

NEW PATIENT QUESTIONNAIRE

Patient Name: _____ **DOB:** _____

Gender M F **Marital Status** S P M D W **# Children:** _____

Please circle your current health condition: Critical Poor Average Good Great

Medical/Surgical History

Please circle any current or previously diagnosed medical conditions:

- | | | |
|--------------------------|-------------------------|----------------------|
| Alcoholism | Glaucoma | Osteoporosis |
| Allergies | Heart Disease | Pregnancy |
| Anemia | Headaches/Migraines | Psychological |
| Arthritis | Hepatitis/Liver Disease | Reproductive |
| Asthma/Emphysema | High Blood Pressure | Respiratory |
| Broken Bones | High Cholesterol | Seizures |
| Cancer _____ | Hormone Imbalance | Skin Condition _____ |
| Cardiovascular _____ | Immune System _____ | Stress |
| Cataracts | Inflammation | Stroke/TIA |
| Depression | Low Blood Pressure | Swelling |
| Diabetes | Menstrual | Thyroid Disorder |
| Dietary Problems | Muscular _____ | Urinary |
| Endocrine (glands) _____ | Nervous System _____ | Varicose Veins |
| Fibromyalgia | Numbness/Tingling | Other _____ |

Do you have any communicable diseases? _____

Please circle any allergies and describe their associated reactions:

Food _____ Latex _____ Medications _____
Animals _____ Plants _____ Other _____

Please List any past surgeries/dates: _____ **Please List any vitamins/supplements/herbs:** _____

Please list all prescription medications you are currently taking and their doses:

Office Use Only:

Provider signature for LMT or LAc: _____

Patient Name: _____

Please circle if you have experienced any of the following during the past year:

- | | | |
|----------------------------|----------------------------------|-------------------------|
| Personal illness or injury | Major illness or death in family | Death of a close friend |
| Change of residence | Loss of a job | Divorce or separation |
| Retirement | Loss of a pet | Marriage |

Family Health History

Please circle the condition a family member has and indicate the relationship:

- | | | |
|-----------------------|---------------|---------------------------|
| Diabetes _____ | Cancer _____ | High Blood Pressure _____ |
| Depression _____ | Suicide _____ | High Cholesterol _____ |
| Heart Attack _____ | Stroke _____ | Alcoholism _____ |
| Thyroid Disease _____ | Other _____ | |

Current Health History

Please circle any conditions you currently have or had in the past:

- | | | |
|---------------------------------------|------------------------------------|---------------------------|
| Vision or eye changes | Autoimmune Condition | Loss of Libido |
| Trouble swallowing or heartburn | Back, joint, or muscle pain | Problems with your feet |
| Lost or gained 10 pounds recently | Difficulty urinating/holding urine | Swelling of ankles/feet |
| Shortness of breath/coughing fits | Frequent or intermittent dizziness | Difficulty sleeping |
| Chest pain or heaviness with activity | Severe headaches/migraines | Suffered any recent falls |
| Recent change in bowel movements | Tire easily or exhaustion | Hearing or ear conditions |

For Women Only:

- | | |
|--|----------------------------------|
| Abnormal vaginal or menstrual bleeding | Taking birth control or estrogen |
|--|----------------------------------|

For Men and Women:

- | | |
|----------------------------------|--------------------------|
| Breast lumps or nipple discharge | Do a monthly breast exam |
|----------------------------------|--------------------------|

- | | | | |
|-----------------------------------|-----|----|---------------------------|
| Do you eat a special diet? | Yes | No | Description: _____ |
| Do you exercise regularly? | Yes | No | How often? _____ |
| Do you currently smoke? | Yes | No | How much? _____ |
| Have you ever smoked? | Yes | No | Description: _____ |
| Do you chew tobacco? | Yes | No | How often? _____ |
| Do you drink alcohol? | Yes | No | How much? _____ |
| Do you drink caffeine? | Yes | No | How much? _____ |

(Caffeine is in soda, energy drinks, tea, coffee, and many other products.)

Patient Name: _____

Please answer the following questions regarding your appointment today:

Is today's visit due to a motor vehicle crash? Yes No
 Is today's visit due to a on the job injury? Yes No

Have you ever been to a chiropractor before? Yes No
 If yes, when? _____ What for? _____

Have you had recent x-rays taken? Yes No
 If yes, when? _____ Where? _____
 What areas were imaged? _____

