

Journey Through Healing Chiropractic Center, LLC

830 Saginaw Street South
Salem, OR 97302

Tel 503-480-0200 Fax 503-480-0203
journeythroughhealingchiropractic.com



Patient information

Last Name	First Name	MI	pronoun/preferred name	Date of Birth	Age	Gender
Street Address	City	State	Zip	Primary Phone H / C ?		
Mailing Address (if different)				Other Phone		
EMAIL	Confidential? <input type="checkbox"/> Yes <input type="checkbox"/> No		Appointment Reminder Preference?			
Primary Care Physician / Clinic				Phone		
Employer		Occupation		Work Phone		
Employer Address	City	State	Zip			
Emergency Contact	Relationship		Phone			
How did you hear about us?						

Insurance Information

Primary Insurance Company	Phone #	ID #	Group #
Subscriber	Date of Birth	Relationship	Phone #
Secondary Insurance Company	Phone #	ID #	Group #
Subscriber	Date of Birth	Relationship	Phone #

My initials beside the following indicate my understanding and consent

_____ I understand that I am ultimately responsible for all charges on my account and that my insurance is billed as a courtesy to me by the staff at Journey Through Healing Chiropractic Center, LLC.

_____ I understand that at any time I may ask for or have a copy of the Patient Privacy Policy (HIPAA).

I was offered and decline a copy of the HIPAA information handout. (They are available in the office lobby)

Assignment of Benefits

I hereby authorize Journey Through Healing Chiropractic Center, LLC to furnish the insured's company(ies) all information which said insurance company(ies) may request concerning my present claim. I hereby assign to Journey Through Healing Chiropractic Center, LLC all monies to which I am entitled for expenses related to the services performed, but not to exceed my indebtedness to Journey Through Healing Chiropractic Center, LLC. It is understood that all monies received from the above names insurance company(ies) over and above my indebtedness will be refunded to said insurers when my bill is paid in full. I understand that I am financially responsible to Journey Through Healing Chiropractic Center, LLC for charges not covered by this assignment.

Patient / Responsible Party's Signature

Print your Name

Date

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Health Records

Name: _____ Date: _____

Smoking Status (Circle One): Non-Smoker / Former Smoker / Occasional Smoker / Daily Smoker

Race (Circle One): American Indian / Alaska Native / Asian / African American / Caucasian
Native Hawaiian or Pacific Islander / Other / I decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Non-Hispanic or Latino / I Decline to Answer

Please list ALL of your current Prescriptions, Over the Counter Medications, vitamins, herbs, etc.
(Please use the back side if necessary)

Medication Name	Dosage and Frequency (ex: 5mg 1x a day, etc.)

Please list any known allergies (medication, food, herbs, etc) if any

Name of allergen	Reaction	Onset Date	Additional Comment

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

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Health History

Patient Name: _____ Date: _____

Have you seen a Chiropractor before? Yes _____ No _____

If Yes, when and for what reason(s)? _____

Is your condition related to: Auto Accident Illness Work Related Other

Date of onset for your condition: _____

Do you Smoke? Y___ N___ If yes, how much? _____ per day. What age did you start smoking? _____

Please Mark all symptoms/conditions that you previously (P) or are currently (C) experiencing.

