equilibrium
chiropractic acupuncture massage

913 SW 16th Avenue
Portland, OR 97205
P: 503.228.5000
F: 503.228.5019
W: equilibriumnw.com

PATIENT INFORMATION

NAME: _____ DATE: _____

ADDRESS: _____ CITY/ST _____ ZIP _____

PHONE (H) _____ (C) _____ (W) _____

DATE OF BIRTH: _____ AGE: _____ SEX: M F SS# (*OPTIONAL*):_____

E-MAIL: _____ Ok to send you our newsletter? ☐ PRIMARY LANGUAGE:_____

EMPLOYER: _____ OCCUPATION: _____

RELATIONSHIP STATUS: ☐ MARRIED ☐ PARTNERED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

SPOUSE/PARTNER NAME: _____ PHONE: _____

EMERGENCY CONTACT:_____ RELATIONSHIP: _____ PHONE: _____

LIVING SITUATION: ☐ ALONE ☐ W/PARTNER OR SPOUSE ☐ W/FRIENDS ☐ W/CHILDREN ☐ W/PETS

WHOM MAY WE THANK FOR THE REFERRAL?_____

AUTHORIZATION TO TREAT A MINOR

If the patient is under the age of 18, or is otherwise unable to sign, please complete the following.

Patient is _____ years of age OR unable to sign because: _____

SIGNATURE: _____ DATE: _____ RELATIONSHIP TO PATIENT:_____

INSURANCE INFORMATION

Please present your insurance card(s) to an Equilibrium front desk employee for photocopying.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. I AGREE TO NOTIFY EQUILIBRIUM IMMEDIATELY WHENEVER I HAVE CHANGES IN MY PERSONAL INFORMATION LISTED ABOVE, INCLUDING MY INSURANCE STATUS. INITIAL HERE: _____

CANCELLATION POLICY *(Effective 02/02/15)*

Equilibrium requires a 24-hour advance cancellation for all appointments. If I am unable to give 24 hours advance notice the following fees will be charged: **$76.50** for a chiropractic appointment, **$75** for a massage appointment and **$88** for an acupuncture treatment. I have read and understand the cancellation policy.

PATIENT SIGNATURE: _____DATE: _____

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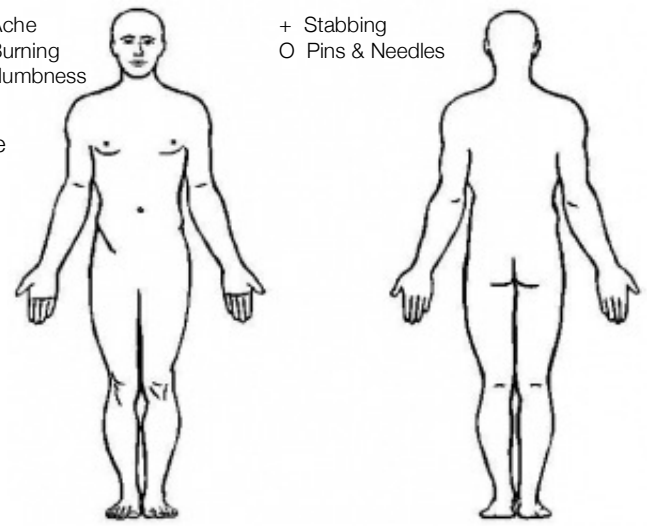
PATIENT NAME: _____ DOB: _____ DATE: _____

Please fill this page out if you are seeking treatment for musculoskeletal issues. Mark all symptom areas on the body diagram below (use the key provided):

* Ache
\- Burning
> Numbness
\+ Stabbing
O Pins & Needles



Please rate your symptom intensity right now: (circle)

0 1 2 3 4 5 6 7 8 9 10

For Provider Use Only

- When did your symptoms begin? _____
- Work-related? Y / N Motor Vehicle Collision? Y / N
- How did your pain begin? (circle) Bending Lifting Fall
  Other: _____
- Prior treatment for your symptoms? (circle)
  Chiropractic Acupuncture Massage PT Medical
  Date: _____ Results: _____
  Diagnoses Given To You: _____
- Anti-inflammatories/Pain Meds? (circle)
  Ibuprofen Acetaminophen Other: _____
- Pain Chronology: (circle):
  Improved Worsened Constant Intermittent
  Other: _____
- Has this happened in the past? NO / YES (when? _____ treatment? _____ results?_____

- **How do the following affect your pain? (circle)**

Cough/sneeze:	worse	better	no difference
Sitting:	worse	better	no difference
Sit to stand:	worse	better	no difference
Bending forward:	worse	better	no difference
Bending back:	worse	better	no difference
In the morning:	worse	better	no difference
Night time:	worse	better	no difference
Lifting:	worse	better	no difference
Standing:	worse	better	no difference
Walking:	worse	better	no difference
Lying face down:	worse	better	no difference
Looking down:	worse	better	no difference
Looking up:	worse	better	no difference
Turning head:	worse	better	no difference

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PATIENT NAME: _____ DOB: _____ DATE: _____

