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)

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

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

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_____

Jade Chiropractic • 5517 N Commercial Ave • Portland, Oregon 97217
Phone: 503-223-0900 • Fax: 503-223-1188 • www.JadeChiropractic.com

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_____

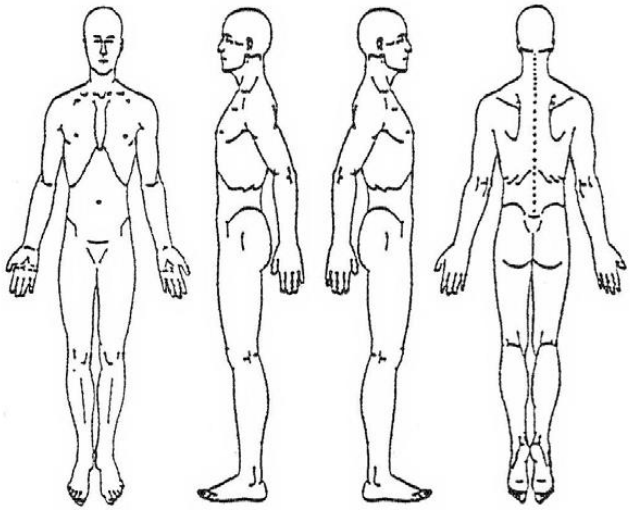
How do the following affect your pain?

	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

Jade Chiropractic • 5517 N Commercial Ave • Portland, Oregon 97217
Phone: 503-223-0900 • Fax: 503-223-1188 • www.JadeChiropractic.com

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

Jade Chiropractic • 5517 N Commercial Ave • Portland, OR 97217
Phone: 503-223-0900 • Fax: 503-223-1188 • www.JadeChiropractic.com

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**