Performance and Spine Chiropractic Center

Jonathan Kinney, D.C. Heather Kinney, D.C. Goretti Nguyen, D.C. Reid Davidson, D.C.
19355 SW Mohave Ct. Suite 100, Tualatin, OR 97062 PHONE (503) 486 – 5199 FAX (503) 486 – 5190

Confidential Patient Information

NAME:_____ **GENDER M F**
Last Name **First Name, Legal** **M.I.**
ADDRESS:_____**CITY:**_____**STATE:**_____**ZIP:**_____
EMAIL:_____ **DOB:**___/___/_____ **SSN (**optional):____-___-_____
MARITAL STATUS:_____ EMERGENCY CONTACT & PHONE :_____
EMPLOYER:_____ _____
Phone numbers and preferred contact (check box):
□[H](____)____-_____ □ [W](____)____-_____ □ [C](____)___-_____

WHO MAY WE THANK FOR REFERRING YOU? _____

HIPPA PHONE AUTHORIZATION

- _____(initial) I authorize Performance and Spine Chiropractic Center, LLC (PSCC, LLC) to leave messages on my voicemail in regarding appointments, treatment related issues and billing issues.
- _____(initial) I authorize PSCC, LLC to leave a message for, or speak to the specified individual(s) listed below in regards to information regarding appointments, treatment related issues and billing issues: (this person must provide us with your birth date). You have the right to withdraw this authorization at any time and such revocation must be in writing.
  - At my home number (___-____-_____) with (name) _____
  - At another number (___-____-_____) with (name) _____

ACKNOWLEGEMENT AND UNDERSTANDING:

Please initial each item below.

1._____ I hereby authorize Performance and Spine Chiropractic Center, LLC (PSCC, LLC) to provide chiropractic and/or massage services and diagnosis for me, and I understand I have the right to revoke treatment at any time if I no longer wish to receive treatment.

2._____ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans, to PSCC, LLC.

3._____ I understand that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at PSCC, LLC. I have been informed of the $20 fee on checks returned. I agree that I will not withhold/delay payment. I understand that I am responsible for knowing my medical benefits/limits/exclusions.

4._____ I understand there may be certain procedures/supplies that are not covered by my insurance/3rd party settlement, and agree that I am financially responsible for those charges, however the doctor and/or office staff will inform me of such charges prior to providing them.

5._____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

6._____ I authorize release of patient records to insurance company agencies requiring these records to process claims for payment, and/or to referring/consulting health care providers as your physician deems appropriate to facilitate care. I understand I have the right to request a restriction as to how my protected health information is disclosed, however PSCC, LLC is not required to agree to such restrictions. I understand I have the right to review PSCC, LLC's Notice of Privacy Practices, which describes the types of uses/disclosures of my protected health information as well as my rights and duties to such information, prior to signing this consent document. I understand PSCC, LCC has the right to change the Notice of Privacy Practices and I may obtain a revised copy upon request.

My signature below recognizes that I understand and agree to the aforementioned HIPPA Phone Authorization, and Acknowledgement and Understanding Agreement:

_____ _____/_____/_____
Patient Signature **Date**

AUTHORIZATION TO TREATMENT OF A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:
(Patient's full name) _____ (Date of Birth) _____
to any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

_____ _____/_____/_____
Signature of Parent/Guardian **Date**

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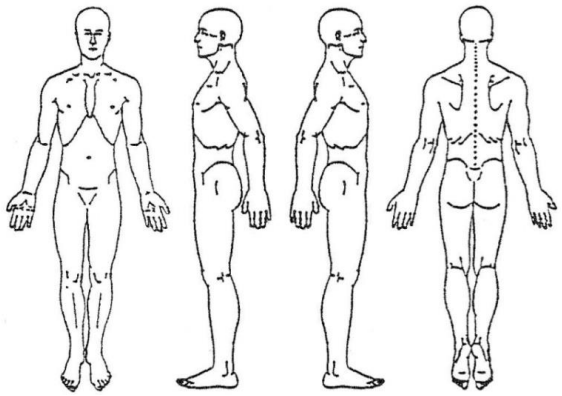
INITIAL COMPLAINT

Patient Name:_____ **Date of Injury:** _____/_____ **(mm/yyyy)**
Primary Care Physician: _____
Other professional treating for this condition: _____
How did your problem begin? *Specific Incident__* *Multiple Incidents__* *Gradual Onset__*
Describe how the injury occurred:_____
_____

Please mark the areas of your complaint:
XX = Pain
OO = Numbness, Tingling



Frequency (overall):
□ Constant (76-100%)
□ Frequent (51-75%)
□ Occasional (26-50%)
□ Intermittent (25% or less)

Is it getting □ **Better** □ **Worse** □ **No Change?**

Please rate your Pain/Discomfort:
0 ----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
(No pain) (Mild pain/discomfort) (Moderate pain/discomfort) (Severe pain/discomfort)

Other Complaints (I.e. Neck Pain, Low Back Pain, etc)
1._____0….1…..2…..3…..4…..5…..6…..7…..8…..9…..10
2._____0….1…..2…..3…..4…..5…..6…..7…..8…..9…..10
3._____0….1…..2…..3…..4…..5…..6…..7…..8…..9…..10

Physical activity at work: □ Sitting more than 50% of day □ Light manual labor □ Manual labor □ Heavy manual labor
Your general stress level: □ No stress □ Minimal stress □ Moderate stress □ Greatly stressed

