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	preferred name/pronoun	Date of Birth	Age	Gender
Street Address	City	State	Zip	Primary Phone H / C		
Mailing Address (if different)				Other Phone		
EMAIL	Confidential ☐Yes ☐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 declined a copy of the HIPAA information handout. (They are available in the office lobby)

*** ***Please Reverse side for additional disclosures*** ***

Patient / Responsible Party's Signature ______________________ Print your Name ______________________ Date ______________

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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.

Non-Discrimination Notice

Our office does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, or receipt of the services and benefits.

*** Date of Birth ___________________________

_________________________________	_________________________	_______________
Patient / Responsible Party's Signature	Print your Name	Date

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Health Records

Name: ____ Date of Birth: _________________________

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

Race: ____ or ____ Decline to Answer
(examples: Caucasian/Asian/Native American/African/Hispanic/Indian)

Ethnicity: ____ or ____ Decline to Answer
(examples: Hispanic or Latino/Non-Hispanic or Latino)

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.)

_______________________________ _______________________________ _______________
Patient / Responsible Party's Signature Print your Name Date

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_______________________________ _______________________________ _______________________________
Patient / Responsible Party's Signature Print your Name Date

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Health History

Patient Name: ____ Date of birth: ______________________

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)***
Headaches	◯	◯
Head feels heavy	◯	◯
Loss of Memory	◯	◯
Light Headed	◯	◯
Fainting (syncope)	◯	◯
Light sensitive	◯	◯
Loss of smell	◯	◯
Loss of Taste	◯	◯
Loss of Balance	◯	◯
Dizziness	◯	◯
Loss of Hearing	◯	◯
Pain in ears	◯	◯
Ringing in ears	◯	◯
Buzzing in ears	◯	◯

Neck:	***(P)***	***(C)***
General Pain	◯	◯
Pain w/ motion	◯	◯
Pain radiating:		
into arms or fingers	◯	◯
Neck feels out of place	◯	◯
Pinched Nerve	◯	◯
Muscle spasms	◯	◯
Popping Sounds	◯	◯
Grinding sensation	◯	◯
Neck Arthritis	◯	◯

Shoulders:	***(P)***	***(C)***
General pain	◯	◯
Pain across shoulders	◯	◯
Bursitis	◯	◯
Arthritis	◯	◯
Shoulder tension	◯	◯
Muscle spasms	◯	◯
Unable to raise arm(s):		
To shoulder level	◯	◯
Over head	◯	◯

Mid Back:	***(P)***	***(C)***
General Pain	◯	◯
Pain between Scapula	◯	◯
Sharp stabbing pain	◯	◯
Pain in the rib area	◯	◯
Muscle spasms	◯	◯

Low Back:	***(P)***	***(C)***
General Pain	◯	◯
Pain INCREASED with:		
Coughing/Sneezing	◯	◯
Lifting	◯	◯
Stooping	◯	◯
Standing	◯	◯
Bending	◯	◯
Squatting	◯	◯
Sitting	◯	◯

Low back:	***(P)***	***(C)***
Burning	◯	◯
Pinching	◯	◯
Herniated Disc	◯	◯
Bulging Disc	◯	◯
Muscle Spasm	◯	◯
Arthritis	◯	◯

Arms and Hands:	***(P)***	***(C)***
Pain in upper arm	◯	◯
Pain in forearm	◯	◯
Pain in hand(s)	◯	◯
Pain in fingers	◯	◯
Nerve pain in arm	◯	◯
Nerve pain in forearm	◯	◯
Nerve pain in wrist	◯	◯
Nerve pain in fingers	◯	◯
Pins / needles in:		
arm(s)	◯	◯
forearm	◯	◯
hands /fingers	◯	◯
Cold hands	◯	◯
Numb hands	◯	◯
Fingers turn blue	◯	◯
Fingers going numb	◯	◯
Loss of grip strength	◯	◯
Swollen wrist/hand	◯	◯
Swollen fingers	◯	◯

Continues on Back - - >

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Date of Birth: __________________

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

Arms and Hands:	***(P)***	***(C)***
Arthritis in wrist	○	○
Arthritis in fingers	○	○
Carpal Tunnel	○	○

Hips, Legs, and Feet	***(P)***	***(C)***
Pain in buttocks	○	○
Pain in hip joint	○	○
Pain in Knees	○	○
Pain down leg	○	○
Leg cramps	○	○
Pins and needles	○	○
Leg Numbness	○	○
Numbness in feet	○	○
Cramps in feet	○	○
Feet feel cold	○	○
Numb feet	○	○
Toes turn blue	○	○
Toes are numb	○	○
Swollen ankles	○	○

Hips, Legs, and Feet	***(P)***	***(C)***
Swollen feet	○	○
Swollen toes	○	○
Joint pain in feet	○	○
Toes go to sleep	○	○
Arthritis in hip	○	○
Arthritis in knee	○	○
Arthritis in feet/toes	○	○

Have you had or are you currently having:	***(YES)***	***(NO)***
Allergies	○	○
Alcoholism	○	○
Anemia	○	○
Asthma	○	○
Bruise Easily	○	○
Cancer	○	○
Constipation	○	○
Depression	○	○
Diabetes	○	○

Have you had or are you currently having:	***(YES)***	***(NO)***
Digestive problems	○	○
Fatigue	○	○
Frequent Urination	○	○
High Blood Pressure	○	○
Irregular Heart Rate	○	○
Kidney Stones	○	○
Nose Bleeds	○	○
Pacemaker	○	○
Prostate Trouble	○	○
Sinus Infections	○	○
Sleep Problems	○	○
Stroke	○	○
Swelling Ankles	○	○
Swollen Joints	○	○
Thyroid Conditions	○	○
Tuberculosis	○	○
Ulcers	○	○
Varicose Veins	○	○

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? ______________________________

______________________________ ______________________ ______________

Patient / Responsible Party's Signature | Print your Name | Date

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Informed Consent to Care

Print Name: ____ Date of Birth: ______________

- 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.

Continued on Back Side ---->

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: ______________

Date of Birth: ___________________________

Parent or Guardian: _______________________ Signature: _________________________ Date: _____________

Relationship to Patient: ____________________________ Age of Minor: _______________________________

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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:

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

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.*
  Please PRINT your Date of birth: ____

_______________________________ _______________________ _______________
Patient / Responsible Party's Signature Print your Name Date

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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

Today's Date:___________________________________ Date of Birth:_______________________________________

Patient Name: ____ Signature: ____

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