Patient Registration & Health History

Today's Date: ____/____/_____ How did you hear about us?_____
Legal Name: _____How do you prefer to be addressed? _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth ____/____/_____ Age: _____ Gender: M / F Marital Status: S / M / D / W
Soc Sec #: _____ Cell# (_____) _____ Home# (_____) _____
Email: _____
Occupation: _____ Employer: _____

How would you like to receive your appointment reminders? ☐ Text Message ☐ Phone call ☐ Email

Emergency Contact: _____ Phone#: (_____)_____
Relationship to patient_____ Address: _____

Do you have insurance? ☐Yes ☐No Insurance Name:_____
Are you the primary Insured? ☐Yes ☐No If No, *Name of Primary & relationship*: _____
Do you have any children? ☐Yes ☐No If so, how many? _____

How often do you drink alcoholic beverages? _____
Do you smoke? ☐Yes ☐No If so, how much? _____
Do you exercise? ☐Yes ☐No If so, how often? _____ Type(s): _____

Do you have any allergies? ☐Yes ☐No Specify type(s): _____
Have you ever suffered from or been diagnosed as having: (circle Yes or No for each)

Y N Broken/Fractured Bone	Y N Excessive Bleeding	Y N Seizures / Convulsions
Y N Osteoarthritis	Y N Congenital Disease	Y N Pacemaker
Y N Eating Disorder	Y N Ruptures	Y N Drug Addiction
Y N Circulatory Problems	Y N Gall Bladder	Y N Alcoholism
Y N Rheumatoid Arthritis	Y N HIV positive	Y N Coughing Blood
Y N High / Low Blood Pressure	Y N Depression	Y N Head Problems (dizzy, vertigo, etc.)
Y N Stroke	Y N Diabetes	Y N Ulcers
Y N Cancer	Y N Tumors	Y N Epilepsy

For any above *Yes* answers, Please provide a detailed explanation:
_____
_____

When was your last Physical Examination?_____
When was the last time you were involved in an accident of any kind? (Specify work, auto, or other)
_____
Please list any previous surgeries and/or hospitalizations: _____
_____
Please list any major health problems your family members have had (e.g. cancer, arthritis, heart disease):
_____

Primary Care Physician: Physician Name: _____
Address: _____
Phone#: (_____)_____

Prescription Medications: _____ date started ___/___/_____ date stopped ___/___/____
_____ date started ___/___/_____ date stopped ___/___/____
_____ date started ___/___/_____ date stopped ___/___/____
Please list any additional medications on the back of this form

Vitamins / Supplements: _____ prescribed by Dr? Y N
_____ prescribed by Dr? Y N
_____ prescribed by Dr? Y N

Dr Initials:

CATALYST CHIROPRACTIC
13025 SW Millikan Way #120, Beaverton, Oregon 97005
ph. 503-526-8782 fx. 503-526-8721

Chief Complaint History

What is your **MAIN COMPLAINT**? _____
When did it start? _____
Explain how it happened: _____
_____
_____
Have you had similar pain in the past? □ Yes □ No If yes, when? _____
Please rate your pain on from 0-10: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imagineable)

What time of day are your symptoms **better?**
a. Morning
B. Afternoon
c. Evening
d. None of the above (constant pain)

What time of day are your symptoms **worse?**
a. Morning
b. Afternoon
c. Evening
d. All of the above (constant pain)

What home remedies have you tried?
a. Ice packs
b. Heating pads/Hot tubs
c. Exercise
d. Other:_____

What makes your pain **better?**
a. Rest
b. Ice packs/Heating pads
c. Prescription Medications
d. Drug store medications (Ibuprofen, Advil)
e. Other:_____

What makes your pain **worse?**
a. Activity (work, repetitive motions)
b. Ice packs/Heating pads
c. Driving (or riding) in car
d. Other:_____

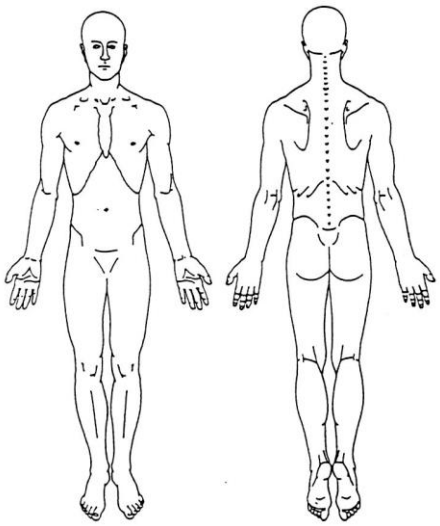
Have you missed any work from this condition?
a. No
b. Yes: When?_____

