FLOCK
CHIROPRACTIC

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your insurance details. All information you supply is confidential; we comply with all federal privacy standards.

Gail Y. Flock, D.C.
1550 Biddle Rd., Ste D
Medford, OR 97504
P:(541) 779-9650
F:(541) 779-5315

Personal Information

Name _____ Birth Date _____ Date _____

Address _____ Age _____

◯ Female ◯ Male

May we contact you at work?
◯ No ◯ Yes

City _____ State _____ Zip _____ SSN _____

Preferred Method of Contact:
◯ Home Phone
◯ Cell phone
◯ Work phone

Home Phone _____ Cell Phone _____ Work phone _____

Email _____ Driver's License _____

Marital Status: S M D W

Spouse's Name (if applicable) _____

Occupation _____ Employer _____

Have you consulted a chiropractor before?
◯ No ◯ Yes
If so, whom? When?

Primary Care Provider _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Acknowledgement of Receipt: Flock Chiropractic's Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

Please list below the names and your relationship of people to whom you authorize Flock Chiropractic to release your private health information:

Name **Relationship**

_____

_____

_____

_____

_____ _____

Signature of Patient, Parent, Legal Guardian or Patient's Legal Representative Date

Current Health Condition Describe your condition and the reasons your are seeking treatment.

Primary Complaint
The primary symptom that prompted me to seek care today is:

_____

_____

_____

Check all that apply
◯ Result of accident or injury:
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in wellness

Onset When did your symptoms start?

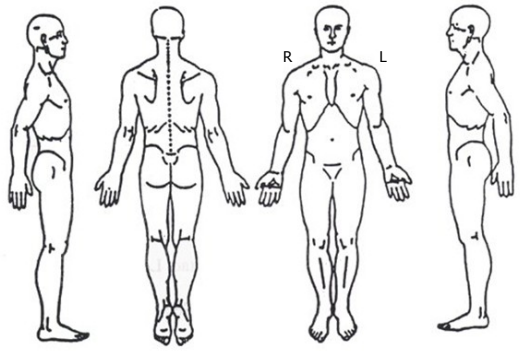
_____

Intensity How extreme are your symptoms?
0 1 2 3 4 5 6 7 8 9 10
Mild Mod Severe

Duration How often do you experience this?
◯ Constant ◯ Frequent ◯ Occasional ◯ Intermittent

Quality of Symptoms
◯ Numbness ◯ Tingling ◯ Stiffness ◯ Dull ache
◯ Cramping ◯ Nagging ◯ Sharp ◯ Throbbing
◯ Stabbing ◯ Burning ◯ Shooting ◯ Other

Location
Where does it hurt? Circle the area(s) on the illustration. "O" for current condition, "X" for conditions experienced in the past.



Radiation Where does your pain radiate or shoot to?

_____

Aggravating or Relieving Factors

Makes it worse: _____

Makes it better: _____

Prior Interventions What have you done for relief?
◯ Ice ◯ Heat ◯ Homeopathic Remedies
◯ Over-the-counter drugs ◯ Prescription medication
◯ Acupuncture ◯ Massage ◯ Chiropractic
◯ Physical therapy ◯ Surgery ◯ Other _____

Secondary Complaint
The secondary symptom that prompted me to seek care today is:

_____

_____

_____

Check all that apply
◯ Result of accident or injury:
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in wellness

Onset When did your symptoms start?

