

<b>Name:</b> _____	<b>Date:</b> /    /
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## Patient Introduction Form

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_' \_\_\_\_\_" Weight \_\_\_\_\_ lbs. Gender:  M  F  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Number of Children \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Who referred you? \_\_\_\_\_ Email address \_\_\_\_\_

Would you like to receive our E-newsletter?  Yes  No Primary care physician name \_\_\_\_\_

Have you had X-Rays?  Yes  No What body part(s)? \_\_\_\_\_ Where were they taken? \_\_\_\_\_

**Women only:** Are you pregnant?  Yes  No What was the first day of your last menstrual period? \_\_\_\_\_

**Insurance Information (If Applicable)**  Cash Payment  Insurance  Auto Accident  Job Related

Insurance Company \_\_\_\_\_ Group/Policy # \_\_\_\_\_

Provider Contact Phone # \_\_\_\_\_ Primary Policy Holder \_\_\_\_\_

Cardholder's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ Cardholder's Employer \_\_\_\_\_

## Initial History

☺ Please answer every question so we can provide you with the best possible service. If you have any questions or need help filling out this form, please ask one of the staff. We will be happy to assist you.

1. What is your **main complaint** today? \_\_\_\_\_

2. Explain **how** it occurred? \_\_\_\_\_

3. **When** did it occur? \_\_\_\_\_ Has your condition **gotten worse** since it started?-----  Yes  No

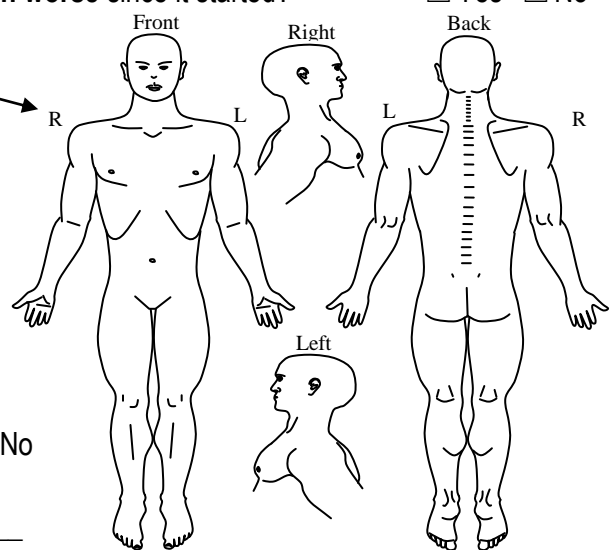
4. On the figure to the right, please mark **all** areas of symptoms? →

5. **Describe** what it feels like:  sharp  stabbing  dull  ache  
 tightness  pulling  burning  numbness  tingling  
 pins & needles  throbbing  other: \_\_\_\_\_

6. On the following scale please circle the **intensity/severity**  
 of your pain: (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

7. Do your symptoms **radiate** or shoot to other areas?-----  Yes  No

a) If yes, where to? \_\_\_\_\_



8. Are your symptoms **constant**?-----  Yes  No  
 a) If not, **when are they** and/or **how long** do they last?\_\_\_\_\_
9. List anything (activities, medication, etc.) that makes your condition **better or worse**:\_\_\_\_\_
10. Have you previously received **chiropractic care**?-----  Yes  No  
 a) If yes, from whom?\_\_\_\_\_
11. Have you been **treated for this complaint before**?-----  Yes  No  
 a) If yes, by whom?\_\_\_\_\_ b) **When** was your treatment?\_\_\_\_\_
12. Has your complaint caused a change or **relationship** with any other parts of your body? (e.g., hearing, vision, eating, sleeping, digestion, breathing, balance, strength, or other)-----  Yes  No  
 a) If yes, what?\_\_\_\_\_
13. Is your current complaint related to an **accident**?-----  Yes  No  
 a) If yes, was it from:  Auto  Work Related  Other (describe)\_\_\_\_\_
- b) If work related, was your **employer notified**?-----  Yes  No
- c) Have you **missed any work** due to your accident?-----  Yes  No
14. Have you ever had any **trauma** or accidents other than normal bumps and bruises?-----  Yes  No  
 a) If yes, what?\_\_\_\_\_
15. Have you ever had any **illnesses** other than colds, flus, and normal childhood illnesses?-----  Yes  No  
 a) If yes, what?\_\_\_\_\_
16. Have you ever had **surgery** (prosthetic hips, knees, pacemaker or any other devices)?-----  Yes  No  
 a) If yes, what?\_\_\_\_\_
17. Are you taking any **medication**?-----  Yes  No  
 a) If yes, please list the medication(s) and what it is for:\_\_\_\_\_
18. What type of **job** do you do (lifting, sitting, standing, driving, walking, etc.)?\_\_\_\_\_
19. What types of **activities** do you participate in?\_\_\_\_\_
20. Have any of your blood relatives had any of the following? (check each that apply)
- Arthritis  Heart disease  High blood pressure  Kidney disease  Tuberculosis  Allergies
- Thyroid disorders  Cancer (type):\_\_\_\_\_  Other:\_\_\_\_\_

