West Portland Chiropractic

Dr. Matthew Todd DC
322 NW 5th Avenue, Suite 305, Portland, OR 97209
p: (207) 370-8516 f: (503) 227-0206
WestPortlandChiropractic@gmail.com

Full Name:_____ **Name preferred to be called by:**_____

Address:_____

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

Date of Birth:_____

Gender: **[ ] Male** **[ ] Female**

Race: **[ ] Caucasian** **[ ] African American** **[ ] Hispanic** **[ ] Asian**
[ ] Am. Indian **[ ] Unspecified** **[ ] Other**

Check Status: **[ ] Single** **[ ] Married** **[ ] Divorced** **[ ] Widowed**

Home Phone:_____ **Work Phone:**_____

Cell Phone:_____ **E-mail address:**_____

How did you here about us?_____

Work Status **[ ] Employed** **[ ] Unemployed** **[ ] Retired** **[ ] Student part-time** **[ ] Student full-time**

Employer_____

Work Address _____

Health Insurance: **[ ] Yes I am Insured** **[ ] I have NO insurance** **[ ] Yes but I don't know my info**

Insurance Co. _____ **Ins. Policy ID#**_____ **Group #**_____

***** If you have insurance but are not the policy holder then complete the following *****

Policy Holder: **[ ] Self** **[ ] Spouse** **[ ] Parent** **[ ] Other**

Insured Name:_____

Insured Address:_____

Insured's City:_____ **State:**_____ **Zip:**_____

Insured Birthdate:_____ **Insured's Gender:** **[ ] Male** **[ ] Female**

Insured's Phone:_____ **Insured's Email:**_____

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Patient Name: _____ Date of Birth: _____ Date: _____

What is your main complaint?
_____

What caused it?
_____
_____

When did it start?
_____

How did your problem start? (check one):
- ☐ Immediately after a specific incident
- ☐ Multiple incidents
- ☐ Gradually developed over time

Has it been getting better, worse, or same since it began?
_____

How often do you feel your pain? (check one)
- ☐ 100% of the time
- ☐ 75-100% of the time
- ☐ 50-75% of the time
- ☐ 25-50% of the time
- ☐ 0-25% of the time

When is it most troublesome?
_____

Was it a work injury or auto injury?
_____

Have you seen anyone for this problem i.e. doctor, massage therapist, acupuncturist, etc?
_____

If so, please list other doctors' names and addresses
_____
_____

Are you taking any medications for this problem?
_____

What makes your problem better?
_____

What makes your problem worse?
_____

Have you injured this area before?
_____

What do you expect our care to accomplish?
_____

Indicate any secondary complaint?
_____
_____
_____

Do you have any other complaints or conditions?
_____
_____

Do you have any current health providers (such as: medical doctor, acupuncturist, naturopath, physical therapist, chiropractor, massage therapist, osteopathic doctor) within the last year. If so please list their name(s) and address(es).
_____
_____
_____
_____
_____
_____
_____

_____
Signature Date

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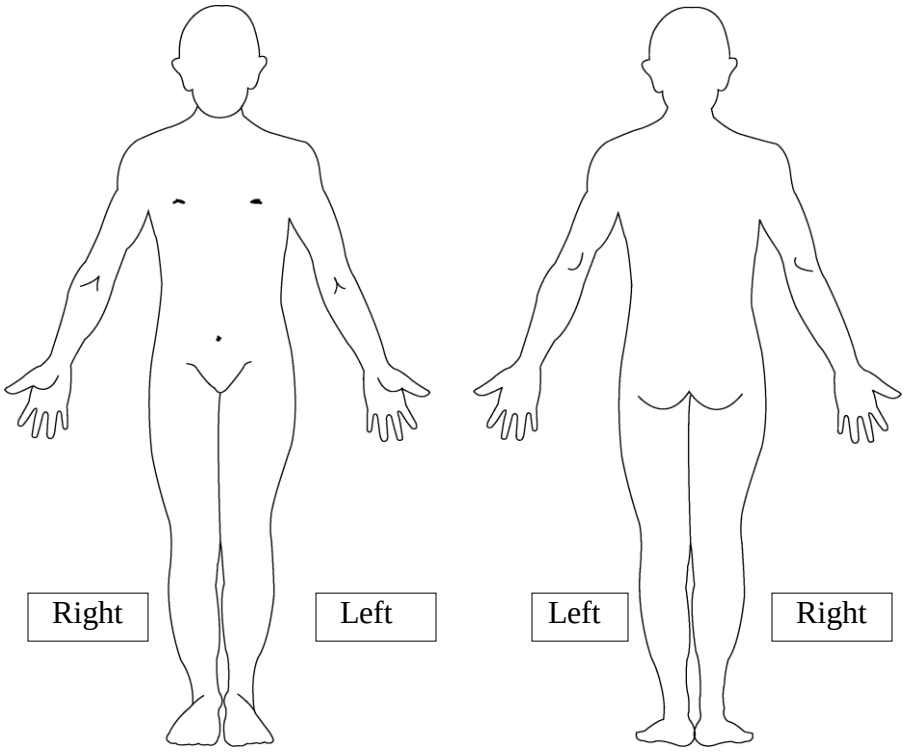
MARK ALL AREA(S) OF PAIN OR UNUSUAL FEELING WITH THE FOLLOWING SYMBOLS ON THE DIAGRAM BELOW

Numb	Tingling	Burning	Cramping/Spasms	Stabbing/Sharp	Achy/Dull
NNNN	TTTTT	BBBB	CCCCCC	SSSSSSS	AAAA



Please mark on the pain scale from 0 to 10 the pain you feel with this condition.

Location of Pain?_____

0 **10**
no pain **severe pain**

Location of Pain?_____

0 **10**
no pain **severe pain**

Location of Pain?_____

0 **10**
no pain **severe pain**

Patient Signature: _____ Date:_____

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Informed Consent

I hereby request, authorize and consent:

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322 NW 5th Avenue, Suite 305
Portland, OR 97209

to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there is a very small risk of serious injury due to treatment (most research shows a risks of 1 in 1,000,000 to 1 in 3,000,000 chance of serious injury), including but not limited to fractures, disc injuries, and stroke. For comparison ibuprofen taken over a long period of time increases the risk of a stroke by almost three times. I do not expect the doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Patient name **D.O.B.**

Patient Signature or Parent/Guardian Signature if younger than 18

Print name of Parent or Guardian **D.O.B.**

Your Relationship to Patient

Date

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Patient Privacy Agreement Verification

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures that you will receive at your first appointment. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Notice of Privacy Practices for Protected Health Information for this office

Patient name **D.O.B.**

Patient Signature or Parent/Guardian Signature if younger than 18

Printed name of Parent or Guardian **D.O.B.**

Your Relationship to Patient

Date