

KRUSE PARK CHIROPRACTIC CLINIC

3990 COLLINS WAY STE-201, LAKE OSWEGO, OR 97035 503-635-1236/FAX 503-697-4741

NEW PATIENT REGISTRATION

Today's Date: _____ How did you hear about the clinic? _____

Name _____

Last Name First Name Middle Initial Gender M F

Address _____

Street City State Zip Code

Phone # _____ Date of Birth _____

SSN # _____ Driver's License # _____

Employer/Occupation _____ Phone # _____

Emergency Contact _____

Name/Relationship _____ Telephone # _____

RESPONSIBLE PARTY INFORMATION (If Patient is a Minor)

Name _____ Relationship to Patient _____

Address (if different) _____

Street City State Zip Code

Phone # (if different) _____ Date of Birth _____

SSN # _____ Drivers License # _____

Employer/Occupation _____ Phone # _____

INSURANCE INFORMATION

(Please present insurance cards for all coverage)

Primary Insurance Name _____ Policy Holder Name _____

Policy Holder DOB _____ Policy Holder Employer _____

Primary Insurance ID # _____ Primary Insurance Group # _____

Primary Insurance Claims Address _____

Secondary Insurance Name _____ Policy Holder Name _____

Policy Holder DOB _____ Policy Holder Employer _____

Secondary Insurance ID # _____ Secondary Insurance Group # _____

Secondary Insurance Claims Address _____

ACCIDENT INFORMATION

Please indicate type of accident: Workers Compensation Motor Vehicle Personal Injury Other

What State? OR WA Other Date of Accident _____

What type of treatment have you received previously for this Accident? Chiropractic Physical Therapy
None Other

****PLEASE TURN TO BACK SIDE****

Name _____ Date _____

Please initial each item below.

1. _____ I authorize Kruse Park Chiropractic Clinic to provide Chiropractic services to me.
2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me by Kruse Park Chiropractic Clinic.
3. _____ If my account is assigned to an attorney for collection and/or suit due to delinquency, the prevailing party shall be entitled to reasonable attorney's fees and cost for collection.
4. _____ I authorize any insurer to make payment for services rendered by Kruse Park Chiropractic Clinic directly to Kruse Park Chiropractic Clinic 3990 S.W. Collins way, Ste 201, Lake Oswego, OR 97035.
5. _____ I understand that there are three physicians in this office and I may receive treatment from any one of the physicians if the others are unavailable. I may, at any time state a preference for one or more of the physicians.
6. _____ From time to time, this office participates in a program with Western States Chiropractic College for the training of their chiropractic interns. These interns may be present during your office visit. You may, at any time, ask that the intern leave the treatment room.
7. _____ Please provide the name of your Primary Care Physician, _____. I authorize my PCP to share health care information with Kruse Park Chiropractic Clinic if necessary.

By signing this application, I affirm under penalty of law that I have given true and complete information.

Patients Signature _____ Date _____

Responsible Parties Signature _____ Relationship _____
(if patient is a minor)

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NEW PATIENT QUESTIONNAIRE

PATIENT NAME _____

D.O.B. _____ MALE FEMALE

OCCUPATION: _____

SINGLE _____ MARRIED _____ PARTNER _____ DIVORCED _____ SEPARATED _____ WIDOWED _____

NUMBER OF CHILDREN _____

HOW WOULD YOU DESCRIBE YOUR HEALTH? _____

MEDICAL AND SURGICAL HISTORY

PLEASE LIST ANY PREVIOUSLY DIAGNOSED MEDICAL PROBLEMS.

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
HEART DISEASE			BREAST CANCER			ARTHRITIS		
HIGH BLOOD PRESSURE			OTHER CANCER			CATARACTS		
HEPATITIS/LIVER DISEASE			BROKEN BONES			GLAUCOMA		
ASTHMA/EMPHYSEMA			STROKE OR TIA			DIABETES		
POSITIVE TB SKIN TEST			TUBERCULOSIS			SEIZURES		
HIGH BLOOD CHOLESTEROL			DEPRESSION			ANEMIA		
THYROID DISORDER			ALCOHOLISM			OTHER		

PLEASE LIST ANY PAST SURGERIES AND THE DATES OF EACH.

