PATIENT INTAKE FORM | Health & Wellness

GRAFFEO ACCIDENT & INJURY CLINIC
Joseph Graffeo, DC, PC
16248 NE Glisan St • Portland, OR 97230

Date: _____

ABOUT YOU

First Name _____ Middle Name _____

Last Name _____ Email Address _____

Street Address _____

City _____ State _____ Zip _____

Date of Birth: _____ / _____ / _____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Number of Children: _____ Spouse's Name: _____

Height: _____ ' _____ " Weight: _____ lbs Dominant Hand: ☐ Right ☐ Left

Cell Phone: ____-____-_____ Home Phone: ____-____-_____ Work Phone: ____-____-_____

Employment Status: ☐ Full-time *(20-40+ hours/week)* ☐ Retired ☐ Homemaker
☐ Part-time *(1-19 hours/week)* ☐ Student ☐ Unemployed
☐ Permanently fully disabled ☐ Permanently partially disabled

Occupation: _____ Employer: _____

EMERGENCY CONTACT INFORMATION

Name _____

Phone Number: ____-____-_____ Relation to you: _____

REFERRAL INFORMATION

Primary Care Doctor: _____ Phone: ____-____-_____

How did you hear about us? ☐ Family or Friend (enter name): _____

☐ Advertisement ☐ Internet ☐ Sign ☐ Other: _____

INSURANCE INFORMATION

Do you have insurance? ☐ Yes ☐ No

Insurance Name _____ Phone: ____-____-_____

Insurance Address _____

City _____ State _____ Zip _____

ID/Policy # _____ Group # _____

Insured's Name: _____ Insured's DOB: ____ / ____ / _____

REASON FOR VISIT

What is the **MAIN** reason for this visit?

☐ Auto Accident ☐ Pain/Home Injury ☐ Other Injury: _____
☐ Work Injury ☐ General Wellness ☐ Other Reason: _____

CURRENT CONDITION

When did this condition begin? **Approximate Date:** _____ / _____ / _____

What caused this condition?

- ☐ After a fall
- ☐ After a long drive
- ☐ After a long flight
- ☐ After a poor night's sleep
- ☐ Associated with prolonged or chronic illness
- ☐ After a slip
- ☐ After lifting an object
- ☐ After reaching or over-reaching
- ☐ After performing household chores
- ☐ After performing yardwork
- ☐ After sitting in one place for too long
- ☐ Of unknown origin
- ☐ Other: _____

How did this condition start? ***(describe in detail)***

_____

_____

_____

_____

_____

_____

_____

_____

What treatment have you received for this condition up to now? ***Choose all that apply***

- ☐ None
- ☐ Chiropractic care
- ☐ Massage
- ☐ Acupuncture
- ☐ Over-the-counter medications
- ☐ Prescribed medications
- ☐ Natural or holistic treatment
- ☐ Medical injection treatment
- ☐ Surgical treatment
- ☐ Physical therapy
- ☐ Other: _____

Have you seen other doctors for this condition? ☐ No ☐ Yes: *Doctor's Name:* _____

Visit Date/s: _____

Have you ever had any previous episodes of this condition? ☐ No ☐ Yes: *Explain:* _____

_____

MEDICAL HISTORY

Have you had in the past or do you have now any of the following health issues?
Mark all that apply. Enter any "Other" conditions not shown. If none apply, mark the box below.

CONDITIONS of the HEAD, EYES, EARS, NOSE or THROAT

- ☐ Sinus Trouble
- ☐ Pain in Jaw Joints
- ☐ Visual Disturbances
- ☐ Hearing Difficulty

CANCER

- ☐ Prior Cancer
- ☐ Current Cancer
- ☐ Leukemia
- ☐ Night Sweats

NEUROLOGICAL CONDITIONS *(Nerve-related)*

- ☐ Migraines
- ☐ Stroke or TIA
- ☐ Fainting or Dizziness
- ☐ Epilepsy or Seizures

PULMONARY CONDITIONS *(Lung-related)*

- ☐ Asthma
- ☐ Lung Disease
- ☐ Breathing Problems
- ☐ Emphysema/COPD

MEDICAL HISTORY
continued

ENDOCRINE CONDITIONS *(Glandular/Hormonal-related)*

☐ Diabetes ☐ Thyroid Disease
☐ Liver Disease ☐ Hypoglycemia

CARDIO-VASCULAR CONDITIONS *(Heart-related)*

☐ Hemophilia ☐ Heart Disease
☐ Anemia ☐ High Blood Pressure

MUSCULOSKELETAL CONDITIONS *(Bone/Muscle-related)*

☐ Osteoporosis ☐ Arthritis/Gout
☐ Artificial Joint ☐ Fibromyalgia

RENAL CONDITIONS *(Kidney-related)*

☐ Kidney Disease ☐ Dialysis
☐ Kidney stones ☐ Bladder Infections

GASTROENTEROLOGICAL CONDITIONS *(Stomach-related)*

☐ Recent Weight Loss ☐ Stomach/Intestinal Disease
☐ Recent Weight Gain ☐ Ulcers

DERMATOLOGICAL CONDITIONS *(Skin-related)*

☐ Significant rashes
☐ Psoriatic disorders

ALLERGIES OR SENSITIVITIES

☐ Describe: _____

PSYCHOLOGICAL CONDITIONS

☐ Describe: _____

☐ ***OTHER CONDITION***: _____ ☐ **I HAVE NONE OF THESE CONDITIONS.**

Are you presently taking ANY medications? ☐ No ☐ Yes: *What are you taking?* _____

