PORTLAND
BACKSMITH
CHIROPRACTIC
★★★★★
EST. 2006

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CONFIDENTIAL PATIENT INFORMATION

Contact Information

Full Name: _____
Address: _____
City/State/Zip: _____
Phone Number: _____ (Home / Work / Mobile)
Email: _____

How did you hear about us? Yelp Google Referral Other
Who can we thank for referring you to our office? _____

Personal Information

Date of Birth: _____ Age: _____
Marital Status: Married / Single / Widow / Divorced
Name of Spouse: _____
Pregnant?: Yes / No Do you have children?: Yes / No If Yes, how many?: _____
Employer: _____ Occupation: _____

Insurance Information

Have you been involved in an accident at home, work or auto?: **Yes / No**
Do you have insurance that covers Chiropractic?: Yes / No / Not Sure

Health Concerns (Please list your health concerns according to their severity)

Concern 1: _____
_____
Onset (When did it start?): _____ Is it related to a specific injury?: Yes / No
How frequently do you experience the symptoms?: Constantly / Daily / Intermittently
Rate Severity: Mild 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Severe
Quality (Sharp, dull, achy, stabbing, shooting, etc: _____
Radiation (Does it radiate to other areas?) _____
What makes it better?: _____
What makes it worse?: _____
Have you experienced this condition before? If so, when?: _____
_____
Are you experiencing numbness or tinging?: _____
Does it hurt when you cough or sneeze?: _____

Full Name: _____ Date of Birth: _____

Health Concerns Continued (Please list your health concerns according to their severity)

Concern 2: _____

_____

Onset (When did it start?): _____ Is it related to a specific injury?: Yes / No
How frequently do you experience the symptoms?: Constantly / Daily / Intermittently
Rate Severity: Mild 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Severe
Quality (Sharp, dull, achy, stabbing, shooting, etc: _____
Radiation (Does it radiate to other areas?): _____
What makes it better?: _____
What makes it worse?: _____
Have you experienced this condition before? If so, when?: _____
_____
Are you experiencing numbness or tinging?: _____
Does it hurt when you cough or sneeze?: _____

Concern 3: _____

_____

Onset (When did it start?): _____ Is it related to a specific injury?: Yes / No
How frequently do you experience the symptoms?: Constantly / Daily / Intermittently
Rate Severity: Mild 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Severe
Quality (Sharp, dull, achy, stabbing, shooting, etc: _____
Radiation (Does it radiate to other areas?): _____
What makes it better?: _____
What makes it worse?: _____
Have you experienced this condition before? If so, when?: _____
_____
Are you experiencing numbness or tinging?: _____
Does it hurt when you cough or sneeze?: _____

List other doctors you have seen for these condition(s): _____
"Limited Scope" Chiropractor (Focuses on neck and back pain): Yes / No
"Wellness' Chiropractor (Focuses on health and wellbeing and underlying cause of pain): Yes / No
Medical Doctor: Yes / No
Dentist: Yes / No
Other (Please explain): _____

Full Name: _____ Date of Birth: _____

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Providing detailed information will help us create an effective and efficient treatment plan.

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition or concern? (i.e. eat better, less alcohol or drugs, meditations, change of aggressive sports or activities) If so, please explain: _____

_____

_____

Is this condition interfering with any of the following? (i.e. work, daily routine, sports & exercise, other) If so, please explain: _____

_____

_____

General Medical History

Have you had any surgery?: Yes / No

Please indicate the type of surgery as well as when it occurred:

1. _____
2. _____

Have you received treatment for any illnesses or injuries in the past year? Yes / No

If yes, please explain: _____

_____

Have you had any accidents and/or injuries? (Auto, work-related or other): Yes / No

Please indicate, especially those related to present concern:

Accident: _____ When: _____ Hospitalized: Yes / No

Accident: _____ When: _____ Hospitalized: Yes / No

Accident: _____ When: _____ Hospitalized: Yes / No

Have you ever taken X-Rays?: Yes / No

If yes, which areas of the body: _____ When: _____

Do you wear orthotics or heel lifts?: Yes / No

Current medicines, Supplements, & Medical Care

Please list any prescription or non-prescription medications or drugs you have taken in the last 6 months: _____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

_____

Please list any other health care providers you have seen in the last 6 months:

_____

Full Name: _____ Date of Birth: _____

Stressers

Because accumulation of stress affects our health and ability to heal, please list the top three stresses you have ever had in each category.

Physical Stress (Falls, accidents, work posture, etc): _____

_____

_____

Bio-chemical stress (Smoking, unhealthy foods, missed meals, dehydration, recreational drugs/alcohol): _____

_____

_____

Psychological, mental or emotional stress (Work, relationships, finances, self-esteem): _____

_____

_____

Rate your current levels of stress, considering physical, bio-chemical, and emotional stresses:

At Work: Mild 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Severe

At Home: Mild 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Severe

At Play: Mild 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Severe

Please rate the following:

Eating Habits:	Very Poor 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Excellent
Exercise Habits:	Very Poor 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Excellent
Sleep:	Very Poor 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Excellent
General Health:	Very Poor 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Excellent
Mindset:	Very Poor 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Excellent

How would you grade your overall physical health?:

Excellent Good Fair Poor Getting Better Getting Worse

How would you grade your overall mental/emotional health?:

Excellent Good Fair Poor Getting Better Getting Worse

What are some of your hobbies/interests?: _____

_____

_____

Is there anything else not discussed which may help to better understand your concerns?:

_____

_____

Full Name: _____ Date of Birth: _____

Do you have a current X-Ray?

A current X-Ray can be beneficial and aide in our ability to make recommendations for treatment. We will outline the benefits of having a current X-Ray during your exam.

Please select one of the following:

_____ I have a current X-Ray. I will provide a signed release so that Portland Backsmith may request them.

_____ I do not have a current X-Ray. I will consult with Portland Backsmith for a prescription.

_____ I do not have a current X-Ray. At this time I am denying X-Ray services.

The current HIPPA privacy policy act is available on view in our waiting area.
I am aware copies are available upon my request.

Signature: _____ Date: _____

____I request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies recommended by the doctor of chiropractic and/or other licensed doctors of chiropractic and support staff employed by Portland Backsmith Chiropractic LLC.

____I understand and I am informed that results are not guaranteed and there is no promise to cure. I further understand and I am informed that in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains.

____I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

____ By signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient:_____

Name Printed of Parent/Guardian: _____

Guardian/Parental Signature:_____

Date:_____