ActiveLife Chiropractic

5201 SW Westgate Dr. Ste. 119 Portland, OR 97221 P: 503-335-0449

*** PLEASE BE SURE TO THOROUGHLY FILL OUT EVERY APPLICABLE LINE AND PROVIDE A SIGNATURE WHERE INDICATED. WE LOOK VERY THOROUGHLY AT EACH CASE TO BE SURE TO GIVE YOU THE BEST DIAGNOSIS AND TREATMENTS.**

Confidential Patient History

Date: _____ Name: _____

Birth Date: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Main Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____ Employer: _____

Who can we thank for referring you to our clinic? _____

Emergency Contact:_____Ph:_____Relationship:_____

As a service, we are happy to check if there is any insurance coverage for your visit here, including coverage for the office visit, rehab, chiropractic manipulation, and custom orthotics.

INSURANCE INFORMATION: ▢ No insurance coverage; I'll pay at time-of-service.

Company: _____ Name of Insured: _____ D.O.B.: _____

Insured's Employer: _____Relationship to Insured: _____

Insured's Address: _____ City: _____ State: _____

Zip: _____ Phone Number: _____

I.D. Number: _____ Group Number: _____

Any Surgeries:_____

Have you received the **Covid-19** vaccine?_____Date:_____

1. **REASONS FOR SEEKING CHIROPRACTIC CARE NOW** (Circle One): diagnosing; nutrition counseling; decrease pain; increase activities; exercise help or rehab; preventive care

Please list any other reasons for seeking care and/or areas of concern:

1._____

2._____

3._____

Patient Name:_____

2. Please circle the character of your current problems now: sharp/stabbing; achey; dull; sore; weakness; throbbing/gnawing; numbness; shooting; gripping/constricting; burning; tingling

3. How often are the complaints present? Circle One:

Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

4. How bad is your ache or pain today? Circle one: 0 1 2 3 4 5 6 7 8 9 10 (10= screaming out loud pain)

5. Since your problem began is the pain: Increasing decreasing not changing

6. When did your problem begin? (specific date if possible)_____

7. Describe how your problem began (do you know what caused it?):_____
_____

8. What treatment have you received for this condition?_____

9. Were you previously treated for a different occurrence of the same condition? Yes or No. If yes by: MD, DC, LMT, PT, Other_____ Name of provider:_____

10. Is this auto-accident related? Yes or No Is it work related? Yes or No

11. What makes your problem better? nothing; lying down; walking; standing; sitting; movement; inactivity; medication

12. What makes the problem worse? nothing; lying down; walking; standing; sitting; movement; inactivity

13. How would you grade your general stress level? No stress,; Minimal stress; Moderate stress; Greatly stressed

14. Physical activity at work: sedentary 50% of workday or more; light manual labor; manual labor

15. General physical activity: No regular exercise Light exercise strenuous exercise

16. Are your complaints affecting your ability to work or otherwise be active? No effect, need limited assistance with common tasks, have significant inability to function without assistance, some physical restrictions, need assistance often, am totally disabled

17. Have you been diagnosed with venereal disease? Yes or No

18. Have you been diagnosed with hepatitis C? Yes or No

19. Have you tested HIV positive? Yes or N

Patient Name_____

20. What surgeries have you had?_____

_____

_____

21. Have you ever tested positive for **Covid-19**?_____Any current shortness of breath, loss of sense of smell, cough, or sore throat?_____

PERSONAL AND FAMILY HISTORY OF PAST ILLNESSES

Please list any pertinent diseases (i.e.: heart disease, cancer, diabetes, kidney disease, etc.) and who had it (you or a relative).

1._____ 3._____

2._____ 4._____

PERSONAL HABITS

Do you smoke? Yes or No Cigarettes: _____ packs per day (used to smoke _____ packs/ day)

Alcohol? Yes or No Amount and frequency_____

Sugar intake amount: High Moderate Low Very Low

CURRENT MEDICATIONS: (include dosage and # pills per day, as well as over the counter meds).

1. _____ 2. _____ 3._____

4. _____ 5. _____ 6._____

What vitamins/ supplements do you take?

