DUNN CHIROPRACTIC CLINIC
301 DUNN PLACE
MCMINNVILLE, OR 97128
Ph# 503-472-6550
Fax 503-472-1039

George Siegfried, D.C.
Chiropractic Physician
Since 1983

CORBETT HILL WELLNESS
4425 SW CORBETT AVE.
PORTLAND, OR 97239
Ph# 503-472-6550
Fax 503-472-1039

WELCOME TO THE CLINIC

New Patient Information Worksheet:

Thank you for taking your time to fill this out. It will reduce your wait at the clinic.

Name:_____ **Date of Birth:**_____ **Age:** _____

Address:_____ **City:**_____ **State:**_____ **Zip:** _____

H. Phone:_____ **W. Phone:**_____ **Cell:** _____

Emergency Contact: Name_____ **Phone:** _____

E-mail: (*only if you want to be on our list. Your information is not shared with anyone*)

Yes_____ No _____ E-mail: _____

Employer: _____

Referred By: ☐Friend ☐Relative ☐Newspaper Ad ☐Yellow Pages ☐Sign ☐Other: _____ Which one of our patients should we thank for referring you? _____

Have you ever been to a Chiropractor? Yes_____ No_____ Last Adjustment _____
Xrays/MRI/CT Scans taken? Yes_____ No _____

Were you satisfied with your care? Yes_____ No _____

Please circle your current chief complaint(s) and/or symptoms:
(Headaches) (Neck Pain) (Neck Stiffness) (Allergies) (Shoulder/Arm Pain) (Upper-Back Pain) (Mid-Back Pain) (Low-Back Pain) (Hip/Pelvis Pain) (Sinus Problems) (Asthma) (Stomach Pain) (Chest Pain) (Numbness) (Arthritis) (Sciatica) (Stress) (Other)_____

My symptoms are due to: ☐Auto Accident ☐Work Accident ☐Home Accident ☐Slip/Fall ☐Gradual Onset ☐Other: _____

When did your symptoms begin: _____

Have you ever had this compliant before? Yes_____ When?_____ No _____

Have you lost any work days? Yes_____ How many?_____ No _____

Doctors you have seen for your complaint(s): ___
How does this affect your daily life? __
Are you taking any medications? Yes No _____
If yes, for what condition(s)? __
Are you under care for any other conditions? _____

Any serious condition the doctor should be aware of? _____

Please go to the next page…

Do you have any root canals? Yes_____No_____Mercury Fillings? Yes_____No _____

What kind of water do you drink? Tap_____Bottled_____Filtered _____
Well_____Spring_____Distilled _____
***Females: Are you pregnant at this time?** Yes_____No_____Due Date:_____Do you wear arch supports? Yes_____No_____If yes, what kind? _____

PAST HEALTH HISTORY:

Please list any surgeries you have had and when:

_____

_____

Please indicate if you have a history of any of the following:

Previous Trauma/Injury: Head, back, neck, other _____

Have you ever broken any bones? _____

Which ones? _____

Known Allergies? _____

Pregnancies/Difficulty? _____

Family Health History:

Back problems:_____Scoliosis: _____
Cancer ☐ Strokes/TIA ☐ Headaches ☐ Heart disease ☐ Neurological Diseases
Adopted/Unknown ☐ Heart problems below age 40 ☐ Mental Illness ☐ Diabetes
Other: _____ None of the above
Anything else the doctor should know about? _____

Social History:

How many hours a week do you work? _____

Do you play sports? Yes_____Which?_____No _____

Do you exercise? Yes_____Which?_____No _____

Any trouble sleeping? Yes_____How many hours a night?_____No _____

Do you drink alcohol? Yes_____No_____Smoke? Yes_____No _____

Please go to the next page…

Patient Health History Worksheet:

Patient Name: _____ **Date:** _____

What time of day are your symptoms better?
Morning ☐Afternoon ☐Evening ☐None of these ☐ Constant Pain

What time of day are your symptoms worse?
Morning ☐Afternoon ☐ Evening ☐ All of the above ☐ Constant Pain

