



P O R T L A N D

CHIROPRACTIC · NEUROLOGY

WELCOME TO OUR OFFICE

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring other patients

We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker's compensation

You have the right to:

- Request a copy of your health record
- Request a list of whom we share your health information with
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your protected health information

These privacy practices are effective: _____

For further information please contact: _____

Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individual treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described.

Patient or guardian signature

Date



P O R T L A N D

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PATIENT REGISTRATION

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

Confidential Health Information

Clinic ID:

Date:

1 PATIENT CONTACT

last name	first name	m.i.	preferred to be called
street			
city		state	zip
home phone		mobile phone	
work phone		e-mail	

2 PATIENT PERSONAL

age	date of birth	social security #			
sex: <input type="checkbox"/> male <input type="checkbox"/> female	status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> partnered <input type="checkbox"/> widowed <input type="checkbox"/> separated <input type="checkbox"/> divorced				

3 EMERGENCY CONTACT

name	home phone
relationship	work phone

4 SPOUSE OR GUARDIAN

last name	first name	m.i.
employer name		
work phone	date of birth	social security #

5 PATIENT EMPLOYMENT

employer name	occupation
street	
city	state zip

Which one of our patients referred you to our clinic? _____

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services
- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost.

Patient or guardian signature

Date



P O R T L A N D

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ACCOUNT INFORMATION

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

Confidential Health Information

Clinic ID: _____

Date: _____

1 PATIENT INFORMATION

last name _____ first name _____ m.i. _____ preferred to be called _____
 age _____ date of birth _____ social security # _____ sex: male female

Are you here because you were involved in a vehicle collision? yes no
 Are you here because you were injured at your place of employment? yes no
 Are you here because you were involved in another type of accident? yes no
 Who is responsible for this account? _____
 Will you be using health insurance to supplement payment to our office*? yes no

*If YES, please complete the INSURANCE COVERAGE and INSURED INFORMATION sections of this form.

2 INSURANCE COVERAGE

type of insurance: employee group health plan personal health insurance health savings account Medicare Medicaid
 personal injury worker's compensation TRICARE/CHAMPUS CHAMPVA FECA

primary insurance company _____ primary ins ID# _____ primary ins group# _____
 secondary insurance company _____ secondary ins ID# _____ secondary ins group# _____

3 INSURED INFORMATION

Are the insured and patient the same person? yes no If YES, do **not** complete section 3.

last name _____ first name _____ m.i. _____
 street _____
 city _____ state _____ zip _____
 age _____ date of birth _____ social security # _____ sex: male female
 relationship to insured: spouse dependent Other _____

We are here to service our patients the best way we know how. We understand the value of health insurance. However, because health insurance plans are intended only to supplement out of pocket expenses for care, it may not cover all the care you need. We will verify your applicable insurance benefits and report the supplemental coverage to you.

Our relationship is with each patient individually, not the insurance companies. If we believe that we may be able to help you and we accept your case, our recommendation will be based on what we believe is best for you – supported by our experience. We take great care in making our services affordable regardless of health insurance coverage.

I understand and agree to the following:

- There is no guarantee that my health insurance plan or policy will pay for all or part of my care
- I will be informed of fees and charges before the associated procedure or service is performed
- As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered

 Patient or guardian signature

 Date



P O R T L A N D

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PATIENT CASE HISTORY

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

Confidential Health Information

Clinic ID: _____

Date: _____

1 PATIENT INFORMATION

last name _____ first name _____ m.i. _____ preferred to be called _____

2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident? yes no

What services interest you? (mark all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> injury prevention | <input type="checkbox"/> treatment for pain | <input type="checkbox"/> patient education classes |
| <input type="checkbox"/> balance and coordination training | <input type="checkbox"/> spinal and body alignment | <input type="checkbox"/> body composition counseling |
| <input type="checkbox"/> range of motion, mobility, or flexibility therapy | <input type="checkbox"/> strengthening and stamina exercise | <input type="checkbox"/> nutritional and supplement counseling |
| <input type="checkbox"/> other: _____ | | |

What is your **primary** complaint? _____

- How long have you been experiencing this **primary** complaint? _____
- How does the **primary** complaint feel? dull/achy sharp numb tingling burning cold
- How often do you exercise the **primary** complaint? constantly daily weekly monthly yearly
- Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

1 no pain or discomfort	2 slight discomfort	3 pain that does not affect my activity	4 pain that affects my daily activities	5 pain that prevents performing my daily activities	6 pain that limits my work schedule	7 pain that prevents working at all	8 pain that prevents working and all personal activity	9 pain that keeps me bed ridden	10 pain that causes thoughts of suicide
-----------------------------------	-------------------------------	---	---	---	---	---	--	---	---

