Affinity Chiropractic
attracting health

1900 Main St. Ste. D
Klamath Falls, OR 97601
(541)887-8555

Confidential Patient Information

_____/_____/_____
DATE

_____ M ____ F____
NAME

_____/_____/_____ _____ _____
BIRTHDATE AGE SSN#

_____ _____ _____
HOME ADDRESS CITY ZIP

_____ _____ _____ _____
HOME PHONE WORK PHONE CELL PHONE E-MAIL

_____
MAILING ADDRESS (if not same)

_____ _____ _____
OCCUPATION EMPLOYER HOW LONG

_____ _____ _____
EMPLOYERS ADDRESS CITY ZIP

Marital Status (circle): Single Married Divorced Separated Widowed _____
SPOUSES NAME (if applicable)

Method of Payment (circle): Cash/Card Ins Medicare Auto Ins Other

How did you learn of our office: yellow pages TV radio Internet Other:_____ referred by: _____

Emergency Information
Who should we contact in case of an emergency? _____

_____ _____ _____
Home Phone Work Phone Cell Phone

Reason For Your Visit
What concern(s) brought you to our office: _____

Is this a documented injury? Y___ N____ If so, what type? Work comp____ Auto Accident___ other:_____

Have you had chiropractic care for this concern? Y____ N____ If yes, results:_____

_____

Other doctors seen for this concern:_____

Health History
What medications are you taking and what are they for?

_____
_____
_____

List any allergies:_____
_____

List previous injuries/ fractures:_____
_____

List previous surgeries/
hospitalizations:_____
_____

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Patient's Name:_____ DOB: _____ Date:_____

Past illnesses of yourself and/or family: (check box S for self; check box F for family**; write down who in the family has the history: M = mother, F = father, S = sibling, GP = grandparent)**

S	F		S	F		S	F	
□	□	Anemia	□	□	High blood pressure	□	□	Stroke
□	□	Arthritis	□	□	High cholesterol	□	□	Thyroid disease
□	□	Asthma	□	□	Kidney disease	□	□	Tuberculosis
□	□	Cancer/tumor	□	□	Liver disease/Hepatitis	□	□	Ulcers
□	□	Diabetes	□	□	Lung disease	□	□	Immune disorder or disease
□	□	Epilepsy/seizures	□	□	Osteoporosis	□	□	Other:_____
□	□	Glaucoma	□	□	Phlebitis			
□	□	Heart disease	□	□	Psychological problem type:_____			

Review of systems: Please indicate if any of the following relate to your health

General

□ Weight loss
□ Fatigue
□ Fever

Head

□ Headache
□ Trauma/concussion

Eyes

□ Glasses/contacts
□ Eye pain
□ Double vision
□ Cataracts

Ears, nose, throat

□ Difficulty hearing
□ Ringing in the ears
□ Vertigo/dizziness
□ Sinus problems
□ Swollen glands
□ Frequent sore throat
□ Sleep apnea
□ Mouth sores

Cardiovascular

□ Murmur
□ Chest pain
□ Palpitations
□ Aneurysm
□ Fainting
□ Heart surgery
□ Swelling in ankles

Respiratory

□ Shortness of breath
□ Cough
□ Coughing blood
□ Wheezing

Gastrointestinal

□ Heartburn/reflux
□ Nausea/vomiting
□ Constipation
□ Hiatal hernia
□ Blood in stool
□ Diarrhea
□ Abdominal pain

Genitourinary

□ Burning urination
□ Frequent night urination
□ Blood in urine
□ Difficult urination
□ Kidney stones

Musculoskeletal

□ Joint pain/swelling
□ Stiffness
□ Muscle pain
□ Gout
□ Implants/artificial joints
□ Back/neck pain
□ Upper extremity pain
□ Lower extremity pain
□ Other pain: _____

Skin

□ Rashes
□ Sores/lesions
□ Dryness
□ Itching/burning

Neurological

□ Loss of strength
□ Numbness/tingling
□ Transient ischemic attack
□ Stroke
□ Tremors
□ Memory loss
□ Paralysis

Endocrine

□ Heat/cold intolerance
□ Hair loss
□ Hormone therapy

Blood/lymph

□ Blood disease
□ Easy bruising/bleeding
□ Swollen lymph nodes

Allergic/Immune

□ Immune disease/disorder
□ Anaphylaxis

Tobacco use? No____ Yes_____ Past use? _____ Type & frequency:_____

Do you have children? Y___ N___ If yes, what ages? _____

Women only:

Menstrual cramping/pain (please circle 0 = none, 5 = severe): 0 1 2 3 4 5
Are you pregnant? Y___ N___ If yes, how long? _____
Are you nursing? Y___ N___

The above information is correct to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my medical status.

Signature:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES

I understand and have read and/or been provided with a copy, at my request, of the ***Notice of Privacy Practices*** brochure that provides a more complete description of information uses and disclosures.

The patient identified above authorizes Affinity Chiropractic to use and or disclose protected health information in accordance with the following:

SPECIFIC AUTHORIZATIONS

- ✓ I give permission to Affinity Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday/holiday cards, and information about treatment alternatives or other health related information.
- ✓ If Affinity Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine, voicemail, or with a person in my household.
- ✓ I give Affinity Chiropractic permission to treat me in an open room where other patients may overhear some of my protected health information during the course of care. Should I need to speak with the doctor, at any time, in private or prefer a closed treatment room, the doctor will be happy to provide a private room for these conversations and/or treatments.
- ✓ I authorize Affinity Chiropractic to discuss my treatment, schedule, or account information with:
  Spouse:_____ Family:_____
  Other:_____
- ✓ By signing this form, you are giving Affinity Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The authorization will expire seven years after the date upon which it was signed.

