ Heart Disease □ Tuberculosis
□ AIDS/HIV □ Hepatitis □ Hernia □ Hypertension
□ Stroke □ Anemia □ Pace Maker □ Blood Thinners
□ Other_____
□ Implants_____

Surgeries/Hospitalizations:
Reason_____Year_____
Reason_____Year_____
Reason_____Year_____
Complications_____

Injury/Fracture/Dislocation:
_____Year_____
_____Year_____
_____Year_____

Review of Systems: (Please check all that apply)
Constitutional: □ Fever □ Night Sweats
□ Unexplained Weight Loss / Gain
□ Excessive Fatigue
Eyes: □ Abrupt Change in Vision
ENT: □ Abrupt Change in Hearing
□ Difficulty Swallowing □Sore throat
□ Gum Bleeding/Sensitivity
Cardiovascular: □ Chest Pain □ Poor circulation
□ Swelling
Respiratory: □ Cough □ Difficulty breathing
GI: □ Nausea □ Vomiting □ Bleeding
□ Diarrhea □ Food cravings
□ Hemorrhoids □ Constipation
Musculoskeletal: □ Pain/swollen joints
Skin: □ Rash □ Broken capillaries
Neurologic: □ Dizziness □ Numbness
□ Muscle weakness
Endocrine: □ Hot flashes
□ Heat / Cold Intolerance
□ Excessive Hair Growth / Loss
Blood/Lymph: □ Bruise easy
Genitourinary: □ Burning on urination
□ Urinary frequency
□ Loss of bladder/bowel control
□ Vaginal bleeding □ Uterine cramping
Infection (recent): □ Urinary tract □ Respiratory
□ Skin □ Other_____
Immune system: □ Other _____
Psychosocial: □ Depression □ Anxiety
□ Difficulty sleeping

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

_____
Signature Date

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Consent

Jade Chiropractic is committed to make sure that every patient be informed of the risks of, and the alternatives to, treatment prior to beginning said treatment. We intend this consent form to cover the entire course of treatment for your present condition, and for any future conditions for which you seek treatment at this office.

Jade Chiropractic takes your health and safety very seriously. Every precaution will be taken to assure your comfort and health. Every chiropractic patientôs treatment is unique and your personalized treatment may include some or all of the following treatments and procedures:

-Adjustments of the spine or extremities
-Heat pack/ice pack application
-Massage therapy/Soft tissue manipulation
-Spinal traction
-Craniosacral Therapy
-Neuromuscular re-education
-X-Rays
-Exercise Rehab, stretching, and strengthening
-Nutritional Counseling

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. With chiropractic adjustments the doctor will use his/her hands or a mechanical device in order to adjust your joints. You may hear a ñclick or popò, and you may feel movement of the joint. Though this therapy is unlikely to have negative repercussions, complications may arise occasionally, as any treatment may have unforeseen repercussions.

While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects to treatments include, but are not limited to, soreness, skin discoloration, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments is debated. These rare complications include injury to the arteries in the neck which could lead to stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 ï 2 incidents per million adjustments for adjustments. The exams that are performed by doctors at Jade Chiropractic are aimed at minimizing these risks.

Alternatives to chiropractic care include home exercise and stretching, weight control, medication, care from other medical providers, and choosing to have no treatment. *(None of these options are without risk either.)*
Item(s) of concern & discussion:

_____
_____

_____ (inital) **I accept treatment and have consulted with the doctor regarding any concerns or questions I have regarding the recommended treatment. I have been informed of the risks and notified of alternative care options.**

_____ _____ _____
Patient's Signature **Printed Name** **Date**

I have discussed the procedures, alternatives and risks of the treatment with the patient and have asked them if they have any questions.

_____ _____
Doctor's Signature **Date**