North Portland Wellness Center – New Patient Info

Welcome to the North Portland Wellness Center. Please print clearly and answer all questions as completely as possible.

Full Name: _____/ _____/_____/ _____
(Legal Last Name) (Legal First Name) (Middle) (Preferred First Name)

Date of Birth: ___/___/___ Age: _____ Gender: ☐ Female ☐ Male ☐ Transgender (circle: FtM/MtF) ☐ Other: _____

Address: _____/ _____/ _____/ _____
(Street/PO box) (City) (State) (Zip Code)

Phone #: (_____) _____ (_____) _____ (_____) _____
(Home) (Work) (Cell/other)

As a courtesy, we can notify you of upcoming appointments. Please check your preference:

☐ Phone ☐ Text message**/Cell Phone carrier (required for text):_____** ☐ Email

Email address: _____

May we send you monthly newsletters and/or occasional coupons and event notices via email? ☐ Y ☐ N

Occupation: _____ Employer: _____ ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Unemployed

Are you: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed Partner's Name: _____

Emergency Contact: _____ Phone #: (_____) _____ Relationship: _____

Is there anyone you wish to authorize to have full access to your medical information without restriction **(including but not limited to making/cancelling appointments on your behalf)**? This authorization is **optional** and you may revoke it in writing at any time.

☐ No ☐ Yes If yes: _____
(Name) (Relationship)

How did you hear about our clinic? Please check **ALL** that apply. Referrals are appreciated and important to us; **please let us know whom specifically to thank:**

☐ Doctor/Clinic: _____
☐ Personal Referral: _____
☐ Event: _____
☐ Other: _____

☐ Live/Work in Neighborhood
☐ Internet Search
☐ Insurance Company
☐ Chinook Book
☐ Gay & Lesbian Yellow Pages

☐ Supportland
☐ Yelp
☐ Facebook
☐ Twitter
☐ Instagram

Primary Insurance

Insurance Carrier: _____ Plan Name: _____

ID/Subscriber #: _____ Group #: _____

Primary on Policy? ☐ Y ☐ N, answer following for Primary Insured: Legal Name: _____ DOB: ___/___/___

Insured's ID #: _____ Patient's Relationship to Insured: _____

By signing below, I verify that the above information is correct and true to the best of my knowledge. I hereby authorize North Portland Wellness Center to submit claims, along with any necessary chart notes, to my insurance carrier(s) or their intermediaries for all services rendered by North Portland Wellness Center and direct them to issue payment directly to North Portland Wellness Center. I understand I am responsible for all charges not covered by my insurance company.

_____ _____
Patient Signature (or Guardian if Patient is a minor) Date

Informed Consent to Treatment

The purpose of this form is to present risks and benefits of the therapies offered at North Portland Wellness Center. While the chances of experiencing most of these complications listed below are small, it is the practice of this clinic to inform patients about them. This form must be signed before treatment is rendered. Please discuss any questions/concerns you may have with our staff or your practitioner.

ACUPUNCTURE
Acupuncture involves using very thin needles and/or pressure to stimulate special points on the body that affect different organ systems. Our acupuncturists are gentle and effective and combine traditional Chinese bodywork and other techniques to aid in energy flow. Side effects may include bruising, minor bleeding, discomfort, and on the rare occasion, fainting. More commonly, relaxation and pain relief are experienced. Your acupuncturist may use acupressure and Chinese bodywork, which stimulates or sedates the points by hand.

CHIROPRACTIC CARE/MANIPULATION
Chiropractic examinations and therapeutic procedures (including chiropractic manipulation, ultrasound, heat and cold application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. However, there are occasions when a procedure intended to help may have complications. These complications may include but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications, such as strokes and disc herniations, are extremely rare.

MASSAGE THERAPY
The purpose of massage/soft tissue therapy is to decrease pain, tension and tenderness, while increasing blood and lymph flow. Your health concern may be caused by poor body mechanics and/or repetitive stress, in which case, exercises or stretches may be indicated. Massage may cause initial soreness, bruising or lightheadedness, but usually pain relief, increased mobility, and relaxation are experienced.

SUPPLEMENTS, HERBALS, HOMEOPATHICS, ETC.
Your practitioner may suggest a product to aid your healing. Be sure to inform your practitioner about all medications you currently take to minimize drug/supplement interactions. Some side effects may be gas, bloating, and less commonly an allergic reaction. If biomechanical support is needed, back braces, cervical pillows, cervical traction, and/or orthotics may be suggested for your particular health issue.