Head:	(P)	(C)	Shoulders:	(P)	(C)	Low back:	(P)	(C)
Headaches	<input type="radio"/>	<input type="radio"/>	General pain	<input type="radio"/>	<input type="radio"/>	Burning	<input type="radio"/>	<input type="radio"/>
Head feels heavy	<input type="radio"/>	<input type="radio"/>	Pain across shoulders	<input type="radio"/>	<input type="radio"/>	Pinching	<input type="radio"/>	<input type="radio"/>
Loss of Memory	<input type="radio"/>	<input type="radio"/>	Bursitis	<input type="radio"/>	<input type="radio"/>	Herniated Disc	<input type="radio"/>	<input type="radio"/>
Light Headed	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Bulging Disc	<input type="radio"/>	<input type="radio"/>
Fainting (syncope)	<input type="radio"/>	<input type="radio"/>	Shoulder tension	<input type="radio"/>	<input type="radio"/>	Muscle Spasm	<input type="radio"/>	<input type="radio"/>
Light sensitive	<input type="radio"/>	<input type="radio"/>	Muscle spasms	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>
Loss of smell	<input type="radio"/>	<input type="radio"/>	Unable to raise arm(s):					
Loss of Taste	<input type="radio"/>	<input type="radio"/>	To shoulder level	<input type="radio"/>	<input type="radio"/>	Arms and Hands:	(P)	(C)
Loss of Balance	<input type="radio"/>	<input type="radio"/>	Over head	<input type="radio"/>	<input type="radio"/>	Pain in upper arm	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>				Pain in forearm	<input type="radio"/>	<input type="radio"/>
Loss of Hearing	<input type="radio"/>	<input type="radio"/>	Mid Back:	(P)	(C)	Pain in hand(s)	<input type="radio"/>	<input type="radio"/>
Pain in ears	<input type="radio"/>	<input type="radio"/>	General Pain	<input type="radio"/>	<input type="radio"/>	Pain in fingers	<input type="radio"/>	<input type="radio"/>
Ringing in ears	<input type="radio"/>	<input type="radio"/>	Pain between Scapula	<input type="radio"/>	<input type="radio"/>	Nerve pain in arm	<input type="radio"/>	<input type="radio"/>
Buzzing in ears	<input type="radio"/>	<input type="radio"/>	Sharp stabbing pain	<input type="radio"/>	<input type="radio"/>	Nerve pain in forearm	<input type="radio"/>	<input type="radio"/>
			Pain in the rib area	<input type="radio"/>	<input type="radio"/>	Nerve pain in wrist	<input type="radio"/>	<input type="radio"/>
Neck:	(P)	(C)	Muscle spasms	<input type="radio"/>	<input type="radio"/>	Nerve pain in fingers	<input type="radio"/>	<input type="radio"/>
General Pain	<input type="radio"/>	<input type="radio"/>				Pins / needles in:		
Pain w/ motion	<input type="radio"/>	<input type="radio"/>	Low Back:	(P)	(C)	arm(s)	<input type="radio"/>	<input type="radio"/>
Pain radiating:			General Pain	<input type="radio"/>	<input type="radio"/>	forearm	<input type="radio"/>	<input type="radio"/>
into arms or fingers	<input type="radio"/>	<input type="radio"/>	Pain INCREASED with:			hands /fingers	<input type="radio"/>	<input type="radio"/>
Neck feels out			Coughing/Sneezing	<input type="radio"/>	<input type="radio"/>	Cold hands	<input type="radio"/>	<input type="radio"/>
of place	<input type="radio"/>	<input type="radio"/>	Lifting	<input type="radio"/>	<input type="radio"/>	Numb hands	<input type="radio"/>	<input type="radio"/>
Pinched Nerve	<input type="radio"/>	<input type="radio"/>	Stooping	<input type="radio"/>	<input type="radio"/>	Fingers turn blue	<input type="radio"/>	<input type="radio"/>
Muscle spasms	<input type="radio"/>	<input type="radio"/>	Standing	<input type="radio"/>	<input type="radio"/>	Fingers going numb	<input type="radio"/>	<input type="radio"/>
Popping Sounds	<input type="radio"/>	<input type="radio"/>	Bending	<input type="radio"/>	<input type="radio"/>	Loss of grip strength	<input type="radio"/>	<input type="radio"/>
Grinding sensation	<input type="radio"/>	<input type="radio"/>	Squatting	<input type="radio"/>	<input type="radio"/>	Swollen wrist/hand	<input type="radio"/>	<input type="radio"/>
Neck Arthritis	<input type="radio"/>	<input type="radio"/>	Sitting	<input type="radio"/>	<input type="radio"/>	Swollen fingers	<input type="radio"/>	<input type="radio"/>

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Please Mark all symptoms/conditions that you previously (P) or are currently (C) experiencing.

Arms and Hands:	(P)	(C)	Hips, Legs, and Feet (P)	(C)	Have you had or are you currently having:	(YES)	(NO)	
Arthritis in wrist	<input type="radio"/>	<input type="radio"/>	Swollen feet	<input type="radio"/>	<input type="radio"/>	Digestive problems	<input type="radio"/>	<input type="radio"/>
Arthritis in fingers	<input type="radio"/>	<input type="radio"/>	Swollen toes	<input type="radio"/>	<input type="radio"/>	Fatigue	<input type="radio"/>	<input type="radio"/>
Carpal Tunnel	<input type="radio"/>	<input type="radio"/>	Joint pain in feet	<input type="radio"/>	<input type="radio"/>	Frequent Urination	<input type="radio"/>	<input type="radio"/>
			Toes go to sleep	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>
Hips, Legs, and Feet (P)	(P)	(C)	Arthritis in hip	<input type="radio"/>	<input type="radio"/>	Irregular Heart Rate	<input type="radio"/>	<input type="radio"/>
Pain in buttocks	<input type="radio"/>	<input type="radio"/>	Arthritis in knee	<input type="radio"/>	<input type="radio"/>	Kidney Stones	<input type="radio"/>	<input type="radio"/>
Pain in hip joint	<input type="radio"/>	<input type="radio"/>	Arthritis in feet/toes	<input type="radio"/>	<input type="radio"/>	Nose Bleeds	<input type="radio"/>	<input type="radio"/>
Pain in Knees	<input type="radio"/>	<input type="radio"/>				Pacemaker	<input type="radio"/>	<input type="radio"/>
Pain down leg	<input type="radio"/>	<input type="radio"/>	Have you had or are you currently having:	(YES)	(NO)	Prostate Trouble	<input type="radio"/>	<input type="radio"/>
Leg cramps	<input type="radio"/>	<input type="radio"/>	Allergies	<input type="radio"/>	<input type="radio"/>	Sinus Infections	<input type="radio"/>	<input type="radio"/>
Pins and needles	<input type="radio"/>	<input type="radio"/>	Alcoholism	<input type="radio"/>	<input type="radio"/>	Sleep Problems	<input type="radio"/>	<input type="radio"/>
Leg Numbness	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>
Numbness in feet	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Swelling Ankles	<input type="radio"/>	<input type="radio"/>
Cramps in feet	<input type="radio"/>	<input type="radio"/>	Bruise Easily	<input type="radio"/>	<input type="radio"/>	Swollen Joints	<input type="radio"/>	<input type="radio"/>
Feet feel cold	<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	Thyroid Conditions	<input type="radio"/>	<input type="radio"/>
Numb feet	<input type="radio"/>	<input type="radio"/>	Constipation	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>
Toes turn blue	<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Ulcers	<input type="radio"/>	<input type="radio"/>
Toes are numb	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	Varicose Veins	<input type="radio"/>	<input type="radio"/>
Swollen ankles	<input type="radio"/>	<input type="radio"/>						