What makes your pain better?
Rest ☐ Ice/Heat pad ☐ Prescription Medications ☐ Drug store medications/Ibuprofen, Advil, etc.
Sitting ☐Standing ☐Laying down ☐ Other: ____

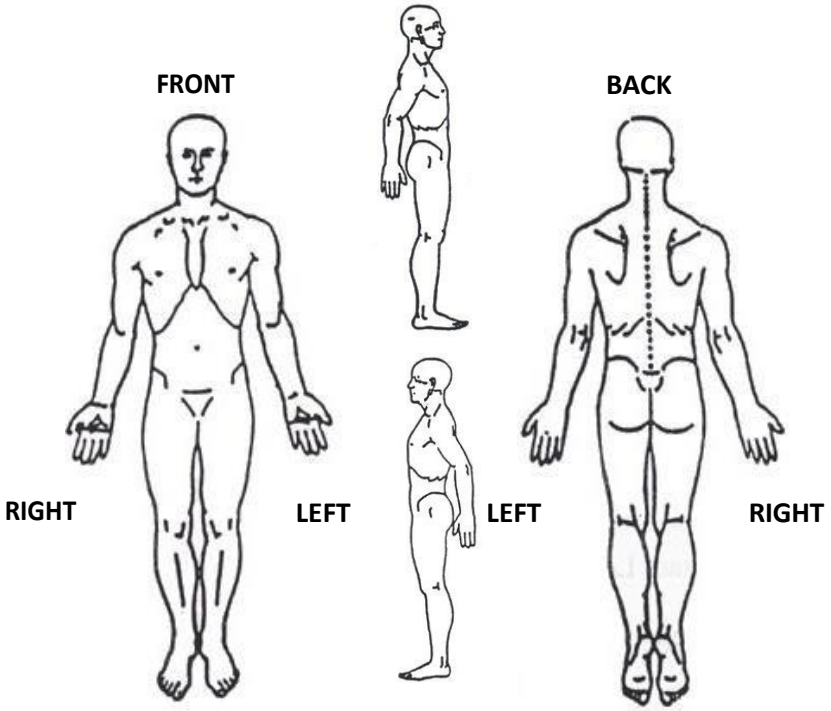
What makes your symptoms worse?
Activity (walk, repetitive motions) ☐ Ice pack/Heating pad ☐ Driving/Sitting in car ☐ Standing
Night time/bed ☐ Other: _____

What home remedies have you tried?
Ice ☐Heat ☐Hot Tub ☐Exercise ☐Stretching
☐ Vitamins ☐Other: __

Please Label The Area(s) of Today's Pain on the picture below and list the Quality of Your Pain
(Sharp, Dull, Radiating, Aching, Burning, Numbness)

Please circle the appropriate number on this scale
(No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)

A=Ache B=Burning N=Numbness S=Stabbing O=Other



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ACTIVITIES OF DAILY LIVING (ADL) WORKSHEET

Patient's Name _____ **Date:** _____

*(Please **circle the number** which most closely describes your "Activities Of Daily Living" today)*

1. Pain Intensity

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Frequency Of Pain

0	1	2	3	4
No Pain	Occasional Pain 25% Of The Day	Intermittent Pain 50% Of The Day	Frequent Pain 75% Of The Day	Constant Pain 100% Of The Day

3. Personal Care (Washing, Dressing, etc.)

0	1	2	3	4
No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to go slowly	Moderate Pain Need some assistance	Severe Pain Need 100% Assistance

4. Travel (Driving, Riding, etc.)

0	1	2	3	4
No Pain On Long Trips	Mild Pain On Long Trips	Moderate Pain On Long Trips	Moderate Pain On Short Trips	Severe Pain On Short Trips

5. Work

0	1	2	3	4
Can Do Usual Work Plus Extra Work	Can Do Usual Work No Extra Work	Can Do 50% Of Usual Work	Can Do 25% Of Usual Work	Cannot Work

6. Recreation

0	1	2	3	4
Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do A Few Activities	Cannot Do Any Activities

7. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed

8. Lifting

0	1	2	3	4
No Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Moderate Weight	Increased Pain With Light Weight	Increased Pain With Any Weight