IMAGING, REFERRALS
Further lab work (x-rays, MRI, blood work, urine analysis, etc.) may be necessary. When co-management or referral is indicated, a prompt referral to another specialist for evaluation or alternative therapy will be suggested.

Please inform your practitioner of any changes in symptoms, medications, diagnoses by other doctors, and if there is a chance of pregnancy <u>at any time during your care</u>. If you would like additional information on side effects/complications that could result from treatment or product use, please discuss these with your practitioner.

I have read and understand the above statements concerning treatment side effects and risks, and I also understand that there is no guarantee for a specific cure or result. I understand both my rights and responsibilities in this practitioner/patient relationship.

I have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments above.

_____ _____
Patient Name (Please Print) Relationship to Patient (if not self)

_____ _____
Patient Signature (or Guardian if Patient is a minor) Date

Health History

Below you will find a number of questions related to your health history. For your convenience, we have tailored this information to be applicable to all modalities available at our clinic. While not all of the questions may seem directly related to your main complaint or reason for seeking care, your answers to these questions will inform your treatment throughout the course of your care at North Portland Wellness Center. Therefore, we ask you to be as thorough and thoughtful as possible as you consider the questions below.

GENERAL INFORMATION

Name: _____ DOB: _____ Age: _____ Today's Date: _____

What are your current expectations in seeking treatment?

_____

_____

Have you previously received: Acupuncture treatment ☐ Yes ☐ No Chiropractic treatment ☐ Yes ☐ No Massage ☐ Yes ☐ No

HEALTH CONCERNS

Primary Health Concern or Complaint:

_____

_____

How long have you had this complaint? _____ Is this related to a work injury or motor vehicle injury? ☐ Yes ☐ No

What caused the condition (if known)?_____

What have you done to address it? _____

Is it getting worse? ☐ Yes ☐ No Is it aggravated by: ☐ Standing ☐ Sitting ☐ Driving ☐ Stress

Does it bother your: ☐ Sleep ☐ Work ☐ Other: _____

Other Concerns or Complaints:

_____

_____

Name of Your Primary Care Physician: _____ Phone: _____

Seen for what condition? _____ Date of Last Visit: _____

I hereby authorize North Portland Wellness Center to contact my primary care physician, as needed:

_____ _____

Signature Date

DIAGNOSTICS

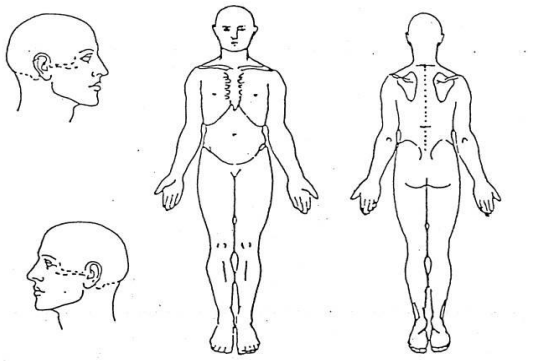
Which diagnostic studies have you had **in the past year**?

☐ Electrocardiogram (EKG) ☐ X-Ray ☐ Bone Density Scan (DEXA) ☐ CT Scan
☐ Electroencephalogram (EEG) ☐ Mammogram ☐MRI ☐ Blood Drawn ☐ Other: _____

Have you been diagnosed with a particular condition? _____

MUSCULO-SKELETAL/PAIN

Please circle any areas where you currently experience **pain.**



Please list the area of pain and circle level of pain severity
(0= no pain, 10= worst pain imaginable)

1. Area: _____ 0 1 2 3 4 5 6 7 8 9 10
2. Area: _____ 0 1 2 3 4 5 6 7 8 9 10
3. Area: _____ 0 1 2 3 4 5 6 7 8 9 10

DO YOU HAVE ANY OF THE FOLLOWING?:

☐ Generalized muscle pain or stiffness
☐ Swollen, painful, stiff joints
☐ Bone pain
☐ Tremors, twitches
☐ Numbness or tingling
☐ Loss of strength
☐ Hernia
☐ Pacemaker
☐ Prosthesis
☐ Breast Implants
☐ Body Jewelry
☐ Other: _____

CURRENT MEDICATIONS & ALLERGIES

Do you take or use?