PLEASE LIST ALL PRESCRIPTION MEDICATIONS THAT YOU ARE TAKING AND THE DOSES.

PLEASE LIST ALL NON-PRESCRIPTION MEDICATIONS, VITAMINS, OR HERBS THAT YOU ARE TAKING?

ARE YOU ALLERGIC TO ANY MEDICATIONS? (circle one) YES NO

IF SO, WHAT MEDICATIONS ARE YOU ALLERGIC TO & WHAT REACTION DID YOU HAVE?

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING DURING THE PAST YEAR?

	YES	NO		YES	NO
PERSONAL ILLNESS OR INJURY			MARRIAGE		
MAJOR ILLNESS OR DEATH IN FAMILY			CHANGE OF RESIDENCE		
RETIREMENT OR JOB CHANGE			DEATH OF SPOUSE		
DIVORCE OR SEPARATION			DEATH OF CLOSE FRIEND		

****PLEASE TURN TO BACK SIDE****

PATIENT NAME _____

FAMILY HISTORY

DO YOU HAVE A BLOOD RELATIVE WITH ANY OF THE FOLLOWING? PLEASE INDICATE RELATIONSHIP TO PATIENT, FOR "YES" ANSWERS.

	YES	NO	RELATION
BREAST CANCER			
BOWEL CANCER			
OTHER CANCER			
DIABETES			
ALCOHOLISM			
DEPRESSION			

	YES	NO	RELATION
HISTORY OF SUICIDE			
HEART ATTACK			
STROKE			
HIGH BLOOD PRESSURE			
THYROID DISEASE			
OTHER			

CURRENT HEALTH

DO ANY OF THE FOLLOWING APPLY TO YOU? PLEASE INDICATE IF CURRENT (C) OR PAST (P).

	C	P
TROUBLE WITH EYES OR VISION		
CHEST PAIN OR HEAVINESS WITH ACTIVITY		
SHORTNESS OF BREATH , PRONE TO COUGHING		
RECENT CHANGE IN BOWEL MOVEMENT OR BLOOD IN STOOL		
SEXUAL PROBLEMS YOU WISH TO DISCUSS		
SWELLING OF FEET OR ANKLES		
SEVERE HEADACHES		
TIRE EASILY		
TROUBLE WALKING OR LOSING BALANCE		

	C	P
TROUBLE WITH EARS OR HEARING		
DIFFICULTY URINATING\HOLDING URINE		
TROUBLE SWALLOWING, CHEWING, HEARTBURN, STOMACH PAIN		
LOST OR GAINED 10 POUNDS IN PAST YEAR WITHOUT TRYING		
BACK, JOINT OR MUSCLE PROBLEMS		
OTHER PROBLEMS WITH YOUR FEET		
FREQUENT DIZZINESS		
TROUBLE SLEEPING		
FALLEN TO GROUND IN PAST YEAR		

HEALTH HABITS

DO YOU EAT A SPECIAL DIET? (circle one) YES NO IF YES, DESCRIBE _____

DO YOU EXERCISE REGULARLY? (circle one) YES NO IF YES, HOW MANY TIMES PER WEEK? _____

WHAT METHOD OF EXERCISE DO YOU USE? _____

DO YOU SMOKE? (circle one) YES NO IF YES, WHAT AND HOW MUCH? _____

DO YOU CHEW TOBACCO? (circle one) YES NO IF YES, WHAT AND HOW MUCH? _____

DO YOU DRINK ALCOHOL? (circle one) YES NO IF YES, WHAT AND HOW MUCH? _____

HAVE YOU EVER SMOKED? (circle one) YES NO IF YES, WHEN DID YOU STOP? _____

FOR WOMEN ONLY

DOES ANY OF THE FOLLOWING APPLY TO YOU?

	YES	NO
ABNORMAL VAGINAL OR MENSTRUAL BLEEDING?		
TAKING BIRTH CONTROL PILLS OR ESTROGEN?		

MALE/FEMALE

BREAST LUMPS OR NIPPLE DISCHARGE?		
DO A MONTHLY SELF-BREAST EXAM?		

