Milwaukie SPINE + SPORT

Milwaukie Spine and Sport, LLC
2100 SE Lake Rd. Suite 1
Milwaukie, OR 97222
503-344-6711 P
milwaukiechiropractor.com

New Patient Paperwork

(If you are seeing us for a motor vehicle collision or a workplace accident please let us know so we can get you different paperwork.)

About You

Name:_____Gender: ○ Male ○ Female
Address:_____
City:_____State:_____Zip:_____
Home Number:_____Work Number:_____Other Number:_____
Email Address:_____
Date of Birth(MM/DD/YYYY)_____ Age:_____
Marital Status: ○ Single ○ Married ○ Other If married please provide spouse's name:_____
If Patient Is a Minor, Name of Parent(s):_____
Primary Care Physician:_____

Emergency Contact

Name:_____Relationship:_____
Contact Number:_____

Employment Information

Status: ○ Full Time ○ Part time ○ Unemployed ○ Student ○ Retired ○ Homemaker
Occupation:_____
Employer:_____
Job duties:_____

How Did You Hear About Us?

(please check all that apply)

○ Google ○ Yelp ○ Facebook ○ Chamber of Commerce ○ Walk/drive by ○ Instagram
○ Referred by:_____ ○ Insurance Company:_____
○ Local Event:_____ ○ Other:_____

For Office Use Only

Patient Info: ☐ Demographics ☐ Primary prov. ☐ Billing prov. (use appt. prov) ☐ Emp. info ☐ Fee sched
Dx: ☐ Date of Current Illness (for MVA or WC it is the date of accident; for all others pick today's date
Insurance Tab 1: ☐ Policy info ☐ Pt. resp. ☐ If e-billing: batch claims, e-claims, EDI **Tab 2:** ☐ Copy pt. Info ☐ Group #
Records: ☐ Scan ID/ins card ☐ Scan intake paperwork ☐ Scan insurance benefits

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What Brought You In Today

Date problem began?:_____ Present issue:_____

Briefly describe injury details:_____

_____

Does anything increase or decrease your pain?_____

On a scale of 1-10(10 being the worst) how bad is your pain?_____

Is you pain: Constant Intermittent

Is your pain worse during: Morning Afternoon Evening No difference

How did your pain begin?

- ❑ Immediately after a specific event
- ❑ Multiple events
- ❑ Gradually developed
- ❑ No apparent reason

Have you had a similar problem before? Yes No

Have you received prior care for this issue? Yes No

If yes, what:_____

Current Symptoms Update

(Please check all that apply)

❑ Fever	❑ Fatigue	❑ Bleeding	❑ Diarrhea
❑ Night Sweats	❑ Sore Throat	❑ Poor Circulation	❑ Rash
❑ Chest Pain	❑ Cough	❑ Dizziness	❑ Numbness
❑ Nausea	❑ Vomiting	❑ Hot Flashes	❑ Bruising
❑ Weight Loss	❑ Changes in Vision	❑ Difficulty Breathing	❑ Anxiety
❑ Muscle Weakness	❑ Constipation	❑ Difficulty Sleeping	❑ Tension
❑ Urinary Tract Infection	❑ Respiratory Infection	❑ Skin infection	❑ Loss of Bowel or Bladder Control
❑ Painful/Swollen Joints	❑ Difficulty Swallowing	❑ Immune System Dysfunction	❑ Other _____

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Personal Medical History

(Please check all that apply)

❑ Diabetes	❑ Ulcers	❑ Cancer	❑ AIDs/HIV
❑ Joint Replacement	❑ Stroke	❑ Arthritis	❑ Seizures
❑ Glaucoma	❑ Hepatitis	❑ Anemia	❑ Alcoholism
❑ Lung Disease	❑ Heart Disease	❑ Diverticulitis	❑ Pacemaker
❑ Kidney Disease	❑ Thyroid Disease	❑ Tuberculosis	❑ Hypertension
❑ Blood Thinners	❑ Depression	❑ Anxiety	❑ Other_____

Surgeries/Hospitalizations/ Major Injuries/Fractures/Dislocations:_____

_____

Current Medications:_____

Lifestyle Habits

Tobacco: Yes No If yes, frequency?:_____ How long have you used tobacco?_____
Caffeinated Beverages: Yes No If yes, #/day?_____
Alcoholic Beverages: Yes No If yes, #/day?_____
Other Substances: Marijuana Cocaine Non-prescription Opiates Other:_____
Do you currently exercise regularly? Yes No
Other information we should know about:_____

_____

Family Medical History

(Please check all that apply)

❑ Diabetes	❑ Hypertension	❑ Cancer	❑ Scoliosis
❑ Heart Disease	❑ Stroke	❑ Osteoarthritis	❑ Muscle Disease
❑ Rheumatoid Arthritis	❑ Other_____		

Other information we should know about:_____

_____

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Consent for Treatment

• I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the client named below, for whom I am legally responsible) by the doctors of chiropractic and at Milwaukie Spine and Sport, LLC and/or other licensed doctors of chiropractic who now, or in the future, treat me while employed by, working or associated with or serving as back-up for the chiropractic physicians of Milwaukie Spine and Sport, LLC. • I have had an opportunity to discuss with the doctor of chiropractic, and/or with other office or clinic personnel at Milwaukie Spine and Sport, LLC the nature and purpose of chiropractic adjustments and procedures. I understand and am informed that, as with all healthcare treatments, results are not guaranteed. • I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack of improvement in symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctors feels at the time, based upon the facts then known, 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.

Practice Privacy Notice

Milwaukie Spine and Sport, LLC is a multi-practitioner office, and on occasion, your treatment may be provided by another doctor due to illness, vacation, time conflict, etc. In order to provide the best care to patients, it may be necessary to discuss health information in a private setting (away from other patients) in order to update other practitioners in the office of a patient's status. By signing this form you acknowledge that you have been made aware and accept that your health information may be discussed among the practitioners. A complete notice of privacy practices is available upon request and at our website milwaukiechiropractor.com and you agree that this has been made available for your review and that you understand your rights and our responsibilities.

Financial Policy

1. Responsibility for Payment: We consider the patient to be responsible for payment of services. In cases where the patient is a minor, the legal guardian signing for the child is responsible for payment. 2. Insurance Billing: As a courtesy to you, we will bill your primary insurance company provided that the pertinent identification numbers are provided. It is the patient's responsibility to inform our office of ANY insurance changes. 3. We reserve the right to, at our sole discretion, charge a no show/late cancellation fee of $25/occurrence for missed appointments or appointments cancelled within 24 hours of their scheduled time and date. 4. Health insurance is a private contract between the patient and insurance company. It is the patient's responsibility to resolve problems with claims processing directly with the insurance company. We are happy to verify and bill your insurance but if coverage disputes arise you are responsible for their resolution. 5. Any amount not covered by the patients health insurance is the FULL RESPONSIBILITY of the patient or patient's guardian.
6. All durable medical equipment, lotions, supplements and other supplies must be paid for at the time they are received.

Patient or Legal Gaurdian Signature:_____

Patient or Legal Guardian Name:_____ Date:_____

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Patient Name:_____ DOB:_____ Provider:_____ Date:_____