☐ Laxatives ☐ Pain relievers ☐ Antacids ☐ Oral Contraceptives
☐ Cortisone ☐ Hormones ☐ Sleep Aids ☐ Blood Pressure medication
☐ Tranquilizers ☐ Thyroid medication ☐ Antidepressants/anti-anxiety ☐ Cholesterol medication
☐ Coumadin

Please list any medications (prescribed and over-the-counter), vitamins, herbs and supplements you are currently taking:

_____

_____

Please list any medications, foods, environmental allergens (including latex) to which **you are hypersensitive or allergic:**

_____

_____

HOSPITALIZATION, SURGERIES, & ACCIDENTS

Have you experienced any previous (if yes, please include description and dates):

☐ Hospitalizations: _____
☐ Surgeries: _____
☐ Accidents: _____

DIAGNOSIS & EXPOSURE

Have you ever been diagnosed or exposed to the following:

☐ HIV Diagnosis & Treatment Dates: _____
☐ Hepatitis Diagnosis & Treatment Dates: _____
☐ Tuberculosis Diagnosis & Treatment Dates: _____

Have you ever been exposed in significant or long-term doses to:

☐ Chemicals ☐ Toxins ☐ Radiation ☐ Other: _____

Have you traveled outside of the USA within the last two years? (list countries): _____

Patient Name (Print): _____ DOB: _____ Date: _____

SYMPTOM SURVEY

Please place a **check mark** next to all symptoms you have experienced in the past or are currently experiencing. If there are multiple symptoms listed on one line, please **circle all that apply.**

GENERAL SYMPTOMS

Past	Current	
☐	☐	Nervousness, irritability, anxiety
☐	☐	Mental tension
☐	☐	Moodiness, depression
☐	☐	Fatigue
☐	☐	Sleeplessness, sleep too much
☐	☐	Frequent colds or other illness
☐	☐	Headaches
☐	☐	Don't sweat enough
☐	☐	Sweat too much
☐	☐	Night sweats
☐	☐	Dizziness, fainting, seizures
☐	☐	Loss or gain of weight
☐	☐	Other: _____

Height: _____

Current Weight: _____

Weight 1 Year Ago: _____

Max Weight: _____

GASTROINTESTINAL

Past	Current	
☐	☐	Change in appetite
☐	☐	Nausea, vomiting
☐	☐	Bad breath, taste in mouth
☐	☐	Heartburn or indigestion
☐	☐	Gas, belching, bloating
☐	☐	Gall Bladder disease
☐	☐	Abdomen tender or painful
☐	☐	Diarrhea or loose stools
☐	☐	Constipation
☐	☐	Light colored or greasy stools
☐	☐	Dark stools, blood in stools
☐	☐	Undigested food in stools
☐	☐	Feeling of incomplete evacuation
☐	☐	Foul odor of stool or gas
☐	☐	Hemorrhoids, anal fissure
☐	☐	Other: _____

URINARY

Past	Current	
☐	☐	Difficult or painful urination
☐	☐	Urinate frequently at night
☐	☐	Incomplete urination or dribbling
☐	☐	Bladder infections
☐	☐	Kidney infections
☐	☐	Kidney stones
☐	☐	Frequent UTI
☐	☐	Other:_____

CARDIOVASCULAR

Past	Current	
☐	☐	Irregular or fast heart beat
☐	☐	Pacemaker
☐	☐	Chest pain
☐	☐	Swollen feet, ankles or legs
☐	☐	Cold hands or feet
☐	☐	Leg pains when walking
☐	☐	Varicose veins
☐	☐	Other: _____

EYE, EAR, NOSE, AND THROAT

Past	Current	
☐	☐	Nearsightedness, farsightedness
☐	☐	Blurred or failing vision
☐	☐	Night blindness
☐	☐	Dryness, burning, itching
☐	☐	Eyes water excessively
☐	☐	Sensitivity to light, floaters
☐	☐	Bloodshot, puffy eyes
☐	☐	Earaches
☐	☐	Noises, ringing in ears
☐	☐	Ear discharge, excessive wax
☐	☐	Loss of hearing
☐	☐	Difficulty breathing
☐	☐	Gagging, difficulty swallowing
☐	☐	Shortness of breath on exertion
☐	☐	Spitting up mucus or blood
☐	☐	Dry mouth, nose or lips
☐	☐	Nosebleeds, bleeding gums
☐	☐	Sore throats, tonsillitis
☐	☐	Cold sores, herpes
☐	☐	Loss of smell or taste
☐	☐	Other: _____

