

## Personal Information

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**

Name Birth Date

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Address |  |  |  |  |  | Age |  | |
| City |  | State |  | Zip |  |  |  |  |
| Home Phone |  | Cell Phone |  |  |  | Work phone |  |  |

Email Spouse’s Name (if applicable

Occupation Employer

Primary Care Provider

## Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

## Name Phone #

## Date

⃝ Female ⃝ Male

Marital Status: S M D W

# May we contact you at work?

⃝ No ⃝ Yes

# Preferred Method of Contact:

⃝ Home Phone

⃝ Cell phone

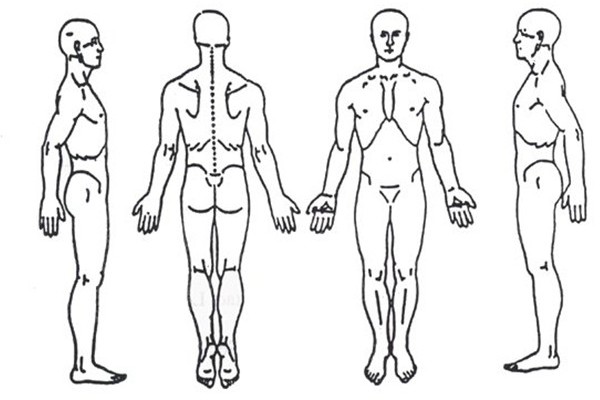
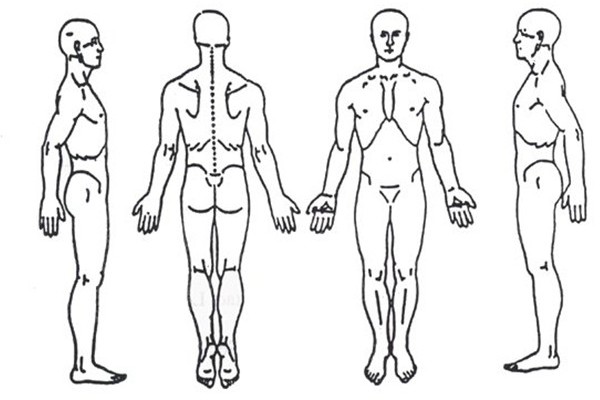
⃝ Work phone

# Have you consulted a chiro- practor before?

⃝ No ⃝ Yes

# If so, whom? When?

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| **Acknowledgement of Receipt: Flock Chiropractic’s Notice of Privacy Practice** |
| I have the option to request 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:  Initial  \_\_\_\_\_\_\_\_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:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signature** of Patient, Parent, Legal Guardian or Patient’s Legal Representative Date |



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| --- | --- |
| **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: | **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 | **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? | **Onset** When did your symptoms start? |
| **Intensity** How extreme are your symptoms? | **Intensity** How extreme are your symptoms? |
| 0 1 2 3 4 5 6 7 8 9 10  Mild Mod Severe | 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 | **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 | **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. | **Location**  Where does it hurt? Circle the area(s) on the illustration. “O” for current condition, “X” for conditions experienced in the past. |
| R L | R L |
| **Radiation** Where does your pain radiate or shoot to? | **Radiation** Where does your pain radiate or shoot to? |
| **Aggravating or Relieving Factors** | **Aggravating or Relieving Factors** |
| Makes it worse: | Makes it worse: |
| Makes it better: | 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 | **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 |

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| **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. | | | | | |
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| **Review of syste** | **ms** C e an  *Had* | hiropra ntire bo d initial  *Have* | ctic care focuses on the dy. Please check the circ  to the right. | ntegri le be  *Had* | ty of y side an  *Have* | our nervous system, w y condition that you’ve | hich co  **had** i  *Had* | ntrols an n the pas  *Have* | d regulates your  t or currently **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 |

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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 |

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| **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 |

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| **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 |  |

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| **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: | | | |

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| --- | --- | --- | --- | --- |
| **Family History** | Family member |  | Notes (for Dr. Flock’s use) |  |
| ⃝ Cancer |  |  |  |  |
| ⃝ Heart disease |  |  |  |  |
| ⃝ Diabetes |  |  |  |  |
| ⃝ Other: |  |  |  |  |

For office use only: Height Weight Blood pressure /

|  |  |  |
| --- | --- | --- |
| **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

|  |  |
| --- | --- |
| **Acknow**  **Initials** | **ledgements** 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. |
|  | 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**

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| 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. |