_____

Have you ever had any MAJOR surgeries? ☐ No ☐ Yes: *Type of Surgery:* _____

Reason: _____ *Surgery Date/s:* _____

Have you been in the hospital in the past FIVE years? ☐ No ☐ Yes: *What Hospital?* _____

Reason: _____ *Date/s:* _____

Have you had any prior AUTO ACCIDENTS or any RECENT injuries? ☐ No ☐ Yes: *Type of Injury:* _____

Date of Injury: _____ *Were you treated for this Injury?* ☐ No ☐ Yes:

Doctor's Name: _____ *Visit Date/s:* _____

Are you currently treating with any other doctor? ☐ No ☐ Yes: *Doctor's Name:* _____

Reason: _____ *Visit Date/s:* _____

Do you have a past family history of illness, such as diabetes, cancer, hypertension, or progressive neurological diseases that we should be aware of? ☐ No ☐ Yes: *Describe:* _____

_____

SOCIAL HABITS *Choose all that apply or select "None apply"*

Personal social habits:
☐ Smoke or use tobacco products
☐ Use recreational drugs
☐ Other: _____
☐ Drink alcohol
☐ Drink caffeine
☐ None apply

Present exercise habits:
☐ No current exercises
☐ Exercise daily
☐ Exercise 3+ times per week
☐ Cannot exercise due to current condtion

Diet and nutrition habits: ☐ Vegan or vegetarian ☐ Daily supplements ☐ None apply

ADULT WOMEN'S HEALTH *- for Women Only*

Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

What was the date of your last menstrual period?

☐ Within the past month or currently
☐ Within the past 1 to 3 months
☐ Greater than 3 months
☐ Postmenopausal
☐ Have not yet begun menstruation
☐ Prefer not to answer or don't know

FINANCIAL AGREEMENT | Health & Wellness

We do not participate in any health insurance plans, and do not accept assignment of any health insurance benefits. We must receive payment in full at the time of service. You may choose to enroll in **ChiroHealthUSA**, a discount medical plan in which our clinic participates, so that you may receive discounts on our standard fees. These discounts are valid only if you enroll in the plan and pay your bill in full at each visit.

While we require payment in full at the time of service, as a courtesy to our patients with health insurance, we will provide you upon your request with a "superbill" which you may submit to your insurance company for reimbursement. However, submitting a bill does not a guarantee that your insurance company will pay you for the services you have paid for. Health insurance policies are an arrangement made between the patient and the insurance carrier. Even though we cannot accept assignment of insurance payments, and cannot bill your health insurance directly, we will be glad to help you work with your insurance company.

INFORMED CONSENT

Chiropractic treatment and physiotherapy (including chiropractic adjustments, manual therapy, therapeutic massage, therapeutic exercise, whole body vibration, cold laser therapy, electrotherapy, and therapeutic nutrition) are highly safe and effective methods of care. Other treatment options for your condition may include: self-administered over-the-counter analgesics; rest; medical care and prescription drugs such as anti-inflammatories, muscle relaxers, or pain-killers; hospitalization; or surgery. While chiropractic care is remarkably safe, as with all types of health care, complications may arise. Although the chance of experiencing any complication is very small, you need to be informed about the potential risks before consenting to treatment. Complications may include soreness, inflammation, sprains, dislocations, or fractures, soft tissue injury, dizziness, or a temporary worsening of your symptoms. More serious complications, such as injuries to the neck arteries, stroke, spinal disc injuries, or spinal fractures are extremely rare. The chance of such injury is estimated to range from one in one million treatments to one in ten million treatments. You are always welcome to ask questions, and we encourage you to participate in your healing process.

ACKNOWLEDGEMENT & CONSENT TO TREATMENT

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic, including the use of my email address for all permissible applications. I authorize this office and its staff to examine and treat my condition as the doctors see fit, and request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named above, for whom I am legally responsible). I authorize and approve treatment by any licensed doctor of chiropractic who now or in the future may be employed by, working with, or associated with the Clinic (or substituting for such doctor or staff member).

I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I understand that payment in full for all products and services is due at the time of service. I promise to pay promptly when presented with my bill, and agree to notify you within sixty days if I think that part of the bill is in error. I agree to permit the clinic to apply a Finance Charge of 0.75% per month (annual percent of 9%) on any amount outstanding after 90 days.

Patient Signature _____ Personal Representative's Signature _____

Description of Personal Representative's authority to act for the patient. _____ Personal Representative's Name *(Printed)* _____

Signature of Physician: _____ *Staff Witness:* _____