1._____ 2._____ 3._____

4._____ 5._____ 6._____

SOCIAL HISTORY:

Occupation:_____ How many hours do you work a week?_____

Number of hours of sleep per night?_____ Is it restful sleep?_____

Number of cups of (circle one) coffee tea soft drinks per day_____

Present weight: _____ Height: _____ feet _____inches

Do you exercise? Yes or No If yes what forms? _____
_____

What/ how much do you know about chiropractic? _____
_____

DO YOU HAVE ANY CONCERNS NOT LISTED ON THESE PAGES? (If so please list?)

1._____

2._____

3._____

4._____

Signature_____ Date_____

Printed Name:_____

Review of Systems: Please circle any you've had in last 6 months:

GENERAL:
unusual fatigue
always warm or cold
unusual weakness
chills, fever, itching
unable to stay asleep
marked weight change
night sweats
easy bleeding

HEAD:
frequent headaches
dizziness or vertigo
loss of balance
fainting spells

EYES:
blurry vision
seeing double
spots before eyes
blind areas

EARS:
hearing loss
ringing in ears

NOSE:
bleeding
sinus trouble

THROAT/ MOUTH:
hoarsenes
bleeding gums

NECK:
stiffness or pain
swelling or goiter

HEART:
high/ low blood pressure
irregular or stopped beats
racing, fluttering, or pounding
chest pain on exertion
heart murmur
sit up to breath at night
swollen feet or ankles

LUNGS:
shortness of breath
persistent cough
coughing up blood, mucus, pus
chest pain

STOMACH/ INTESTINAL:
difficulty swallowing
frequent indigestion
heartburn
nausea
diarrhea
constipation
abdominal pain

BONES, JOINTS, MUSCLES:
painful or stiff joints
swollen joints
pain in feet/ legs
cramps
muscle weakness

SKIN:
rash, hives, or itching
bruise easily
change in mole or wart
dryness
chronic sore, not healing well

MOOD:
lack of memory
depressed
irritable
tense or under stress

SEXUAL:
painful intercourse

MENSTRUAL:
menstrual pain
bleeding between periods
excessive menstrual bleeding
hot flashes
birth control pill

PREGNANCIES:
live births:_____
abortions:_____
C-sections:_____
complications:_____

NEUROLOGICAL:
chronic pain:_____
numbness:_____
tingling:_____
loss of sensation:_____
paralysis:_____
trembling:_____
seizures:_____

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REVIEW OF FEES, PRIVACY DISCLOSURE, & OTHER POLICIES

Please take the time to read thoroughly and sign below:

Private Insurance: If you have insurance coverage, as a courtesy, we will verify your coverage for spinal manipulation, rehab codes, and office visits, and bill your insurance. You will be expected to pay any co-pays, co-insurance, and/or deductible amounts at the time of service. There is a bounced check fee of $35.00. Supplements, vitamins and braces are usually not covered by private insurance. Dr. Kirnak is a preferred provider with several private insurances, including Aetna, Cigna, Moda, Providence, Blue Cross, United Healthcare and others.

We ask that patients give 48-hours' notice for cancellations or rescheduling. **Patients who do not show up or cancel appointments without at least two business day's notice will be charged a $50.00 cancellation fee, for which the patient is responsible regardless of insurance coverage.**

H.I.P.P.A. Notice:

The notes that are taken during appointments are kept in your chart and are secured in our clinic at all times. Access to this office is limited to practitioners, employees, and supervised guests.

Should we see you socially, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc.

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. Copies of released records are sent by mail or fax and are accompanied by a Confidential Patient Information cover sheet if faxed. Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university or healthcare clearing house in the normal course of the business, and 2) relates to the past, present, or future physical or mental or condition of an individual, the provisions of healthcare to an individual, or the past, present, or future payment for the provision of healthcare to an individual.

"I have read and understand the fees policies as well as my right to privacy, as stated above, and agree to have the practitioners and employees of ActiveLife Chiropractic maintain my records confidentially in accordance with the law. I agree to inform the practitioner and/ or the employees of ActiveLife if I need any special arrangements pertaining to this issue."

Name Printed:_____ Signed:_____ Date:_____