SKIN AND HAIR

Past	Current	
☐	☐	Acne, pimples
☐	☐	Skin rashes, hives
☐	☐	Skin ulcers or sores
☐	☐	Dryness, roughness, scaling
☐	☐	Flush easily
☐	☐	Hair loss, thinning
☐	☐	Dry, brittle hair, split ends
☐	☐	Bruise easily
☐	☐	Brown spots, browning of skin
☐	☐	Moles, warts, skin tags
☐	☐	Sunburn easily
☐	☐	Cuts heal slowly, scar badly
☐	☐	Athlete's Foot, toe fungus
☐	☐	Other: _____

MALE – SPECIFIC

Past	Current	
☐	☐	Difficult or unusual urination
☐	☐	Discomfort/pain in genital area
☐	☐	Diminished sexual desire
☐	☐	Excessive sexual desire
☐	☐	Difficulty maintaining an erection
☐	☐	Premature ejaculation
☐	☐	Prostate problems
☐	☐	Hernias
☐	☐	STDs
☐	☐	Other:_____

FEMALE – SPECIFIC

Past	Current	
☐	☐	Painful or swollen breasts
☐	☐	Discharge from breasts
☐	☐	Lumps in breasts
☐	☐	Irregular cycles
☐	☐	Bleeding between periods
☐	☐	Depressed or irritable w/ periods
☐	☐	Painful menses, clotting
☐	☐	Excessive flow
☐	☐	Pain during intercourse
☐	☐	Diminished sexual desire
☐	☐	Excessive sexual desire
☐	☐	Difficulty having orgasm
☐	☐	Vaginal discharge/dryness
☐	☐	Genital pain, discomfort, itching
☐	☐	Use birth control: _____
☐	☐	Difficulty conceiving
☐	☐	Menopausal symptoms
☐	☐	STDs
☐	☐	Other:_____

Typical # of bleeding days: _____

Typical Length of cycle: _____

Date of last pap smear: _____

Was it normal? ☐ Yes ☐ No

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages: _____

Number of abortions: _____

Are you pregnant? ☐ Yes ☐ No

If yes, how many weeks? _____

Patient Name (Print): _____ DOB: _____ Date: _____

HABITS/LIFSTYLE

HABITS/LIFESTYLE

How do you rate your stress level on a scale of 1-10?
0 = lowest, 10 = highest: _____

Do you consume:
☐ Cigarettes or tobacco _____ packs a day
☐ Coffee/tea/soda _____ cups a day
☐ Sugar _____ times a day
☐ Processed/Fast foods _____ times a day
☐ Alcohol _____ drinks per week
☐ Marijuana/other drugs _____ times per week

How much water do you drink a day? _____

Do you exercise regularly? What and how often?_____

_____

TYPICAL FOOD INTAKE

Do you typically eat three meals per day? _____

Do you feel you have a healthy diet? _____

Any foods you do not eat? _____

_____

Do you strongly dislike any particular foods?_____

_____

Do you strongly desire any particular foods? _____

_____

Are there any foods that aggravate any of your symptoms?

_____

FAMILY HISTORY

☐ Please check here if you are adopted or otherwise unaware of your family's medical history

Please Check All that Apply	Self	Mother	Father	Siblings	Children	Spouse
Cancer						
Heart Disease/Angina/Heart Attack						
Diabetes/Pre-diabetic						
Hypoglycemia						
Thyroid Disease						
Low/High Blood Pressure						
Anemia						
Arthritis/Rheumatoid Arthritis						
Lupus						
Migraines						
Stroke						
Epilepsy						
Asthma/Hay Fever						
Kidney Disease						
Blood Disorder						
Mental Health Issues/Concerns						
Substance Dependency						
Other:						
Cause of Death	NA					
Age at Death, if applicable	NA					

Patient Name (Print): _____ DOB: _____ Date: _____

Office Policies

Please take the time to read, initial, and sign our *Office Policies* to acknowledge your understanding of them. If you have any questions regarding these agreements, please discuss them with NPWC staff.

_____ Your insurance policy is a contract between you and your insurance company. As a service to you we can bill your insurance provider. It is your responsibility to provide our office with your insurance details and present your insurance card to our staff. Please be aware that an estimate of benefits is not a guarantee of payment. If an insurance company provides you or our staff with inaccurate information they may not honor the benefits that were quoted. It is your responsibility to be aware of your coverage and co-pay, as well as any deductible and maximums.