If you have missed work because of your **primary** complaint, what was your last day of work? _____

What do you believe is causing your **primary** complaint? _____

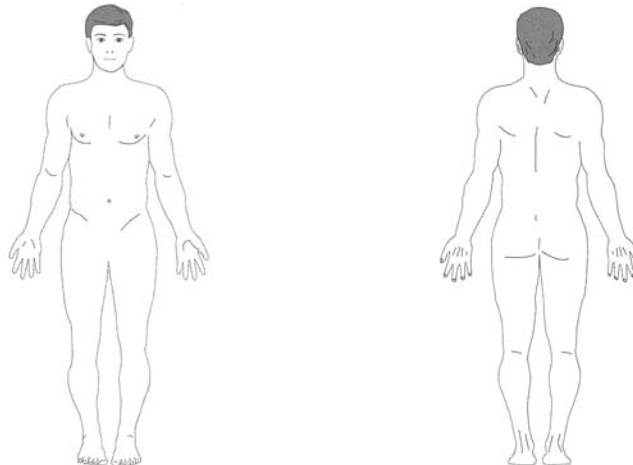
List other health complaints (2-5) on the following lines.

2 _____ 4 _____
3 _____ 5 _____

Do you have any other condition other than what brings you here? yes no

If YES, list it here: _____

Please mark the areas of all of your complaints on the diagrams to the right. Include any descriptors or comments, concerning your health complaints that were not mentioned above.



3 LIFESTYLES & HABITS

How many hours of television do you watch a day? < 1 1-3 3-5 > 5

Do you usually snack while watching television? yes no

How many hours per day do you use a computer at work or home < 1 1-3 3-5 > 5

How many hours per day do you ride in a car or other vehicle? < 1 1-3 3-5 > 5

How often do you exercise? Daily 3x's/week 2x's/week 1x/week I don't exercise

How long do your exercise work outs last? >1 hour 1 hour 30 minutes < 30 minutes n/a

What are your exercise activities? (mark all that apply) I don't exercise

Walking swimming weight lifting

Stretching/flexibility yoga/Pilates resistance bands

Running/treadmill/rowing/climbing group exercise classes other _____

Do you take a multi-vitamin? yes no If YES, what brand do you take? _____

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1 _____		3 _____	
2 _____		4 _____	

How often do you use tobacco? never daily weekly monthly yearly

How many servings of alcohol do you drink each week? 0 1-2 3-5 >5

How many servings of coffee do you drink each week? 0 1-2 3-5 >5

How many servings of soda do you drink each week? 0 1-2 3-5 >5

4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

diabetes	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c
heart problems	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c
kidney problems	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c
cancer	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c
headaches	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c
back pain	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c
obesity	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c
poor conditioning	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c

5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism <input type="checkbox"/> yes <input type="checkbox"/> no	epilepsy <input type="checkbox"/> yes <input type="checkbox"/> no	low back pain <input type="checkbox"/> yes <input type="checkbox"/> no	polio <input type="checkbox"/> yes <input type="checkbox"/> no
anemia <input type="checkbox"/> yes <input type="checkbox"/> no	goiter <input type="checkbox"/> yes <input type="checkbox"/> no	measles <input type="checkbox"/> yes <input type="checkbox"/> no	rheumatic fever <input type="checkbox"/> yes <input type="checkbox"/> no
appendicitis <input type="checkbox"/> yes <input type="checkbox"/> no	heart disease <input type="checkbox"/> yes <input type="checkbox"/> no	mental disorder <input type="checkbox"/> yes <input type="checkbox"/> no	tuberculosis <input type="checkbox"/> yes <input type="checkbox"/> no
arthritis <input type="checkbox"/> yes <input type="checkbox"/> no	HIV positive <input type="checkbox"/> yes <input type="checkbox"/> no	mumps <input type="checkbox"/> yes <input type="checkbox"/> no	venereal infection <input type="checkbox"/> yes <input type="checkbox"/> no
cancer <input type="checkbox"/> yes <input type="checkbox"/> no	influenza <input type="checkbox"/> yes <input type="checkbox"/> no	pleurisy <input type="checkbox"/> yes <input type="checkbox"/> no	whiplash <input type="checkbox"/> yes <input type="checkbox"/> no
		pneumonia <input type="checkbox"/> yes <input type="checkbox"/> no	whooping cough <input type="checkbox"/> yes <input type="checkbox"/> no

6 INJURIES

List any **auto collisions** that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____

List any **job injuries** that you experienced below. Begin with the most recent.

type of job injury	type of treatment received	date of job injury
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____

List any **sports injuries** that you experienced below. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____

List any **other injuries** that you experienced below. Begin with the most recent.

type of injury	type of treatment received	date of injury
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____