PATIENT NAME _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

	YES	NO
IS THIS DUE TO A MOTOR VEHICLE ACCIDENT?		
IS THIS DUE TO AN ON THE JOB INJURY?		
HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE?		

IF YES, WHEN _____

HAVE YOU HAD ANY RECENT X-RAYS TAKEN?		
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IF YES, OF WHAT AREA? _____ WHO TOOK THEM? _____

NAME OF YOUR PRIMARY CARE PHYSICIAN? _____

DATE OF YOUR LAST PHYSICAL EXAM? _____

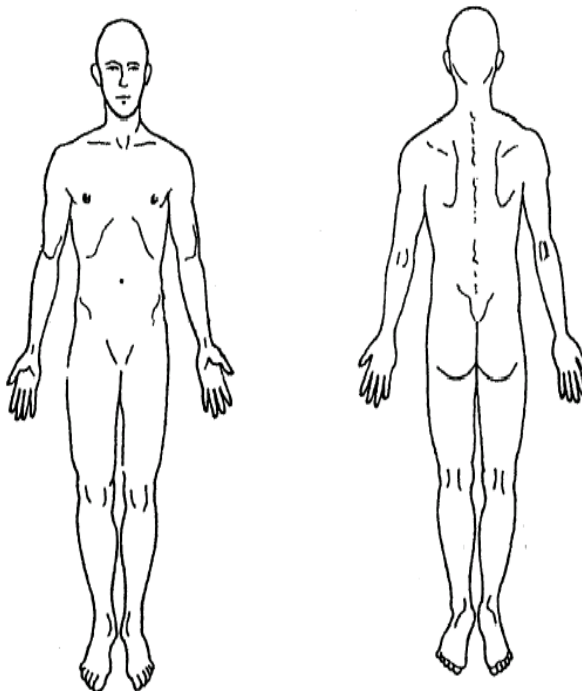
DO YOU WEAR: HEEL LIFTS SOLE LIFTS INNER SOLES ARCH SUPPORTS NEGATIVE HEELS PLATFORM SHOES
(CIRCLE)

DATE YOUR CURRENT SYMPTOMS APPEARED?	
--------------------------------------	--

WHAT ARE YOU CONCERNED ABOUT TODAY?	
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TELL US WHERE YOU'RE HURT: Mark the areas on your body where you feel pain. If your pain radiates, draw an arrow from where it starts to where it stops. Use the symbols listed below.

Ache >>>>>	Burning xxxxx	Numbness =====
Stabbing /////	Pins/Needles 00000	Throbbing ~~~~~



• How often are your symptoms present? (Please circle)
0-25% 26-50% 51-75% 76-100%

• In the past week, how much has your pain interfered with your daily activities?

No interference Unable to carry out activities
0 1 2 3 4 5 6 7 8 9 10

SYMPTOM RATING SCALE

Instructions: Please circle the number that best describes your symptoms in each of the questions below.

What is your symptom intensity **RIGHT NOW**?

0	1	2	3	4	5	6	7	8	9	10
No Symptoms						Unbearable Symptoms				

What is your **TYPICAL** or **AVERAGE** symptom intensity?

0	1	2	3	4	5	6	7	8	9	10
No Symptoms						Unbearable Symptoms				

What is your symptom intensity **AT ITS WORST**?

0	1	2	3	4	5	6	7	8	9	10
No Symptoms						Unbearable Symptoms				

DOCTORS INITIALS _____ DATE _____

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INFORMED CONSENT

To our patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound therapy, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. However, 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.

These complications include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications 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.

Patient Name: _____

Patient Signature: _____

Date: _____

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PRIVACY POLICY

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this policy outlining our privacy practices.

We reserve the right to change this policy at any time, provided the applicable law allows the changes. These changes may apply to health information that was created or received before the changes were made. Before we make a significant change in our privacy practices, we will make the new policy available on request.

You may request a copy of this policy at any time. If you have questions, concerns or complaints about this policy or our privacy practices, please contact Dr. Galligan.

USE AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. Examples include:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing care to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your healthcare information in connection with our healthcare operations. Examples of healthcare operations include provider training, licensing or credentialing activities and quality assessment.

