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

*** PLEASE BE SURE TO THOROUGHLY FILL OUT EVERY 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: _____ Married/Single/Partner (circle) Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

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

E-Mail: _____ Employer: _____

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

Emergency Contact:_____Ph:_____Relationship:_____

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

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

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

Insured's Employer: _____Your Relationship to Insured: _____

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

Zip: _____ Phone Number: _____ID#_____

Group Number: _____ **Note: We bill primary, not secondary insurance**

REASONS FOR SEEKING CHIROPRACTIC CARE NOW (Circle): diagnosing;

nutrition counseling; decrease pain; increase activities; exercise help or rehab; preventive care

Please list **location(s)** of any discomfort or concern, or other reasons for seeking care:

#1_____

#2_____

#3_____

2. Please circle the character of your **#1 problem** now: sharp/stabbing; achey; dull; sore; weakness; throbbing/gnawing; numbness; shooting; gripping/constricting; burning; tingling

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

(76-100% of day) (51-75% of day) (26-50% of day) (25% or less of day)
Where?_____

4. How bad is your ache or pain today? Circle one: mild/ mild-to-moderate/ medium/ severe

5. Since your #1 problem began is the pain: Increasing decreasing not changing

6. When did your problem begin? (specific date if there is one,)_____or gradual?_____

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 providers:_____

_____

10. Is this caused by auto accident? (If so, fill out MVA forms instead)! Yes or No; Is it <u>caused</u> by your work? (Workers' Comp Case): Yes or No

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

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

13. How would you grade your stress level? None; Low stress; Moderate stress; High stress

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 **(Circle closes one)**

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

20. What surgeries have you had?_____

_____

21. Any current shortness of breath, loss of sense of smell, cough, sore throat or fever? Yes/No.

22. Any history of trauma in past years/decades?
List:_____

_____

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 do you know about chiropractic? _____
_____

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

1._____

2._____

3._____

4._____

REVIEW OF SYSTEMS: Please circle any of the following you currently have, and mark "P" if it's something you had a year or more ago:

Numbness/tingling in extremities headaches/migraines shortness of breath

chest pain difficulty getting to sleep, or staying asleep high/low blood pressure

ringing in ears jaw clicking or discomfort dizziness/vertigo

seizures high or low blood sugar heart problems

severe anxiety or panic attacks suicidal thoughts alcoholism

depressed mood

****MEDICARE ADVANTAGE PLAN PATIENTS: PLEASE READ AND SIGN: Feel free to ask questions, as this can be confusing!**

Many Medicare Advantage Plans will usually cover, if medically necessary, **ONLY** the following, for chiropractors:

—-Spinal manipulation ONLY

Non-covered services may/may not include the following (we will call to check, as certain plans do cover some of these):

—**Exam**/office visit

—Manipulation of ribcage, pelvis, or feet

—Therapeutic Exercises

—massage therapy, physiotherapies, or other **soft tissue treatment**

Since treatment here ***generally includes these non-covered services***, if your plan does not cover them, (we will check), we charge an additional, flat, **Senior discount fee** for soft tissue work, ***in addition to your co-pay***. For an **exam**, this is an additional **$150**, and ***after the 1st visit***, I charge an **additional $55 to your regular co-pay**.

"I have read and understand the fee policy for **Medicare Advantage Plan**, and agree to receive non-covered services as needed, and agree to pay extra, discounted fee, out of pocket for the additional services, in addition to my regular co-pa"

Signed:_____ Date:_____

ActiveLife Chiropractic
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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 **Pacific Source, Moda, Providence, Blue Cross, United Healthcare** and others. We are **no longer in-network for Cigna, Healthnet, or most Kaiser Plans (except Intel Kaiser Plan).**

Fees for Exam/Office visit range from $94-220, for manipulation: $55-100, and from $20-58 for various soft tissue work/physiotherapy modalities.

We ask that patients give a full **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:_____

Or Name of parent/guardian:_____Signed:_____