SCHLENKER CHIROPRACTIC

Chiropractic • Sports Medicine • Massage

PATIENT INFORMATION

Patient Name_____ Today's Date _____

Birthdate_____ Sex: M / F Marital Status: Married / Single / Other Student: Y / N

Weight_____lbs Height_____ Smoking Status: Current Smoker / Former Smoker / Non Smoker

If a smoker, Frequency_____ Start Date_____ End Date_____

(For legal reasons, we do need the smoking status sections completed. It will not affect your care or treatment with us.)

Address_____ City_____ State____ ZIP_____

Home Phone _____ Cell _____ Work _____

E-mail Address_____ Please contact me at: Home / Cell / Work / E-mail

Number of Children_____ Referred to this Office By_____

If a Minor (under 18 years old), name and address of responsible parent/guardian:

Name_____ Birthdate _____

Address_____ City_____ State____ ZIP_____

Home Phone _____ Cell _____ Work _____

EMPLOYMENT INFORMATION

Employer_____ Professional Title_____

Address_____ City_____ State____ ZIP_____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact_____ Relationship_____

Home Phone _____ Cell _____ Work _____

ACCIDENT INFORMATION

1. Date of Accident_____ Time of Day_____ am / pm
2. Were You: Driver____ Passenger____ Front Seat____ Back Seat____ Pedestrian____
3. Number of people in your vehicle? _____ Were you wearing seat belts? Yes____ No____
4. Your vehicle? None / Bicycle / Motorcycle / Car / Truck / Bus Other vehicle? None / Bicycle / Motorcycle / Car / Truck / Bus
5. In what direction were you headed? North / East / South / West on (name of street) _____
6. In what direction was the other vehicle headed? North / East / South / West on _____
7. Were you struck from: Behind____ Front____ Left side____ Right side____
8. Approximate speed of your car: _____mph Other car: _____mph
9. Were you knocked unconscious? Yes____ No____ If yes, for how long?_____
10. Were police notified? Yes____ No____

11. In your own words, please describe the accident:_____

_____

_____

12. Did you have any physical complaints BEFORE THE ACCIDENT? Yes____ No____

If yes, describe: _____

_____

13. Please describe how you felt:
    a. DURING the accident:_____
    b. IMMEDIATELY AFTER the accident:_____
    c. LATER THAT DAY:_____
    d. THE NEXT DAY:_____
14. Were you taken to the hospital after THIS accident? _____
15. What are your PRESENT complaints and symptoms? _____

_____

_____

16. Do you have any congenital (from birth) factors which relate to this problem? _____

_____

17. Do you have any previous illnesses which relate to this case? Yes____ No____
    If yes, please describe: _____

_____

18. Have you ever been involved in an accident before? Yes____ No____
    If yes, please describe: _____

_____

19. Have you been treated by another doctor since the accident? Yes____ No____

If yes, names: _____

20. Since this injury occurred, are your symptoms: Improving____ Getting Worse____ Same____
21. Have you lost time from work as a result of this accident? Yes____ No____
    a. Last day worked: _____
    b. Type of Employment: _____
    c. Are you being compensated for time lost from work? Yes____ No____
       If yes, type of compensation you are receiving: _____
22. Do you notice any activity restrictions as a result of this injury? Yes____ No____
    If yes, please describe: _____

_____

23. Was there any damage to your car? Yes____ No____
24. Other pertinent information: _____

_____

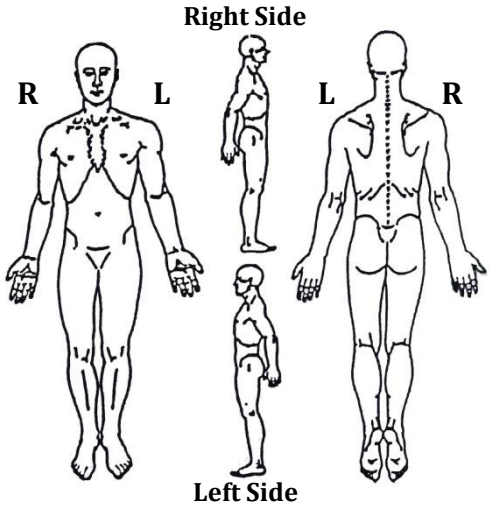
25. If you are female, are you pregnant? Yes____ No____

CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

HEADACHE	IRRITABILITY	NUMBNESS-TOES	FACE FLUSHED	FEET COLD
NECK PAIN	CHEST PAIN	SHORTNESS-BREATH	BUZZING IN EARS	HANDS COLD
NECK STIFF	DIZZINESS	FATIGUE	LOSS OF BALANCE	STOMACH UPSET
SLEEPING PROBLEMS	HEAD IS HEAVY	DEPRESSION	FAINTING	CONSTIPATION
BACK PAIN	PIN/NEEDLES – ARMS	LIGHT SENSITIVE - EYE	LOSS OF SMELL	COLD SWEATS
NERVOUSNESS	PIN/NEEDLES – LEGS	LOSS OF MEMORY	LOSS OF TASTE	FEVER
TENSION	NUMBNESS – FINGERS	EARS RING	DIARRHEA	