Your Primary Physician: _____ Your last physical exam? _____

Do you wear? Heel Lifts Inner Soles Arch Supports Negative Heels Platforms

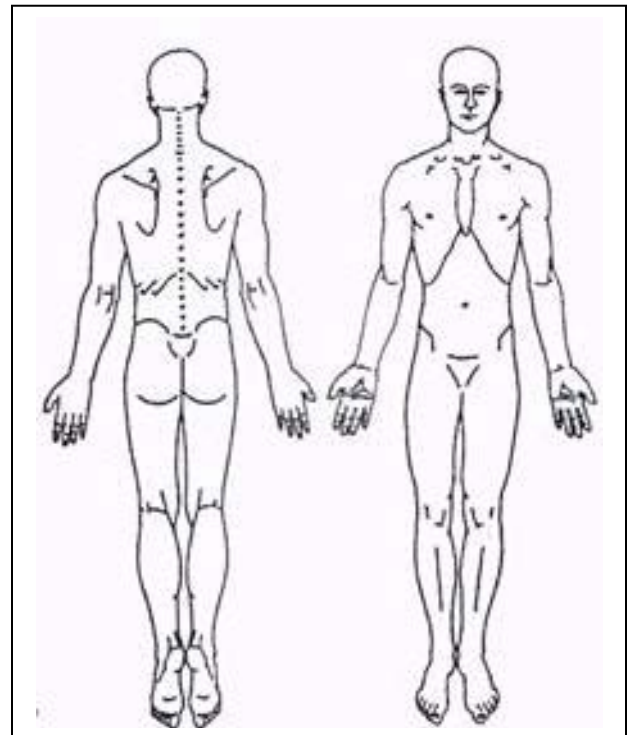
Date your current symptoms appeared: _____

Indicate Where You Are Hurt

Indicate using the symbol key the areas of your body where you are feeling symptoms. If you are experiencing pain that radiates, please use an arrow where it begins and ends.

Ache <<<<	Numbness	Pins & Needles ooooo
Burning XXXX	Stabbing /////	Throbbing ~~~~~

- What is your symptom intensity right now?**
 0 1 2 3 4 5 6 7 8 9 10
None *Unbearable*
- What is your typical or average symptom intensity?**
 0 1 2 3 4 5 6 7 8 9 10
- What is your symptom intensity at its worst?**
 0 1 2 3 4 5 6 7 8 9 10
- How often are your symptoms present?**
 0-25% 26-50% 51-75% 76-100%
- How much do your symptoms interfere with your daily activities?**
 0 1 2 3 4 5 6 7 8 9 10
None *Unable to perform*



Drs Initials _____ Date _____

CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic treatment procedures (including spinal adjustments, ultrasound, heat/cold application, electrotherapy, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise with any procedures intended to help. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are rare and their association with spinal adjustments/manipulation is debated. The patient's best interest combined with known facts will be considered for best judgment regarding these risks. Additional information on the possible side-effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above statements regarding treatment and the possible complications thereof. I also understand that there is no guarantee or warranty for a specific cure or result.

_____ I understand that if I have any prosthetics or surgical implants (including breast implants, artificial joint(s), etc.), I should discuss this with the doctor providing me chiropractic care.

_____ I understand that I play an important role in my own healthcare. Just as a patient can choose to discontinue care at any time, Blyss Chiropractic reserves the right to terminate a doctor/patient relationship if a patient is continually unable to comply with reasonable treatment plans.

_____ I understand that the practitioners at Blyss Chiropractic may terminate the doctor/patient relationship if I miss 3 scheduled appointments without providing 24 hours advanced notice of my cancellation or if I behave inappropriately toward practitioners or clinic staff.

_____ Occasionally, this clinic participates in internships for chiropractic students. This intern may be present in the treatment room during your office visit. You may request privacy at any time.

Patient Name: _____

Signature _____ **Date:** _____

PRIVACY POLICY

Please read this notice carefully as it describes how medical information about you may be used and disclosed and how you can get access to this information.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment and/or health care operations, and for other purposes that are permitted or required by law. It also describes your right to access and control your PHI. "PHI" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health and/or condition and related health services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and/or disclosed by your physician, their office staff, and others outside the office who are involved in your care and treatment for the purpose of providing healthcare services to you, paying your healthcare bills, supporting the operation of the physician's practice, and any other use required by law.

Treatment: We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you to coordinate and/or manage your healthcare and any related services to ensure necessary information is provided to diagnose and/or treat you.

Payment: Your PHI will be used, as needed, to obtain payment from your insurance company for healthcare services provided.

Healthcare Operations: PHI information may be used to support the business activities of your physician's practice. These include quality assessment and improvement activities, review of competence or qualifications of healthcare professionals, evaluation of practitioner and provider performance, and training of healthcare service providers.

As required by law: PHI information may be used or disclosed to certain entities without your authorization when required by law, including for public health reasons (e.g. disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization in writing at any time, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following is a statement of your rights with respect to your PHI:

You have the right to inspect and copy your PHI. Paper copies may be made upon request for a nominal fee. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to a law(s) that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for the notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and for whom you want the restriction to apply. Please note that your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of our PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to amendment. Upon written request explaining the reason, amendments to records can be made. All requests must be approved by the treating physician and will be clearly marked in the files as a patient requested amendment.

