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(optional)_____ 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 – ***Only fill out 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 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 (if patient unable to sign)/ 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 ,

Signature_____ Date _____

I agree to future treatment if a parent or legal guardian is not available when the child is brought in for treatment. _____ intials Date _____

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Dr. Molly Ouellette and Dr. Adam Bramble, chiropractic physicians

Child's name _____ DOB _____ Today's Date _____
Parent's names: _____

PRESENT HEALTH CONCERNS

What is the complaint?_____
When did it first occur? _____
How did this start?_____
How often does the child notice the complaint? Intermittently / Occasional / Frequent / Constant
Since it began, is your problem: Improving / Staying the same / Worsening
Does problem radiate? Yes/ No/ If Yes, where? _____
What makes the problem better:_____
What makes the problem worse: _____
Is the child taking any medications (prescriptions, over the counter or natural) for this problem?
Yes / No; If yes, please list: _____
Has your child ever seen a chiropractic physician before? Yes / No
Name of Chiropractor _____ Date of last visit:_____
Other professionals seen for this condition: _____
Results with that treatment? _____
Recent tests done (list date beside): Bloodwork _____ Urine _____
X-Rays _____ Other: _____

Please circle if your child has had any of the following

Constitutional

weight loss	weight gain	fatigue	fevers
cold sweats	weakness		

Heart/Lungs

Chest pressure	frequent colds	asthma	sinus congestion
sore throats	ear pain/infections	bronchitis	pneumonia
shortness of breath	allergies	difficulty breathing	heart palpitations

Digestion

heartburn	constipation	diarrhea	bloating/gas
urinary problems	spitting up		

Other

headaches	ears buzzing	dizziness	loss of concentration
loss of balance	fainting	poor coordination	vision changes
light sensitivity	loss of smell	loss of taste	

PAST HEALTH HISTORY

Pregnancy and Birth History

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) Yes / No
If yes, please explain _____
Any complications during pregnancy? _____

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Any prescriptions taken during pregnancy? Yes / No _____
What was the child's gestational age at birth? ____ weeks.
Was your child's birth:__ at home __in a birthing center __hospital __other_____
Duration of birth: _____ hours
Was labor: __spontaneous __induced
Assistances used during delivery: __Forceps __Vacuum extraction__ C-section __Episiotomy
Were medications or epidurals given to the mother during birth? Yes / No
What was the baby's position at birth? _____
Were there any complications? Yes / No If Yes, please explain _____
Birth weight _____lbs _____oz Birth length _____ inches
Is there anything else we need to know about the birth? _____

Daily activities
What position does your child sleep in? _____
Was this child breast-fed? Yes / No If yes, how long: _____
Formula introduced at what age: _____
Introduction of cow's milk at what age: _____
Began solid foods at what age: _____
Types of solid foods:_____
Bowel movements per day _____ Urination/wet diapers _____

Injuries and physical stressors
Any falls from beds, change tables, couches, etc? Yes / No
If yes, please explain _____
Any traumas resulting in bruises, cuts, stitches or fractures? Yes / No
If yes, please explain _____
Any hospitalizations or surgeries? Yes / No
If yes, please explain _____

FAMILY HEALTH HISTORY
Have any blood relatives (parents, grandparents, siblings) had any of the following?

Heart Disease	High Blood Pressure	Stroke	Blood Disease
Epilepsy	Rheumatoid Arthritis	Scoliosis	Cancer
Diabetes	Genetic disease		

Authorization
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 child's 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 patient's 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 "click or pop", 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 – 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:

_____

_____

_____ (initial) **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.**

_____	_____	_____	_____
Printed Name	**Patient's Signature**	**Parent/Guardian signature** (if patient is a minor)	**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**