This authorization is requested by Affinity Chiropractic for its own use/disclosure of PHI (protected health information). You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Affinity Chiropractic will not refuse to provide treatment. You have the right to inspect or copy the PHI to be used/disclosed.

A COPY OF THIS SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON YOUR REQUEST.

ADDITIONAL DOCUMENTATION

I have been provided with a copy of the Financial and Office Policies for Affinity Chiropractic. I understand my obligations to comply with these policies and all questions regarding these policies have been answered to my complete satisfaction.

I have been provided with a copy of the Fee Schedule for Affinity Chiropractic.

_____ _____
Patient signature Date

_____ _____
Legal guardian signature-relationship to patient Date

Fee Schedule-Cash/Medical Insurance Patients

Welcome to Affinity Chiropractic we are pleased to provide you with quality chiropractic care at the following rates:

Service	Fee
Initial examination & report of findings (no adjustment)	$90-180
Initial examination, report of findings, first adjustment	$135-240
Office visit – spinal adjustment only	$45
Office visit – extra-spinal adjustment	$15
Office visit - No adjustment	$45
Re- examination	$70-90
Self care / rehab instruction (in office-15 min)	$55
Cold laser	$20
Neuromuscular re-education	$40
Custom orthotic management	$40

Please ask about discounted pre-payment options and family wellness packages.

Financial and Office Policies

Financial Responsibilities

- Payment is due at time of service.
- Initial visit is paid in full at time of service.
- If you do not attend and do not cancel a scheduled appointment, you will be assessed a $25.00 "no show fee". This fee must be paid prior to any further appointments being scheduled.
- We bill insurance as a courtesy to our patients once insurance has been qualified. We will bill secondary insurance companies on a case by case basis based on the types of insurances involved. Patients are responsible for all deductibles and co-payments. You are responsible for any amount that is not paid by your insurance company.
- There is a $25.00 Charge for any returned checks.
- If an account has gone 90 days without a payment, the account will be sent to collections.
- If care is discontinued for any reason, account balance is to be paid in full.
- Payment plans are available and will be presented to you with your exam results.

Office Policies

- We know that your time is valuable, so we strive to see all patients at their scheduled time. In return, we expect you to be on time.
- If you should need to cancel an appointment please call the office 2 hours prior to scheduled time, this will allow another patient to be seen in that time slot.
- You may be terminated as a patient in our office if you choose to No Call/No Show more than 3 times in a month's period.
- Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to getting to know you and your family.

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Patient's Name:_____ DOB: _____ Date:_____

Informed Consent to Chiropractic Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Signature:_____ Date:_____

Witness Name:_____ Signature:_____ Date:_____

Authorization For Care of Minor (sign only for care of a child)

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

I clearly understand and realize that I am responsible for all fees charged by this office and I agree to pay for all services provided.

_____ _____

Signature Date

_____ _____

Witness signature Date

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Patient's Name:_____ DOB: _____ Date:_____

Complaint history form

Symptom:_____

- On a scale of 1-10, with 10 being the worst, please circle the number that indicates your pain level for the symptom most of the time? 1 2 3 4 5 6 7 8 9 10
- What percentage of the time that you are awake do you experience the symptom at the above intensity?
  Less than 25% 25-50% 50-75% 75-100%
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (check all that apply)
  □Bending neck forward □Bending neck backward □Tilting head to the left □Tilting head to the right □Turning head to the left □Turning head to the right □Bending forward at waist □Bending backward at waist □Tilting left at waist □Tilting right at waist □Twisting left at waist □Twisting right at waist □Sitting □Standing □Getting up from sitting □Lifting □Driving □Walking □Running □Deep breathing □Pushing □Pulling □Nothing □Other please describe:
  _____
- What makes the symptom better? (check all that apply)
  □Rest □Ice □Heat □Stretching □Exercise □Massage □Pain medication □Muscle relaxers □Nothing □Other: _____
- Describe the quality of the symptom? (check all that apply)
  □Sharp □Dull □Achy □Burning □Numb □Tingling □Throbbing □Stabbing □Deep □Shooting □Stinging □Other (please describe): _____
- Does the symptom radiate to another body part? (please circle) Yes No
  - If yes, where does it radiate:_____
- Is the symptom worse at different times of the day or night? (please check all that apply)
  □Morning □Afternoon □Evening □Night □Unaffected by time of day

Symptom:_____

- On a scale of 1-10, with 10 being the worst, please circle the number that indicates your pain level for the symptom most of the time? 1 2 3 4 5 6 7 8 9 10
- What percentage of the time that you are awake do you experience the symptom at the above intensity?
  Less than 25% 25-50% 50-75% 75-100%
- When did the symptom begin? _____
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  _____
- What makes the symptom better? (check all that apply)
  □Rest □Ice □Heat □Stretching □Exercise □Massage □Pain medication □Muscle relaxers □Nothing □Other: _____
- Describe the quality of the symptom? (check all that apply)
  □Sharp □Dull □Achy □Burning □Numb □Tingling □Throbbing □Stabbing □Deep □Shooting □Stinging □Other (please describe): _____
- Does the symptom radiate to another body part? (please circle) Yes No
  - If yes, where does it radiate:_____
- Is the symptom worse at different times of the day or night? (please check all that apply)
  □Morning □Afternoon □Evening □Night □Unaffected by time of day