

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: \_\_\_\_\_

**\*\*Fragrance Free Clinic: due to allergies, please refrain from perfumes when you come in!**

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**

### Credit Card Information:

**\*\*Is your insurance an HSA plan, or have unmet deductible?** ActiveLife Chiropractic requires that you put a card on file for contactless payments. This card will be charged for the amount your insurance allows after they process your claims, towards your deductible.

Card Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Exp.: \_\_\_\_ / \_\_\_\_

**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 \_\_\_\_\_ Names of providers: \_\_\_\_\_  
\_\_\_\_\_

**10. Is this caused by auto accident? (If so, fill out MVA forms instead)! Yes or No; Is it caused 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    depression

**\*\*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 \$65 to your regular co-pay**. (So if your copay is \$15, you pay \$80 total).

"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

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

### 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, Blue Cross, United Healthcare** and others. We are **no longer in-network for Cigna, Healthnet Providence,, 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:** \_\_\_\_\_