Mark the exact location of your symptoms on the diagram:

A = Ache
P = Pins & Needles
B = Burning
S = Stabbing
N = Numbness
O = Other



COMMENTS:

PAST HEALTH

Other Conditions (current/past)_____

Surgeries_____

Broken Bones_____

Major Trauma/Car Accidents_____

Medications/Supplements_____

Last Doctor Seen_____

Last Physical_____

Xrays/MRI/CT_____

Circle any of the following diseases you have had:

APPENDICITIS	MALARIA	CHICKEN POX	ALCOHOLISM
SCARLET FEVER	TUBERCULOSIS	DIABETES	VENEREAL INFECTION
DIPHTHERIA	WHOOPING COUGH	CANCER	ARTHRITIS
TYPHOID FEVER	ANEMIA	HEART DISEASE	EPILEPSY
PNEUMONIA	MEASLES	GOITER	MENTAL DISORDER
RHEUMATIC FEVER	MUMPS	INFLUENZA	LUMBAGO
POLIO	SMALL POX	PLEURISY	ECZEMA

SCHLENKER CHIROPRACTIC
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Dr. Jason Schlenker, DC, DACBSP
35 82nd Drive, Gladstone, OR 97027
Ph. 503.908.0582 Fax. 503.908.0583

Auto Accident / Personal Injury Insurance Verification

Name_____ Date of Accident: _____

NOTE: When involved in an auto accident, medical claims are managed through each driver's own auto insurance. For example, if you are rear-ended and the accident is deemed entirely the other party's fault, any medical care provided to you as an injured party is still handled through your auto insurance policy.

If you are seeking medical care related to an auto accident, contact your auto insurance company and file a claim. Inform them that you are seeking medical attention related to the accident and write down the following information as your proof of insurance for the medical facility. It is against the law for your insurance company to raise your rates for filing a med-pay (personal injury) claim.

Your Auto Insurance (PIP)

Name of Insured: _____ Policy #: _____

Insurance Company: _____ Claim #:_____

Insurance Company Address (where claims should be sent):

_____

City_____ State_____ ZIP_____

Name of the Claims Adjuster assigned to your claim: _____

Claims Adjuster's Phone Number: _____

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Health and Medical Information Release Form

I, _____, give permission to Dr. Jason Schlenker, DC, DACBSP, and staff of Schlenker Chiropractic and Associates to share private and medical information with my medical doctor, _____, as well as his or her staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Schlenker.

Signature: _____ Date: _____

Patient Information

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Date of Birth: _____

Medical Doctor Information

Medical Facility: _____ Doctor's Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

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Consent to Treatment

I wish to receive examinations and treatment provided at Schlenker Chiropractic and Associates. The diagnosis and methods of treatment have been explained to me.

I understand that individuals respond differently to treatment and that there is no guarantee of results during any treatment. I understand the examination and treatment involve certain risks and those risks have been explained or communicated to me.

I therefore authorize Dr. Schlenker to examine and treat me to the extent that he deems suitable.

Signature:_____Date:_____

Parent Signature:_____Date:_____

The patient is unable to consent for the following reasons:

_____

_____

I therefore give consent on the patient's behalf.

Signed:_____ Date: _____

Relationship:_____

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Financial and Cancelation Policies

Thank you for choosing our office to meet your chiropractic and massage healthcare needs. It is our optimal goal to provide you and your family with the highest quality of care, while maintaining a friendly and relaxing environment. In order to keep our standard of care at a level which best serves your healthcare needs, we ask you to please observe the following guidelines.

Office and Financial Policies

We require you to pay at the time we provide services to you. If your insurance covers chiropractic and/or massage therapy, we require you to pay any remaining deductible and the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. For your convenience, we accept cash, check, Visa, MasterCard, and Discover.

We cannot emphasize too strongly that the extent of your insurance benefits is a contract between you, your employer and your insurance company. WE are not a party to that contract. As your chiropractic and massage healthcare provider, our relationship is only with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend our clients, all charges are your responsibility from the date that the services were rendered. We will help you by processing your insurance claim form and sending it in promptly, however, we highly recommend that you know your specific chiropractic and massage therapy benefits before your care begins. This can be done by calling your insurance company, as you are financially responsible for any of the charges not covered by your insurance.

Cancellation Policy

The office requires a minimum of 24 hours notice if an appointment must be rescheduled. If less than 24 hours notice has been given a fee will be assessed. In the event that no notice is given and the client does not show up for their appointment, then you will be required to pay the full cost of the treatment booked.

I accept full financial responsibility for expenses incurred at Schlenker Chiropractic & Associates.

I accept full financial responsibilities for failures on my part to provide or know my insurance benefits information at the time services are rendered.

I have read and understand the above conditions.

_____ _____

Signature of Responsible Party **Date**

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Privacy Practices Acknowledgement Form

Per HIPAA (Health Insurance Portability and Accountability Act) regulations, we will protect and keep confidential your protected health information. A full copy of the Notice of Privacy Practice is available to read upon request.

Name (printed)_____ Date of Birth_____

Signature_____ Date_____