Please check any additional symptoms you may be experiencing:

_blurred vision	_buzzing in ears	_cold feet	_concentration loss/confusion	_ear pain
_constipation	_diarrhea	_dizziness	_face flushed	_ears ringing
_headaches	_insomnia	_light sensitivity	_loss of balance	_nervousness
_muscle jerking	_finger numbness	_toe numbness	_tingling in arms	_tingling in legs
_tension	_loss of smell	_loss of taste	_fainting	_chest pain
_shortness of breath	_stiff neck	_upset stomach	_sleeping trouble	_depression
_cold hands	_cold sweats	_fever (in last 3 mo.)	_loss of memory	_fatigue

If a family member has had any of the following, please mark the appropriate box:

_Cancer	_Chronic Back Problems	_Chronic Headaches	_ Diabetes
_Heart Problems	_High Blood Pressure	_Other Conditions	

Patient Signature & Date ➔➔➔➔_____ _____/_____/_____

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Jonathan Kinney D.C. Heather Kinney D.C. Goretti Nguyen D.C. Reid Davidson, D.C.

Patient Name:_____

NEW PATIENTS MUST PLEASE FILL OUT THE FOLLOWING:

If you have ever been treated for a listed condition in the past, please check it in the Past column.
If you are currently under the care of a medical professional for a listed condition, check it in the Present column.

Past	Present	
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Pain in Upper Arm or Elbow
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Pain in Upper Leg or Hip
☐	☐	Pain in Lower Leg or Knee
☐	☐	Pain in Ankle or Foot
☐	☐	Headache
☐	☐	Jaw Pain
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Chest Pains
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Cancer
☐	☐	Blood Disorder
☐	☐	Asthma
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Fainting
☐	☐	Dizziness
☐	☐	Pregnancy
☐	☐	Hormonal/Estrogen Replacement
☐	☐	Liver/ Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Colitis
☐	☐	HIV/AIDS
☐	☐	Chronic Sinusitis
☐	☐	Irregular Menstrual Flow
☐	☐	Breast Soreness/Lumps
☐	☐	Painful Urination
☐	☐	Abdominal Pain
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Other:_____

Height: _____Weight: _____

Any known allergies?_____
_____
_____

Current medications: _____
_____
_____

Past Surgeries: _____
_____
_____
_____

Personal social habits: *Please circle one if checked*
__Smoke or use tobacco products? Frequent or Occasional
__Drink alcohol? Frequent or Occasional
__Use recreational drugs? Frequent or Occasional

I have read/understand the information that I provided is true and accurate to the best of my knowledge.

Patient Signature & Date ➔➔➔➔_____ **Date**_____**/**_____**/**_____

PERFORMANCE AND SPINE CHIROPRACTIC CENTER, LLC
INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND MASSAGE CARE

Chiropractic treatment consists of manipulations of joints and soft tissues, using the hand and/or a mechanical instrument. You may feel joint movement, and you may hear joint clicks or other noises. Some patients will feel some stiffness and soreness following the first few days of treatment. These are normal and not a cause for concern. There are different techniques used in Chiropractic spinal manipulations. There are also alternatives to Chiropractic care, including but not limited to: Physical Therapy, Massage therapy, Osteopathic manipulations, and Medical care. There are also material risks inherent in the above listed alternatives, which should be discussed between you and the specialty care provider. You also have the option of not seeking any care. The risk of remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are certain risks which may arise during the exam and treatment. While rare, those complications include: strokes or stroke-like conditions, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, pathological fracture, cervical disc protrusions, cervical dislocations, costovertebral strains, rib fractures, costochondral separations, compression of the cauda equina. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise clinical judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. The risks of massage are bruising, local tenderness, and the release of toxins in the body. There are also risks in taking nutritional supplements, please contact your Primary Care Physician/ health care practitioner before using any nutritional products, including those dispensed in this office.

I have read or have had read to me the above explanation of the nature and purpose of chiropractic adjustments, other alternatives/ procedures for care, massage, and possible risk. I have also had the opportunity to ask questions about its content and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risk involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended, and listed below. Having been informed of the risk, **I hereby request and consent to the performance of** chiropractic adjustments, other chiropractic procedures, and diagnostic x-rays-if warranted, massage, and the use of natural substances, such as vitamins, minerals, or other natural substances on me or on the patient name below, for whom I am legally responsible, by the doctor of chiropractic named below and/or license doctors of chiropractic who now or in the future treat me while employed by, working or associated with or servicing as backup for the doctor of chiropractic named below and by the Licensed Massage Therapist listed below, including those working at the clinic or office listed below or any other office or clinic. I intent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

****

To be completed by patient:

_____
PRINT Patient's Name

_____
Signature of Patient

_____
Date

If patient is a **MINOR**, *this section to be completed by patient's legal guardian, legally responsible adult.*

_____
PRINT Name of Patient's Guardian

_____
Signature of Patient's Guardian

_____
Date

To be completed by Office Staff

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Name of Doctor(s)/LMT treating this patient:
Jonathan Kinney, D.C.
Heather Kinney, D.C.
Goretti Nguyen, D.C.
Reid Davidson, D,C
Licensed Massage Therapist

_____
Witness to Patient's Signature

_____
Translated by:

_____
Date

_____
Date