7 HOSPITAL/MEDICINE

- Have you had breast implant surgery? yes no
- Have you had knee or hip replacement surgery? yes no
- Do you have a pacemaker? yes no
- Do you have any other implantable medical devices in your body? yes no

Mark all of the following procedures as they pertain to you.

vaccinations <input type="checkbox"/> yes <input type="checkbox"/> no	tubes in ears <input type="checkbox"/> yes <input type="checkbox"/> no	rectal surgery <input type="checkbox"/> yes <input type="checkbox"/> no
tonsillectomy <input type="checkbox"/> yes <input type="checkbox"/> no	appendectomy <input type="checkbox"/> yes <input type="checkbox"/> no	hernia surgery <input type="checkbox"/> yes <input type="checkbox"/> no
gall bladder removal <input type="checkbox"/> yes <input type="checkbox"/> no	female/male surgery <input type="checkbox"/> yes <input type="checkbox"/> no	thyroid surgery <input type="checkbox"/> yes <input type="checkbox"/> no
back surgery <input type="checkbox"/> yes <input type="checkbox"/> no	_____	stomach surgery <input type="checkbox"/> yes <input type="checkbox"/> no

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1 _____	_____	3 _____	_____
2 _____	_____	4 _____	_____

- Have you ever had a lapse of memory? yes no
- Were you ever knocked unconscious? yes no
- List any broken bones or dislocations that you had. _____
- Have you ever had a spinal tap or spinal injection? yes no

8 SYSTEM REVIEW

Mark the following conditions that are currently a cause of significant concern for you.

- General
- consistent fainting
 - loss of weight
 - weight gain
 - chills
 - fatigue
 - neuralgia
 - convulsions
 - fever
 - night sweats
 - depression
 - headache
 - wheezing
 - dizziness
 - loss of sleep
 - nervousness
- Gastro-Intestinal
- constipation
 - liver problems
 - rectal bleeding
 - diarrhea
 - nausea
 - vomiting
 - gall bladder problems
 - stomach pain
 - vomiting blood
 - hemorrhoids
 - poor appetite
 - jaundice
 - poor digestion
- Eye/Ear/Nose/Throat
- asthma
 - ear noises
 - nasal obstruction
 - sore throat
 - crossed eyes
 - enlarged thyroid
 - nose bleeds
 - tonsillitis
 - deafness
 - frequent colds
 - pain in eyes
 - earache
 - hay fever
 - poor vision
 - ear discharge
 - hoarseness
 - sinusitis
- Respiratory
- chest pain
 - chronic cough
 - difficulty breathing
 - spitting blood
 - spitting phlegm
- Muscles/Joints/Bones
- backache
 - spinal curvature
 - foot problems
 - swollen joints
 - pain bet. shoulders
 - tremors
 - painful tailbone
 - twitching
 - stiff neck
 - weakness
- Cardio-Vascular
- ankle swelling
 - poor circulation
 - high blood pressure
 - rapid heart
 - low blood pressure
 - slow heart
 - heart trouble
 - strokes
 - pain over heart
- Skin or Allergies
- bruise easily
 - sensitive skin
 - dryness
 - eczema
 - hives
 - itching
- Women
- cramps
 - excessive flow
 - hot flashes
 - irregular cycle
 - painful periods

9 PREGNANCY WOMEN ONLY

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant? yes no On what date did your last period begin? _____

Do you want to take a pregnancy test now? yes no OFFICE USE ONLY – result of clinic pregnancy test: + -

Mark the following situations as they pertain to you.

- tubal ligation yes no complete or partial hysterectomy yes no
- less than 10 days since the start of my last period yes no partner had a vasectomy yes no
- taking birth control pills yes no

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request.

Patient or guardian signature

Date



IN CONSIDERATION OF YOUR AGREEMENT TO TREAT ME, I AGREE TO THE FOLLOWING:

1. Authorization to release information:

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney and/or adjustor in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Dated the ___ day of _____, 20 _____

 (Patient Signature)

2. Authorization to pay directly to the doctor:

In consideration of the services rendered in the amount of \$____ to date, and any future services to be rendered by the doctor, I authorize and direct payment to Dr. Aaron MacArthur, DC any sum I owe now or hereafter owe, by my attorney and/or insurance company, out of the proceeds of any settlement of my case and/or insurance obligation to reimburse me in whole or in part for the charges made for services.

Dated the ___ day of _____, 20 _____

 (Patient Signature)

3. Acknowledgement and understanding:

I hereby acknowledge that I received health care services from Dr. Aaron MacArthur, DC. I understand that if it is determined either:

- a) There is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the doctor; or
- b) If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney;

Then payment in the amount of \$_____ for services rendered by Dr. Aaron MacArthur, DC will be made by me.

Dated the ___ day of _____, 20 _____

 (Patient Signature)