9. Walking

0	1	2	3	4
No Pain Any distance	Increased Pain After One Mile	Increased Pain After Half Mile	Increased Pain After Quarter Mile	Increased Pain With All Walking

10. Standing

0	1	2	3	4
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After One Hour	Increased Pain After Half Hour	Increased Pain With Any Standing

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Patient Name: _____ **Date:** _____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
Asthma/difficulty breathing ☐ COPD ☐ Emphysema ☐ Other ☐ None of the above

Have you had any of the following **cardiovascular (heart –related)** issues or procedures?
Heart surgeries ☐ Congestive heart failure ☐ Murmurs or valvular disease ☐ Heart attacks/MIs
Heart disease/problems ☐ Hypertension ☐ Pacemaker ☐ Angina/chest pain ☐ Irregular heartbeat
Other _____

Have you had any of the following **neurological (nerve-related)** issues?
Visual changes/loss of vision ☐ One-sided weakness of face or body ☐ History of seizures ☐ One-sided decreased feeling in the face or body ☐ Headaches ☐ Memory loss ☐ Tremors ☐ Vertigo ☐ Loss of sense of smell
Strokes/TIAs ☐ Other _____ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
Thyroid disease ☐ Hormone replacement therapy ☐ Injectable steroid replacements ☐ Diabetes
Other _____ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
Renal calculi/stones ☐ Hematuria (blood in the urine) ☐ Incontinence (can't control) ☐ Bladder Infections
Difficulty urinating ☐ Kidney disease ☐ Dialysis ☐ Other_____ ☐ None of the above

Have you ever had any of the following **gastroenterological (stomach-related)** issues?
Nausea ☐ Difficulty swallowing ☐ Ulcerative disease ☐ Frequent abdominal pain ☐ Hiatal hernia
Constipation ☐ Pancreatic disease ☐ Irritable bowel/colitis ☐ Hepatitis or liver disease ☐ Bloody or black tarry stools ☐ Vomiting blood ☐ Bowel incontinence ☐ Gastroesophageal reflux/heartburn ☐ Other _____ None of the above

Have you ever had any of the following **hematological (blood-related)** issues?
Anemia ☐ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) ☐ HIV positive
Abnormal bleeding/bruising ☐ Sickle-cell anemia ☐ Enlarged lymph nodes ☐ Hemophilia
Hypercoagulation or deep venous thrombosis/history of blood clots ☐ Anticoagulant therapy ☐ Regular aspirin use
Other _____ None of the above

Have you ever had any of the following **dermatological (skin-related)** issues?
Significant burns ☐ Significant rashes ☐ Skin grafts ☐ Psoriatic disorders ☐ Other _____
None of the above

Have you had any of the following musculoskeletal **(bone/muscle-related)** issues?
Rheumatoid arthritis ☐ Gout ☐ Osteoarthritis ☐ Broken bones ☐ Spinal fracture ☐ Spinal surgery None of the above
☐ Joint surgery ☐ Arthritis (unknown type) ☐ Scoliosis ☐ Metal implants ☐ Other _____

Have you had any of the following **psychological** issues?
Psychiatric diagnosis ☐ Depression ☐ Suicidal ideations ☐ Biopolar disorder ☐ Homicidal ideations
Schizophrenia ☐ Psychiatric hospitalizations ☐ Other_____ ☐ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to George Siegfried, D. C. / Dunn Chiropractic Clinic / Johns Landing Clinic for the services performed.

Patient or Guardian Signature_____ Date _____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

Please go to the next page…

Office Policies: *If I am accepted as a patient at Dr. Siegfried's Office, I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or-rays will be released from this office if I owe any money on my account.*

Consent To Treat: *I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Siegfried to proceed with any necessary treatment. I have read Dr. Siegfried's office policies and consent to treat information, and I agree with them by signing below:*

Note: *Payment is due at the time of service, unless other arrangements have been made.*

Thank you again for filling out this health information it will help the doctor serve you better.

Name (Printed Please)	Signature	Date

If you are a minor, or if you are being represented by another party.

Personal Representative Print	Personal Representative Signature	Date

Submit Form