On the diagram below, please **mark where** you're experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain
S: sharp pain **D:** dull pain
W: weakness **N:** numbness **T:** tingling

For this complaint, have you:
- □ been hospitalized
- □ seen another chiropractor
- □ seen another medical provider
- □ never received care for this problem

Please list previous treatments (if any) for this complaint:_____
_____
_____



By signing below, I acknowledge that the above information is true & accurate to the best of my knowledge

Patient Signature: _____ Date: ____/____/_____

Physician use ONLY:

Additional Notes:_____
_____
_____

Dr Initials:

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Patient Health Information Consent Form

We want you to know how your Protected Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. You will be provided with more detailed account of our policies and procedures concerning the privacy of your Patient Health Information. We encourage you to read the provided HIPAA notice. HIPAA stands for Health Information Privacy Accountability Act.

I AUTHORIZE **CATALYST CHIROPRACTIC & REHABILITATION, or DR KIP THOMPSON, DC (the Office)** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

I understand and agree to allow the Office to use my PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. I authorize the Office to make inquires and to release any pertinent information to any insurance company, billing service, adjustor, physicians' office, or attorney.

I have the right to examine and obtain a copy of my health records at any time and request corrections. I may request to know what disclosures have been made and submit in writing any further restrictions on the use of my PHI. The Office is not obligated to agree to these restrictions.

My written consent need only be obtained one time for all subsequent care given in the Office.

I may provide a written request to revoke consent at any time during care. This would not affect the use of records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

I give permission to use my address, phone number and clinical records to contact me via telephone or mail with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information. I give permission to send me health related emails & newsletters.

If contacted by phone, I give the Office permission to leave a phone message on my answering machine or voice mail.

I give permission to treat me in an open room* where other patients are also being treated. I am aware that other persons in the Office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
**Dedicated massage therapy sessions will be provided in a closed, private room.*

I give permission to contact my primary care physician if needed to co-manage my case.

If I refuse to sign this consent for the purpose of treatment, payment and health care operations, Dr Kip Thompson, DC or Catalyst Chiropractic and Rehabilitation have the right to refuse to give care.

By signing this form I am giving *Catalyst Chiropractic & Rehabilitation* permission to use and disclose my protected health information in accordance with the directives listed above.

Signature of Patient (Guardian): _____ Date ____/____/_____

Printed Name: _____

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Assignment of Benefits

This office will provide insurance billing services for you as a courtesy if you so desire. Please remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, co-pay, and or any other balances not paid by your insurance carrier at the time of service. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.

I authorize payment of insurance benefits directly to:

Kip Thompson, DC LLC (dba Catalyst Chiropractic & Rehabilitation),
3300 SW Hocken Ave Suite #108, Beaverton, OR 97005

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Missed Appointments

Any missed appointments or cancellations made after the close of business 1 day prior to an appointment will result in a $20 charge to your account.

_____ _____/_____/_____
Signature of Insured/Patient (Parent/Guardian) Date

_____
Printed Name of Insured/Patient

Examination and Treatment Consent

It is prudent for us to obtain your informed consent prior to examination and treatment. The purpose of this information is to inform you, not to alarm you. What you are being asked to sign is simply a confirmation that we have discussed the following:

Inherent Risks:
Examination and therapeutic procedures (including chiropractic adjustments, ultrasound, heat application, electrotherapy, and therapeutic massage and manual therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them.

Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures.

Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

I hereby authorize Catalyst Chiropractic and Rehabilitation and its affiliated providers to administer examination, X-ray studies, chiropractic care, physical therapy, massage therapy, or any clinic services that they deem necessary to treat my condition.

Patient's (Guardian) Signature: _____Date:_____

Patient's Name Printed: _____

If patient is a minor:
As a parent or legal guardian of the above-named patient, I hereby authorize the application of any treatment listed above which is deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of (date):_____.

Signature_____

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