Medical History

- **Height**: _____ **Weight**: _____ Recent Gain? Loss? Amount: _____

  Past maximum/minimum weight: _____/_____ When?
- **What was your most recent blood pressure reading?** _____/_____ When?
- **Have you ever been treated with acupuncture before?** Yes No
- **Is your condition due to an accident?** Yes No Explain:_____
- **Main problem(s) you would like us to help you with:**
- **How long ago did this problem begin (be specific):**
- **To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?**
- **Have you been given a diagnosis for this problem If so, what?**
- **What kind(s) of treatment have you tried?**
- **Are you (or have you ever been) under the care of a primary care physician in the last year?** Yes No

  Physician's Name: _____

  Reason:
- **List any surgeries you've had:**
- **List any significant trauma you've experienced (auto accidents, falls, etc):**
- **List any allergies you have (drugs, chemicals, foods, etc):**
- **What is your occupation? Level of occupational stress?**
- **Do you have a regular exercise program? If yes, please describe:**

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- **Medicines taken within the last two months (include vitamins, OTC drugs, herbs, etc):**

- **Have you, or have you ever been, on a restricted diet? What kind?**

- **Please describe your average daily diet:**

- **Habits (cigarettes, coffee, tea, cola, alcohol, drugs, sugar, salt, other):**

- **Do you or any of your immediate family members have any of the following inheritable conditions? NO / YES (circle and indicate whom below)**
  heart disease cancer diabetes strokes high blood pressure arthritis scoliosis mental illness
  other: _____

- **If you are working, please circle all of the following items that pertain to your job or jobs:**
  Full Time (>35 hrs/wk) Part Time (<35 hrs/week) Sitting Standing Heavy Lifting Air Travel

- **Have you taken a leave from work because of your injuries?**
  NO / YES (when? _____ restrictions? _____)

Please check if you have had any of the following in the last three months OR a chronic tendency towards any of the following:

General

☐ Poor appetite	☐ Bleed or bruise easily	☐ Tremors	☐ Night sweats	☐ Strong thirst (hot/cold drinks)
☐ Fevers	☐ Peculiar tastes or smells	☐ Poor balance	☐ Cravings	☐ Sudden energy drop
☐ Sweat easily	☐ Poor sleeping	☐ Weight loss	☐ Change in appetite	(What time of day?)
☐ Localized weakness	☐ Chills	☐ Fatigue	☐ Weight gain	

Skin & Hair

☐ Rashes	☐ Itching	☐ Dandruff	☐ Ulcerations	☐ Eczema
☐ Loss of hair	☐ Hives	☐ Pimples	☐ Recent moles	☐ Change in hair or skin texture

Any other hair or skin problems?

Head, Eyes, Ear, Nose & Throat

☐ Dizziness	☐ Glasses	☐ Poor vision	☐ Cataracts	☐ Ringing in ears
☐ Sinus problems	☐ Grinding teeth	☐ Teeth problems	☐ Concussions	☐ Eye strain
☐ Night blindness	☐ Blurry vision	☐ Poor hearing	☐ Nose bleeds	☐ Facial pain
☐ Jaw clicks	☐ Migraines	☐ Eye pain	☐ Color blindness	☐ Earaches
☐ Spots in front of eyes	☐ Recurrent sore throats	☐ Sores on lips or tongue	☐ Headaches (Where and when?)	

Any other head or neck problems?

Cardiovascular

☐ High blood pressure	☐ Irregular heartbeat	☐ Cold hands or feet	☐ Blood clots	☐ Low blood pressure
☐ Dizziness	☐ Swelling of hands	☐ Phlebitis	☐ Chest pain	☐ Fainting
☐ Swelling of feet	☐ Difficulty breathing			

Any other heart or blood vessel problems?

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Respiratory

☐ Cough ☐ Bronchitis ☐ Coughing blood ☐ Asthma
☐ Pain with a deep breath ☐ Difficulty breathing lying down ☐ Pneumonia ☐ Production of phlegm? What color?

Any other lung problems?

Gastrointestinal

☐ Nausea ☐ Constipation ☐ Black stools ☐ Bad breath ☐ Abdominal pain or cramps
☐ Chronic Laxative use ☐ Vomiting ☐ Gas ☐ Blood in stools ☐ Rectal pain
☐ Diarrhea ☐ Belching ☐ Indigestion ☐ Hemorrhoids

Any other problems with your stomach or intestines?

Genitourinary

☐ Pain on urination ☐ Urgency to urinate ☐ Decrease in flow ☐ Frequent urination ☐ Unable to hold urine
☐ Impotency ☐ Blood in urine ☐ Kidney stones ☐ Sores on genitals Do you wake to urinate? How often?

Any particular color to your urine?

Any other problems with your genital or urinary systems?

Pregnancy and Gynecology

_____ No. of pregnancies _____ Number of births _____ Premature births ____ Miscarriages _____ Abortions

_____ Age at first menses ___Age last menses _____ First date of last menses _____ Period between menses _____ Duration

☐ Irregular periods ☐ Unusual character (heavy/ light) ☐ Changes in body/psyche prior to menstruation ☐ Vaginal discharge ☐Clots

☐ Painful periods ☐ Vaginal sores ☐ Last PAP ☐ Breast lumps

Changes in body/psyche prior to menstruation:

Do you practice birth control? What type & for how long?