Your Authorization: In addition to the above uses of your healthcare information, you may give us written authorization to release your healthcare information to anyone at any time. You may also revoke this authorization at any time. Revocation of authorization would not affect any information that was released while the authorization was in effect. Unless you give written authorization, we cannot release your healthcare information for any reason other than those described above.

Your family and friends: Your healthcare information will not be released to your family and friends unless we have your specific permission.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location and/or general condition, if necessary. If you are able to authorize this contact, you will have the opportunity to do so. We will use our professional judgment and our experience with common practice to make reasonable decisions regarding your best interest in allowing a person to pick up your x-rays, supplies or records for you.

Marketing: We will not use your healthcare information for marketing purposes without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse or neglect, domestic violence or a victim of other crimes. This disclosure will be to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your healthcare information to provide you with appointment reminders (such as postcards, phone messages or letters).

PATIENT RIGHTS

Access: You have the right to look at or gain access to your healthcare records. If you wish to have copies of your records, you must make that request in writing. You will be charged a minimum of \$25.00 for these copies.

Amendment: You have the right to request that your health records be amended. This request must be in writing, along with an explanation for the amendment. All requests for an amendment must be approved by the treating physician and will be clearly marked in the file as a patient requested amendment.

Restrictions: You have the right to place additional restrictions on the use or disclosure of your health information. We may not be required to agree with the request for additional restrictions.

Disclosure accounting: You have the right to ask for a list of all instances of disclosure of your records, other than those disclosures for treatment, payment, healthcare operations or certain other purposes, after April 14, 2003.

QUESTIONS AND COMPLAINTS

If you have questions, concerns or complaints regarding the handling of your healthcare information, please contact Dr. Kathleen Galligan, DC.

Telephone: 503-635-1236

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ACCIDENT HISTORY

Patient Name: _____

Date and time of accident: _____

State how the accident happened: _____

Where were you sitting? ___Driver ___Right Front ___Right Rear ___Left Rear

Whose vehicle were you in? _____

Where were you facing on impact? _____

Were you aware of the impending impact? _____

Did you lose consciousness? _____ If so, how long? _____

Did your head hit the headrest? _____

Did the airbag deploy: ___on the driver's side ___on the passenger's side ___not at all?

Were you cut or bruised from the accident? Please describe. _____

Since your accident, have you experienced? Check those that apply:

___Headache

___Sore throat

___Blurred vision

___Pain on swallowing

___Dizziness

___Trouble sleeping

___Ache/pain in jaw

* Please turn page over*

Patient Name: _____

Accident History, Page 2

What were your immediate symptoms? _____

What are your current symptoms? _____

Have you received any care for your injuries? If so, who was the provider? _____

What type of care did you receive and for how long? _____

How often did you have any of the following **before** the accident?

	Never	Sometimes	Often	Always
Headache				
Ache/pain in lower back				
Ache/pain in mid-back				
Ache/pain in neck/shoulder				
Ache/pain in jaw				
Dizziness				
Trouble sleeping				

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ACCIDENT INFORMATION FORM

Patient's Name: _____ Date of Accident: _____

Your Insurance Information

Name of Policy Holder: _____

Policy Holder's Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone #: _____ Agent or Claims Contact: _____

Policy Number: _____ Claim Number: _____

Attorney Information

Attorney Name and Phone #: _____

Attorney Address: _____

THIS FORM MUST BE COMPLETED AND RETURNED TO KPCC WITHIN 72 HOURS OF YOUR FIRST VISIT. ALSO, AN APPLICATION FOR MEDICAL BENEFITS MUST BE FILLED OUT AND FILED WITH YOUR INSURANCE COMPANY TO ACTIVATE A CLAIM.

Release of Information and Assignment of Benefits

I authorize Kruse Park Chiropractic Clinic to release my records in order to obtain payment on my account for services provided to me. I authorize payment for such services to be paid directly to Kruse Park Chiropractic Clinic. I understand that I am financially responsible for any charges not paid by my insurance carrier or attorney. If I do not file a completed application for medical benefits form with my insurance company, I understand that I will be required to pay cash at the time of service for all care.

Signature

Date