Your PHI will not be released to friends and family unless there is written authorization to do so.

You have the right to obtain an accounting of the PHI disclosures we have made.

Your PHI will not be used for marketing communications without written authorization.

Persons involved in care: We may use or disclose health information to notify (or assist in the notification of) a family member, your personal representative or another person responsible for your care, of your location and/or general condition, if necessary. If you are able to authorize this contact, you will have the opportunity to do so. We will use our best judgment and professional experience with common practice to make reasonable decisions regarding your best interest in allowing a person to pick up your PHI for you.



Our Duties and Rights

Our duties consist of the following. We must:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect about you through this Notice
- Abide by the terms of this Notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you have made to communicate health information by alternative means or at alternative locations.

We have the right to:

- Change our Notice of Privacy Practices and the term of this Notice at any time, provided the changes are permitted by law
- Make the changes in our Notice of Privacy Practices effective for all medical information we keep, including information previously created or received before the changes (note: before we make an important change in our privacy practices, we will change this Notice and make the new Notice available upon request).

I have read and understand the contents of this document.

Print Name: _____

Patient/Guardian's Signature: _____ **Date:** _____

NEW PATIENT REGISTRATION

Last Name: _____ **First Name:** _____ **M. I.** _____

Date of Birth: _____ **Gender:** Male Female Other

Weight: (pounds) _____ **Height:** (feet) _____ (inches) _____

Marital Status: Single Married Other **Employment:** Full time Student Part time student

Preferred Language: _____

Do you Smoke: Current Former Never **Frequency:** (per day) _____

Race: American Indian Asian African American White Other: _____

Ethnicity: Non-Hispanic Hispanic Mexican Puerto Rican Unknown

Religion: Non-Religious Atheist Buddhist Christian Hindu Jewish Muslim Other

Address: _____ **Apt #** _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Home Phone:** _____

Email Address: _____

Employment: Full time Part time Student Unemployed

Company Name: _____

Job Title: _____

Work Phone: _____ **Ext:** _____ Check if you do not want to be contacted at work

Emergency Contact

Name: _____ **Relationship to Patient:** _____

Phone Number: _____ **Alt Phone:** _____

Blyss Chiropractic, 111 SW Columbia, Suite 100, Portland, OR 97201

CLINIC ACCOUNT POLICY

Payment is due at the time of service. If necessary, payment plans can be arranged on an individual basis and must be made prior to the visit.

As a courtesy to our patients, we will gladly submit your claim to your primary insurance if we are provided with complete, timely and accurate information. We will accept payment from them directly but any monies owed on your account are ultimately your responsibility. All estimated co-pays, co-insurances and deductibles are due at the time of service.

Insurance policies are a contractual arrangement between an insurance carrier and the insured. It is the patient's responsibility for determining benefits in advance of your treatment and to keep track of the expense and/or visits. Possession of a medical insurance member ID card is **NOT** a guarantee of coverage. Payment is subject to the terms and conditions of your policy. In the event we are not paid in full by your insurance company (less any contractual write offs we are to take with insurances we are contracted with) you will be balanced billed any remaining charges after your insurance has addressed a claim and required to pay us directly and work out your difficulties with your insurance carrier. These balances can include but are not limited to deductibles, co-pays, co-insurance, amounts billed over your insurance allowable, and charges not covered by your policy. If you have a credit balance, we will reimburse you after payment is received.

If your insurance requires a referral for chiropractic care, you are responsible for obtaining this prior to your visits. Any visits that are not covered by the referral are the patient's financial responsibility.

All supplies, durable medical equipment and supplements must be paid for at the time they are received by the patient.

Personal Injury/Motor Vehicle Collisions

All expenses from personal injury and motor vehicle collision cases will be submitted to your auto insurance company providing the appropriate paperwork has been filled out and a claim filed. **Please note that your claim MUST be activated before your insurance will pay for services.** If you have not done this yet, be sure all appropriate paperwork is filled out and sent in to your PIP (personal injury protection) carrier within 72 hours of receiving care.

If you choose not to fill out this paperwork, you must pay at the time of service for care and be reimbursed by any insurance company involved.

Worker's Compensation Claims

All expenses from worker's compensation claims will be submitted directly to the insurance company providing the appropriate paperwork has been filled out and a claim filed. If the claim is denied, we will bill your private insurance carrier, if you have coverage. Please keep in mind if your claim is denied, you are responsible for prompt payment of your account.

Self Paying Patients

Patient's paying cash in full at the time of service will receive a 20% discount. If, at a later date, insurance billings are asked to be done, this discount will be added back prior to any billing being done.

I have read, understand and agree with the above financial policy, and hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, private insurance and all other health plans to Blyss Chiropractic.

Patient/Guardian's Signature: _____ **Date:** _____