_____ Your insurance provider may pay only a portion of the charges for your treatment. You are responsible to pay for any balance on your account. Any account that carries a balance beyond 30 days will incur a monthly billing administration fee of $5-$10. Considerably delinquent accounts are subject to collection procedures. Any collection fees will become the patient's responsibility.

_____ **PLEASE NOTE:** There is a **$50.00 fee** for each no-show and/or appointment cancellation with less than 24 hours notice. This fee cannot be billed to insurance and is fully the patient's responsibility. If you need to cancel or reschedule an appointment, please be sure to notify us at least 24 hours in advance to avoid being charged.

_____ Patients must be responsible for following the referral, prescription, or treatment plan prescribed by their physician, practitioner, and/or insurance provider. Insurance companies may not pay for services when the treatment plan is not followed, thus patients are responsible for scheduling and attending appointments accordingly.

_____ Patients are financially responsible for the cost of supplements, herbal products, supplies and equipment - to be paid at the time of pick up. We are unable to give refunds or credits on any supplements or herbal products, opened or unopened.

_____ Gift cards/certificates are valid for a specified dollar amount and are not redeemable for cash. They must be presented at the time of service to be redeemed. We are not responsible for lost or stolen gift cards/certificates.

_____ For your convenience, we accept payment in cash, Visa, MasterCard and Discover. We also accept local (in-state) checks with photo ID that lists the address matching the check and the Patient Info form. Please note, there is a **$30 fee** for each returned check.

_____ As a courtesy to our patients, we ask that **you silence your cell phone and other personal devices** when entering the center and step outside to take a phone call. We also ask that you use a soft voice while in the building, so as not to disturb other patients receiving treatment.

As a patient of the North Portland Wellness Center, I acknowledge and agree to the above statements and understand that a part or all of my care may not be a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

_____ _____

Patient Name (Please Print) Relationship to Patient (if not self)

_____ _____

Patient Signature (or Guardian if Patient is a minor) Date

Privacy Practices

As our patient, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which we secure your information confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

In-Office Security
Notes taken during appointments are kept in your chart and are secured in our clinic at all times. If patient charts are in public areas, they are kept private with the names covered. Access to this office is limited to practitioners, employees, preceptors, and supervised guests.

Public Interaction
Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health only in the office setting to protect your privacy and to ensure that important information is kept in your chart.

Consultations
North Portland Wellness Center practitioners may consult with each other, other healthcare practitioners and/or clinical/laboratory specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, fax, or email are confidential and names are not used unless necessary and consent is provided from you either verbally or in writing.

Records Released
Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. Copies of released records are sent by mail or fax and are accompanied by a confidential patient information cover sheet, if faxed. This clinic is not able to email patient records at this time.

Definitions and Penalties to Comply
Protected health information is any information, whether oral or recorded, in any form or medium that: 1) Is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse in the normal course of business, and 2) Related to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual. This information may reside in any medium: paper, disc, fax, email, and/or digital voice message.

Voicemail & Email Policy
Practitioners and staff will not leave detailed information when leaving a voicemail or email message unless authorized by the patient to do so, so as to protect confidentiality.

I authorize the NPWC to leave appointment reminders and detailed medical and insurance messages via (please check all that apply and provide appropriate contact information):

☐ Home Phone _____
☐ Cell Phone _____
☐ Work Phone _____

☐ Email _____
☐ I **DO NOT** authorize the NPWC to email or leave any detailed information via voicemail.

****Please note, should circumstances change consent can be revoked in writing at any time****

I have read and understand my right to privacy, as stated above, and agree to have the practitioners/staff of North Portland Wellness Center maintain my records confidentially in accordance with the law. I agree to inform the practitioners and/or staff of North Portland Wellness Center if I need any special arrangements pertaining to this issue.

North Portland Wellness Center has the right to update the terms described in this Privacy Practices notice. I may obtain a revised Privacy Practices notice by calling the office and requesting a revised copy be sent in the mail, or by asking for one at my next appointment.

_____ _____
Patient Name (Please Print) Relationship to Patient (if not self)

_____ _____
Patient Signature (or Guardian if Patient is a minor) Date

FOR OFFICE USE ONLY: WE ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT OF THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WERE UNABLE TO DO SO AS DOCUMENTED BELOW:

Date: _____ Reason: _____ Staff Initials: _____