_____

Intensity How extreme are your symptoms?
0 1 2 3 4 5 6 7 8 9 10
Mild Mod Severe

Duration How often do you experience this?
◯ Constant ◯ Frequent ◯ Occasional ◯ Intermittent

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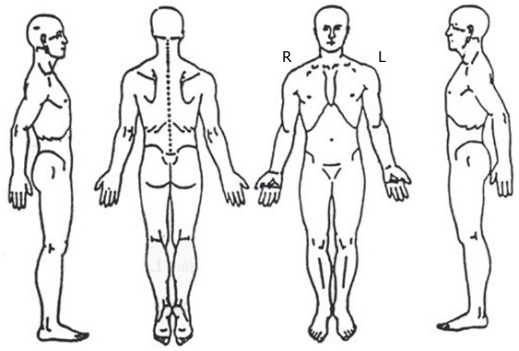

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◯ Physical therapy ◯ Surgery ◯ Other _____

Activities of Daily Living What kind of negative effect does your condition have on your ability to function in the following situations? **0 = No effect, 1 = Mild, 2 = Moderate, 3 = Severe**

Sitting	0	1	2	3	Climbing Stairs	0	1	2	3	Using a computer	0	1	2	3
Standing	0	1	2	3	Concentrating	0	1	2	3	Rising out of a chair	0	1	2	3
Walking	0	1	2	3	Showering/bathing	0	1	2	3	Getting into/out of a car	0	1	2	3
Lying down	0	1	2	3	Getting dressed	0	1	2	3	Driving	0	1	2	3
Bending over	0	1	2	3	Exercising	0	1	2	3	Grocery shopping	0	1	2	3
Lifting objects	0	1	2	3	Getting to sleep	0	1	2	3	Household chores	0	1	2	3
Reaching overhead	0	1	2	3	Staying asleep	0	1	2	3	Yard work	0	1	2	3
Looking over shoulder	0	1	2	3	Love life	0	1	2	3	Caring for family	0	1	2	3

Medications and Supplements Please list all prescriptions, over the counter drugs, natural supplements, enzymes, vitamins and minerals that you are currently taking.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Review of systems Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check the circle beside any condition that you've **had** in the past or currently **have** and initial to the right.

	Had	*Have*		*Had*	*Have*		*Had*	*Have*	
Musculoskeletal	○	○	Osteoporosis	○	○	Neck pain	○	○	Knee injuries
	○	○	Arthritis	○	○	Back problems	○	○	Foot/ankle pain
	○	○	Scoliosis	○	○	Hip disorders	○	○	Shoulder problems
	○	○	TMJ issues	○	○	Poor posture	○	○	Elbow/wrist pain
Neurological	○	○	Anxiety	○	○	Headache	○	○	Pins and needles
	○	○	Depression	○	○	Dizziness	○	○	Numbness
Cardiovascular	○	○	High blood pressure	○	○	Angina	○	○	High cholesterol
	○	○	Low blood pressure	○	○	Excessive Bruising	○	○	Poor circulation
Respiratory	○	○	Asthma	○	○	Emphysema	○	○	Shortness of breath
	○	○	Apnea	○	○	Hay fever	○	○	Pneumonia
Digestive	○	○	Anorexia/bulimia	○	○	Food sensitivities	○	○	Constipation
	○	○	Ulcer	○	○	Heartburn	○	○	Diarrhea
Sensory	○	○	Blurred vision	○	○	Hearing loss	○	○	Loss of smell
	○	○	Ringing in ears	○	○	Ear infection	○	○	Loss of taste
Skin	○	○	Skin cancer	○	○	Eczema	○	○	Hair loss
	○	○	Psoriasis	○	○	Acne	○	○	Rash
Endocrine	○	○	Thyroid issues	○	○	Hypoglycemia	○	○	Swollen glands
	○	○	Immune disorders	○	○	Frequent infection	○	○	Low energy
Genitourinary	○	○	Kidney stones	○	○	Bedwetting	○	○	Erectile dysfunction
	○	○	Infertility	○	○	Prostate issues	○	○	PMS symptoms
Constitutional	○	○	Fainting	○	○	Poor appetite	○	○	Weakness
	○	○	Low libido	○	○	Sudden weight gain or loss (circle one)	○	○	Fatigue

Patient's Name _____ Signature _____ Date _____

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Health History Identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

Illnesses Check the illnesses you've **had** in the past or **have** now.

