equilibrium
chiropractic acupuncture massage

913 SW 16th Avenue
Portland, OR 97205
P: 503.228.5000
F: 503.228.5019

PATIENT INFORMATION

NAME_____DATE_____
ADDRESS_____
CITY_____ST_____ZIP_____
PHONE(H)_____(C)_____
(W)_____DATE OF BIRTH_____
EMAIL_____
AGE_____ SEX: M F SS#(optional)_____
EMPLOYER_____OCCUPATION_____
ARE YOU CURRENTLY:
MARRIED_____ PARTNERED_____ DIVORCED_____ WIDOWED_____ SINGLE____
SPOUSE/PARTNER NAME_____PHONE_____
WHOM MAY WE THANK FOR THE REFERRAL_____
EMERGENCY CONTACT:
NAME_____
PHONE#_____RELATION_____

INSURANCE INFORMATION

NAME OF INSURED_____
RELATION TO PATIENT_____ DATE OF BIRTH_____
INSURANCE COMPANY_____PHONE_____
ADDRESS_____
CITY_____ ST_____ ZIP_____
MEMBER ID#_____
GROUP NAME/#_____
ADDITIONAL /SECONDARY INSURANCE INFORMATION (if applicable)
NAME OF INSURED_____
RELATION TO PATIENT_____ DATE OF BIRTH_____
INSURANCE COMPANY_____PHONE_____
ADDRESS_____
CITY_____ST_____ ZIP_____
MEMBER ID#_____
GROUP NAME/#_____

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 _____

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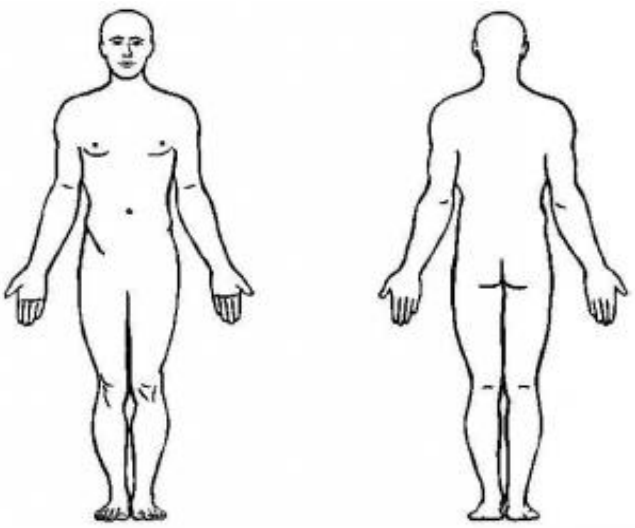
PLEASE MARK ALL SYMPTOM AREAS ON THE BODY DIAGRAM BELOW (use the key provided):

YOUR NAME: _____ DATE: _____

* 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

- 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? _____)

For Provider Use Only

- 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

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YOUR NAME:_____ DATE: _____

- **Are you (or have you ever been) under the care of a primary care physician in the last year?**
  NO / YES (physician name, reason): _____

- **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 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? _____)

- **If you are currently exercising, please circle any of the following items that pertain:**
  Frequent (>5 times/week) Moderate (3-4 times/week) Infrequent (1-2 times/week)
  Aerobic Exercise (> 30 mins) Aerobic Exercise (<30 mins) Weight Lifting Yoga/Pilates
  Other: _____

- **Do you currently smoke/drink alcohol/use recreational drugs? (circle)**
  NO/YES (How much and how frequent? _____)

- **Please list any surgeries and/or hospitalizations you have had:**
  Procedure: _____ Year: _____ Result: _____
  Procedure: _____ Year: _____ Result: _____
  Procedure: _____ Year: _____ Result: _____

- **Please list any medications you are currently taking:**
  Name: _____ Dosage: _____ Date started taking: _____
  Name: _____ Dosage: _____ Date started taking: _____
  Name: _____ Dosage: _____ Date started taking: _____

- **Please circle any of the following symptoms/complaints you have experienced:**
  fever night sweats unexplained weight loss changes in bowel/bladder function headaches
  change in vision change in hearing difficulty swallowing chest pain poor circulation
  cough difficulty breathing nausea vomiting bruise easily swollen/painful joints
  dizziness allergies depression anxiety difficulty sleeping skin rashes/irritation

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by an Equilibrium chiropractic physician and/or other licensed doctors of chiropractic who now or in future will treat me while employed by, working for or associated with or serving as back-up for Dr. Bhalerao, including those working at the clinic or office listed herein or any other office or clinic.

I understand that the doctor will conduct a full exam with a complete report of findings. I have had or will have an opportunity to discuss with the doctor and/or other office or clinic, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course if the procedure which the doctor feels at the time, based upon facts then known, to be in my best interest.

AUTHORIZATION FOR DIRECT PAYMENT OF INSURANCE BENEFITS TO THE HEALTHCARE PROVIDER AND CLINIC: I, or my representative, authorize direct payment to the provider(s) and/or clinic rendering services during this visit or any insurance benefits payable to me.

AUTHORIZATION TO RELEASE INFORMATION: In obtaining payment for services, I authorize my healthcare provider and the clinic to furnish information form my medical records to any company that may be responsible for payment of all or part of my visit and provider charges, including my insurance companies and their representatives, and my employer or union if they are involved in the processing of the claim. If I have been referred by, or am being referred to another healthcare provider, I authorize the release of my clinical information to this provider for continuing care.

PROTECTED DIAGNOSIS: If my medical record contains information about drug or alcohol diagnosis or treatment, or HIV testing, I specifically authorize the release of this information for billing purposes ONLY. Any other release of such information may only be released with another specific consent form.

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I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE CONSENT. I HAVE ALSO HAD OR WILL HAVE AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW I AFREE TO THE CONDITIONS STATED ABOVE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF TREATMENT FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK TREATMENT.

_____

Patient name – PLEASE PRINT DATE

_____

Patient signature – PLEASE SIGN

AUTHORIZATION TO TREAT 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

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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, $75.00 for a massage appointment and $88.00 for an acupuncture treatment. I have read and understand the cancellation policy.

Patient Signature Date

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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.

_____

Print Name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify Below)

_____
_____
_____
_____
_____