Musculoskeletal

☐ Neck pain ☐ Back pain ☐ Hand/wrist pains ☐ Muscle pains ☐ Muscle weakness
☐ Shoulder pain ☐ Knee pain ☐ Foot/ankle pains ☐ Hip pain

Any other joint or bone problems?

Neuropsychological

☐ Seizures ☐ Areas of numbness ☐ Concussion ☐ Bad temper ☐ Dizziness
☐ Lack of coordination ☐ Depression ☐ Easily susceptible to stress ☐ Loss of balance ☐ Poor memory
☐ Anxiety

Have you been treated for emotional problems?

Any other neurological or psychological problems?

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EXPLANATION OF SERVICES AND FEE SCHEDULE

Please read the laminated form that was given to you by the front desk, titled "Explanation of Services and Fee Schedule", before signing below.

I HAVE READ AND UNDERSTAND THE PROVIDED STATEMENTS regarding the services available by Melissa Miesen, LAc, LMT, the potential for side effects, how best to minimize the side effects and gain optimum results. I also understand that there are no guarantees or warranty for a specific cure or outcome. I consent to the fees to be paid at the times of service unless insurance is to be billed. I consent to the release of my clinical information for the purpose of obtaining insurance payments and for provider referrals for the purpose of continuing care.

Equilibrium requires a 24 hour advance cancellation for all appointments. I agree to pay the full cost of treatment if I fail to give a 24 hour cancellation notice.

By signing below, I agree to the conditions stated above.

Print Name _____

Signature _____ Date _____

Protected Diagnosis: If your medical records contain information about drug or alcohol diagnosis or treatment, or HIV testing, you may authorize the release of this information for billing purposes only.
Non-disclosure of Sensitive information: I request that information about drug/alcohol or HIV treatment and related disease not be released.

Signature _____ Date _____

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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.

In the course of your care as a patient at Equilibrium, we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, a collection agency, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you. Including information needed for independent collection agencies.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your voicemail or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to

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whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

Nicole Bhalerao, DC, Shireesh Bhalerao, DC, or Melissa Miesen, LAc

If you would like further information about our privacy policies and practices please contact:

Nicole Bhalerao, DC, Shireesh Bhalerao, DC, or Melissa Miesen, LAc

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of December 2, 2014

Your signature below acknowledges that you have read a copy of this notice. You have the right to a paper copy of this notice at any time. You may also find a copy of this notice on our web site.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that by signing below that I have received a copy of this office's Notice of Privacy Practices.

Patient name – PLEASE PRINT DATE Patient signature – PLEASE SIGN

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Dear Friends and Patients without acupuncture insurance coverage:

I invite you to take advantage of my time of service discount series. These two incentive options are designed to help patients maintain their acupuncture and massage achievements with regularly scheduled and prepaid appointments. Patients who consider a series of consistent prescheduled treatments may benefit with quicker and longer lasting results while enjoying enhanced mobility, flexibility, and ability to handle stress.

1) For acute or long standing conditions, purchase 6 treatments to be used in 3 weeks (2 prescheduled treatments a week) for a time of service discount of $440 (save $88 or 16.6%).

2) For enhanced wellness and preventative care, purchase 6 treatments to be used in 3 months (2 prescheduled treatments a month) for a time of service discount of $484 (save $44 or 8.3%).

The Reason:

A) For acute and long standing conditions it is ideal for the body to receive a healing “re-boot” in relative succession. It is rare for one treatment of acupuncture to completely cure these types of symptoms, but it is common for a treatment to relieve symptoms by 20-80%, the outcome depending on the overall health of the patient. It is also rare for the achieved results to last indefinitely, but it is common for the results to build with succeeding treatments. The sooner the intensity (acuteness) and chronicity of the symptoms are relieved, the sooner the balance of health will be the norm, and the better the body will be able to adapt to stress.

B) The idea of wellness or preventative care – care in the absence of acute symptoms – has long been recognized as important and cost effective. The theory being, if we catch something early, we can prevent it from becoming an acute, painful and expensive health care issue. Stresses of a physical, emotional, dietary, traumatic or environmental nature naturally accumulate throughout our lives and exponentially accelerate when we are unable to make good lifestyle choices. Our culture encourages constant thought and motion; go, think, do more!... The chronic results can cause a disconnect from our bodies and then, over time, real psychological, emotional or physical pain emerges. Acupuncture, chiropractic, Oriental medicines and massage help activate our bodies’ innate healing response which then helps regenerate our more natural state of health.

I agree to the terms of the Time of Service Discount Series: A) $440 for 6 prepaid and prescheduled treatments, 2 per week for 3 consecutive weeks, or B) $484 for 6 prepaid and prescheduled treatments, 2 per month for 3 consecutive months.

Signature _____ Date _____