Had	*Have*		*Had*	*Have*		*Had*	*Have*	
◯	◯	AIDS	◯	◯	Goiter	◯	◯	Polio
◯	◯	Alcoholism	◯	◯	Gout	◯	◯	Rheumatic fever
◯	◯	Allergies	◯	◯	Heart disease	◯	◯	Scarlet fever
◯	◯	Arteriosclerosis	◯	◯	Hepatitis	◯	◯	Sexually transmitted disease
◯	◯	Cancer	◯	◯	HIV positive	◯	◯	Stroke
◯	◯	Chicken pox	◯	◯	Malaria	◯	◯	Tuberculosis
◯	◯	Diabetes	◯	◯	Measles	◯	◯	Typhoid fever
◯	◯	Epilepsy	◯	◯	Multiple sclerosis	◯	◯	Ulcer
◯	◯	Glaucoma	◯	◯	Mumps	◯	◯	Other _____

Operations Surgical interventions, which may or may not have included hospitalization.

◯	◯	Appendix removal	◯	◯	Eye surgery	◯	◯	Tonsillectomy
◯	◯	Bypass surgery	◯	◯	Hysterectomy	◯	◯	Vasectomy
◯	◯	Cancer	◯	◯	Pacemaker	◯	◯	Cosmetic surgery
◯	◯	Spine	◯	◯	Elective surgery	◯	◯	Other
		_____			_____			_____

Injuries Have you ever…?

	When?		*When?*
◯ Had a fractured bone	_____	◯ Been injured in an accident	_____
◯ Had a spine or nerve disorder	_____	◯ Used a crutch or other support	_____
◯ Been knocked unconscious	_____	◯ Used neck or back bracing	_____

Social History	*Daily*	*Weekly*	*How much?*		*Daily*	*Weekly*	*How much?*
Alcohol use	◯	◯	_____	Soft drinks	◯	◯	_____
Coffee use	◯	◯	_____	Water intake	◯	◯	_____
Tobacco use	◯	◯	_____	Job pressure/stress	◯	◯	_____
Exercise	◯	◯	_____	Recreational drugs	◯	◯	_____
Pain relievers	◯	◯	_____	Hobbies: _____			

Family History	Family member	Notes (for Dr. Flock's use)
◯ Cancer	_____	_____
◯ Heart disease	_____	_____
◯ Diabetes	_____	_____
◯ Other: _____	_____	_____

For office use only: Height _____ Weight _____ Blood pressure _____ / _____

_____ _____ _____

Patient's Name Signature Date

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Financial Policy

In order to help you determine your responsibility toward payment for services, please read the following and initial your preference for the method of payment for your account. Please notify this office if the status of your insurance changes.

Initial an option and write the corresponding letter in the blank below.

Private pay, no insurance:

A _____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered. As allowed by Oregon state law, I am requesting a "Time of Service Discount" when I pay for my services on the same day that services are performed.

Private pay, patient filing own claims:

B _____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered. As allowed by Oregon state law, I am requesting a "Time of Service Discount" when I pay for my services on the same day that services are performed. I am requesting a "Super Bill" be provided to me which includes the diagnosis so that I can submit a claim to my insurance company.

Health insurance:

C _____ I would like Flock Chiropractic to bill my insurance. I understand that I am responsible for the costs of treatment, should my insurance company deny coverage for the claim submitted on my behalf. I acknowledge that it is my responsibility to find out whether my insurance covers all services rendered. I understand that if I let the office know which services are not covered, I will be eligible to receive the "Time of Service" discount for those services. I understand that I will be required to pay all co-pays or co-insurance percentages as stated in my insurance plan contract.

By my signature, I request option _____ as the method by which I will pay for my services performed in this clinic.

I am aware of the office's no show and 24-hour cancellation policy and understand that I will be charged a fee of $50 for missing an appointment without giving 24 hours notice.

_____
Signature

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials

_____ I grant permission to be called to confirm or reschedule appointments and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by Dr. Gail Y. Flock, D.C.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel 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, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend 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.

_____ _____ _____
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