Please list ANY family related illnesses or issues and your relationship.

Have you had X-Rays taken of your spine: Yes ___ NO ___ When? _____

Other X-Rays (list body part and when): _____

Have you had an **MRI**? Yes ___ No ___ When? _____ **CT SCAN**? Yes ___ No ___ When? _____

Female only: Date of last Period _____ Are you Pregnant? Yes ___ No ___ How long? _____

Do you suffer from PMS? Yes ___ No ___

Which of these do you experience if any? Menstrual pain Irregularity

Cramping Water Retention Abnormal PAP Smear Hot Flashes

Have you had a Hysterectomy? Yes ___ No ___ If yes, was it: Partial? _____ or a Complete? _____

Are you in Menopause? Yes ___ No ___ If yes, when did it start? _____

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Informed Consent to 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, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.
- With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur 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.
- The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

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Informed Consent to Care (continued)

- 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.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Relationship to Patient: _____ Age of Minor: _____

Witness Name: _____ Signature: _____ Date: _____

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Laser Therapy Information and Consent

Laser Therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasm and promotes vasodilation. Pain relief from Laser therapy may be dramatic and substantial, lasting hours, days, or weeks. However, your results may be minimal or insignificant. Adverse effects of Laser therapy may occur from multiple causes including hypersensitivity, pre-existing health conditions, thermal effects, laser overstimulation. Laser light can damage the retina in your eye. Always wear the protective glasses provided.

Laser therapy is most likely NOT covered by your insurance and may be an out-of-pocket expense. The cost is \$40 per treatment.

The most common adverse effects are:

Temporary increase in pain the following day after Laser therapy, Mild bruising from vasodilation, Temporary dizziness, Reaction when photosensitizing drugs are used with Laser therapy, Temporary sleepiness.

Please check if any of the following medications, treatments, or conditions applies to you:

- | | |
|--|---|
| <input type="checkbox"/> Using Photosensitizing drugs such as steroids | <input type="checkbox"/> Taking any cyclin drugs such as tetracycline |
| <input type="checkbox"/> Recent cortisone injections (within a week) | <input type="checkbox"/> Taking Immunosuppressant drugs |
| <input type="checkbox"/> On Dialysis | <input type="checkbox"/> Meningitis or Encephalitis |
| <input type="checkbox"/> Pregnant Female | <input type="checkbox"/> Pacemaker and or other electronic implants |
| <input type="checkbox"/> Areas of large bruising and or hemorrhage | <input type="checkbox"/> Tattoos |
| <input type="checkbox"/> Areas with decreased sensory perception | |

Attention:

You will need to double your water intake after having Laser therapy, this is going to flush out the toxins, hydrates your tissues, and lubricates your joints.

- *My signature acknowledges that I have read and understand the cost, benefits, and risks of Laser therapy and agree to the treatment as determined by my doctor.*

Patient / Responsible Party's Signature

Print your Name

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Functional Rating Index Neck / Back Problems Only

Instructions: In order to properly assess your condition, we must understand how much your neck and or back problems have affected your ability to manage everyday activities. Please select a response which most closely describes your condition right now.

TODAY- Do you or would you have any difficulties at all with:

	Activities	0	1	2	3	4
1	Pain intensity	No pain	Mild Pain	Moderate Pain	Severe pain	Worst pain possible
2	Sleeping	Perfect sleep	Mildly disturbed	Moderately disturbed	Greatly disturbed	Totally disturbed
3	Personal care (washing dressing ect)	No pain; No restrictions	Mild pain No restrictions	Moderate pain Need to go slowly	Moderate pain Need some assistance/help	Sever pain Need 100% Assistance/help
4	Travel (driving, etc)	No Pain On long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain need 100% assistance
5	Work	Can do usual work plus unlimited extra work	Can do usual work No extra work	Can do 50% of usual amount of work	Can do 25% of usual amount of work	Can Not work
6	Recreation	Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Can not do any activities
7	Frequency of pain	No Pain	Occasional Pain 25% of the day	Intermittent pain 50% of the day	Frequent Pain 75% of the day	Constant pain 100% of the day
8	Lifting	No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
9	Walking	No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking
10	Standing	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

DATE: _____

Patient Name: _____ Signature: _____

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