5922 NE Killingsworth St
Portland, OR 97218
503-788-6800

PATIENT INFORMATION

Date: _____

Patient: _____

Address: _____

City, State, Zip: _____

Email (print clearly):_____

Sex: ❒ M ❒ F Age:_____ Birthdate: _____

❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Patient SSN: _____

Occupation: _____

Employer:_____

Employer Phone: _____

Spouse's Name:_____Birthdate: _____

Occupation:_____

Spouse's Employer: _____

Who may we thank for referring you? ❒ Website ❒ Internet ❒ Insurance Plan ❒ Friend ❒ Other _____

PHONE NUMBERS

Home:_____Cell:_____

Work:_____ Ext:_____

Best time and place to reach you: _____

IN CASE OF EMERGENCY CONTACT:

Name:_____ Relationship:_____

Home Phone:_____Work Phone:_____

Cell: _____

INSURANCE

Who is responsible for this account?_____

Relationship to Patient:_____

Insurance Co:_____

ID #:_____

Group #:_____

Subscriber's Name (if other than patient): _____

Birthdate:_____ SSN:_____

Relationship to Patient:_____

Is patient covered by additional insurance? ❒ Yes ❒ No

Assignment and Release:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Joseph Medlin, DC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

Responsible Party Signature: _____

Relationship:_____Date:_____

ACCIDENT INFORMATION

Is condition due to an accident? ❒ Yes ❒ No

Date of Accident: _____

Type of Accident ❒ Auto ❒ Work ❒ Home ❒ Other

To who have you made a report of your accident?

❒ Auto Insurance ❒ Employer ❒ Worker's Comp ❒ Other

Attorney name (if applicable): _____

PATIENT CONDITION

Reason for visit:_____

When did your symptoms appear? _____

Is this condition getting progressively worse? ❒ Yes ❒ No ❒ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

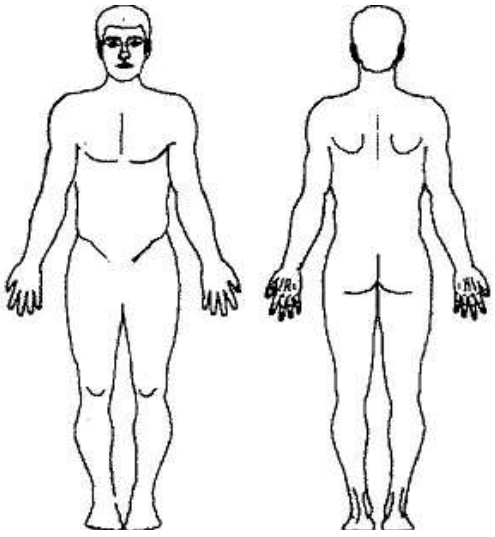
Type of pain: ❒ Sharp ❒ Dull ❒ Throbbing ❒ Numbness ❒ Aching ❒ Shooting ❒ Burning ❒ Tingling ❒ Cramps ❒ Stiffness ❒ Swelling ❒ Other

How often do you have this pain? (e.g. daily, 3x/week) _____

Is it constant or does it come and go?_____

Does it interfere with ❒ Work ❒ Sleep ❒ Daily Routine ❒ Recreation ❒ Other

Activities or movements that are painful to perform: ❒ Sitting ❒ Standing ❒ Walking ❒ Bending ❒ Lying Down ❒ Turning ❒ Getting Up



Mark an X on the picture where you continue to have pain, numbness, or tingling.

- **OVER** –

HEALTH HISTORY

Have you ever seen a chiropractor? ❒ Yes ❒ No

What treatment have you already received for your condition? ❒ Medication ❒ Surgery ❒ PT

❒ Chiropractic Services ❒ None Other _____

Name and address of other doctor (s) who have treated you for your condition: _____

Date of last: Physical Exam _____ Spinal X-Ray_____

Spinal Exam _____ Chest X-Ray _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a check "Yes" or "No" to indicate if you have had any of the following:

Arthritis	❒ Yes	❒ No	Gout	❒ Yes	❒ No	Osteoporosis	❒ Yes	❒ No
Back Pain	❒ Yes	❒ No	Headaches	❒ Yes	❒ No	Pinched Nerve	❒ Yes	❒ No
Cancer	❒ Yes	❒ No	Herniated Disc	❒ Yes	❒ No	Scoliosis	❒ Yes	❒ No
Concussion	❒ Yes	❒ No	Migraine Headaches	❒ Yes	❒ No	Stroke	❒ Yes	❒ No
Fractures	❒ Yes	❒ No	Neck Pain	❒ Yes	❒ No	Whiplash	❒ Yes	❒ No

Additional Health Problems/Conditions:

_____

_____

_____

_____

	Description	**Date**
Surgeries	_____	_____
	_____	_____
Auto Accidents	_____	_____
	_____	_____

Are you pregnant? ❒ Yes ❒ No Due Date: _____

EXERCISE	**WORK ACTIVITY**	**DIET**	**HABITS**	
❒ None	❒ Sitting	❒ Excellent	❒ Smoking	Packs/Day _____
❒ Moderate	❒ Standing	❒ Good	❒ Alcohol	Drinks/Week_____
❒ Daily	❒ Light Labor	❒ Mediocre	❒ Coffee/Caffeine Drinks	Cups/Day _____
❒ Heavy	❒ Heavy Labor	❒ Bad	❒ High stress level:	Reason_____

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPINE TREE CHIROPRACTIC CONSENT FORM

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are **extremely rare**. Following are the known risks:

Temporary soreness or increased symptoms or pain. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.
Dizziness, nausea, flushing. These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures. When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Stroke. A certain **extremely rare** type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits are likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before their stroke.

Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

I have read or had read to me this informed consent document. *I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction* ***prior to my signing this informed consent document***. I have made my decision voluntarily and freely.

Signature of Patient_____Date_____

Signature of Chiropractor_____Date_____

24 Hour Cancellation Policy

We understand life is busy! If you need to reschedule an appointment please do us the courtesy of calling 24 hours in advance and we will be happy to find another time that works for you. Given notice, we are often able to give those spots to community members in need of immediate care.

Spine Tree Chiropractic reserves the right to charge a $50.00 Cancellation Fee for appointments that are not canceled 24 hours in advance of the scheduled appointment.

Thank you for your cooperation.

Signature: _____