Please mark any of the following you have had difficulty with:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Numbness in arms or hands       | <input type="checkbox"/> Stomach problems        | <input type="checkbox"/> Night pain   | <input type="checkbox"/> Loss of consciousness or momentary blackouts  |
| <input type="checkbox"/> Pins & Needles in arms or hands | <input type="checkbox"/> Kidney problems         | <input type="checkbox"/> Thyroid problems                                       | <input type="checkbox"/> Numbness or loss of feeling in the face, fingers, hand, arms, legs, or other part of your body            |
| <input type="checkbox"/> Pain in arms or hands           | <input type="checkbox"/> Bladder problems        | <input type="checkbox"/> Anemia   | <input type="checkbox"/> Weakness, clumsiness, or loss of strength in your face, fingers, hands, arms, or legs                     |
| <input type="checkbox"/> Pain in legs or feet            | <input type="checkbox"/> Frequent urination      | <input type="checkbox"/> Hernia   | <input type="checkbox"/> Sudden collapse without loss of consciousness   |
| <input type="checkbox"/> Numbness in legs or feet        | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Weakness   | <input type="checkbox"/> Sudden severe pain in the side of your head and/or neck, which is different from pain you have had before |
| <input type="checkbox"/> Pins & Needles in legs or feet  | <input type="checkbox"/> Gallbladder problems    | <input type="checkbox"/> AIDS/HIV   | <input type="checkbox"/> Loss of taste or smell  |
| <input type="checkbox"/> Headaches                       | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Blurred or double vision                               | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Disc problems                   | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Complete or partial loss of vision in one or both eyes | <input type="checkbox"/> Other (describe): _____   |
| <input type="checkbox"/> Jaw problems                    | <input type="checkbox"/> Sleeping problems       | <input type="checkbox"/> Ringing, buzzing or any noise in your ear(s)           | _____  |
| <input type="checkbox"/> Joint swelling                  | <input type="checkbox"/> Tension                 | <input type="checkbox"/> Recent hearing loss in one or both ears                | _____  |
| <input type="checkbox"/> Painful joints                  | <input type="checkbox"/> Lights bother eyes      | <input type="checkbox"/> Slurred speech or other speech problems                |  |
| <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Loss of balance         | <input type="checkbox"/> Difficulty swallowing                                  |  |
| <input type="checkbox"/> Chest pains                     | <input type="checkbox"/> Prostate problems       | <input type="checkbox"/> Dizziness  |  |
| <input type="checkbox"/> Heart problems                  | <input type="checkbox"/> Menstrual cramps        | <input type="checkbox"/> Temporary disorientation or confusion                  |  |
| <input type="checkbox"/> High blood pressure             | <input type="checkbox"/> Swollen ankles          |   |  |
| <input type="checkbox"/> Low blood pressure              | <input type="checkbox"/> Unexplained weight loss |   |  |
| <input type="checkbox"/> Sinus problems                  | <input type="checkbox"/> Excessive fatigue       |   |  |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Smoking                 |   |  |
|  | <input type="checkbox"/> Frequent illnesses      |   |  |

21. In what **position(s) do you sleep?**  Back  Stomach  Side  Other: \_\_\_\_\_

22. Do you **“pop”** your own joints or do they ever “pop” on their own?-----  Yes  No

### Consent to Treatment

I \_\_\_\_\_(PRINT) authorize Dr. Benjamin H. Oien to perform chiropractic adjustments, treatments and procedures. I further consent to examinations, consulting services, and diagnostic procedures rendered in conjunction with the adjustments, treatments, and procedures.

#### Release of Information

Dr. Benjamin H. Oien may disclose information from the patient’s records to doctors, hospitals, or others for continuous care and to any third party who requires that information in order to fulfill an obligation benefiting the patient.

#### Responsibility for Payment

I acknowledge my responsibility to and agree to pay in full for the professional services rendered. I understand that if the doctor may bill my health insurer for the services, such billing does not relieve me of my responsibility to pay for the services. I also understand a charge will be made for broken appointments unless 24 hours notice is given. I agree to pay for any costs incurred as a result of sending my bill to a collection agency or any other legal action as well as 1.5% interest per month on any money owed for service rendered.

#### Informed Consent of Risks

I understand that chiropractic care, as with any health intervention, has inherent risks. These risks, though rare, could occur ranging from a minor aggravation of current condition to serious conditions such as cerebral vascular accidents. I also understand that the doctor is not liable for any problems that might arise if I decide not to follow the treatment in which he prescribes. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic care, including but not limited to sprain and strain, fractures, dislocations, and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor and/or intern and/or other office personnel the nature and purpose of the chiropractic procedures I will receive. I understand that the doctor and/or

intern will perform an examination in order to minimize any risk of care, however, I do not expect the doctor and/or intern to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor and/or intern to exercise judgment during the course of the procedure which the doctor and/or intern feels at the time, based upon the facts as then known, is in my best interest.

**Medicare Patients Authorization and Assignment of Benefits**

I authorize payment of government benefits to Oien Family Chiropractic who accepts assignment for services covered by Medicare. I also understand it is my responsibility to pay for all other services which Medicare does not cover.

**CVA Signs**

If during your visit you suffer from any of the following **please notify the doctor or staff immediately:**

- |  |   |
|--|---|
| 1. Sudden severe pain in the side of your head and/or neck | 5. Dizziness                                    |
| 2. Vision problems   | 6. Hearing problems                             |
| 3. Numbness, loss of feeling, or abnormal feeling          | 7. Disorientation or confusion                  |
| 4. Weakness, clumsiness, or loss of strength               | 8. Speech problems                              |
|  | 9. Loss of consciousness or momentary blackouts |

I have read, or have had read to me, the above consent and reviewed the information herein and represent that the same is true, correct and complete. I understand that the doctor is relying upon the information in rendering treatment. By signing below, I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

-----End of questionnaire. Please DO NOT write below this line-----

Doctor's comments regarding question: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Initial Exam**

**BP** \_\_\_\_\_ / \_\_\_\_\_     **HR** \_\_\_\_\_ bpm     **RPM** \_\_\_\_\_

Vertebrobasilar Circulation	(-)	Results					Indications	Comments
		R rot	Dizziness	Nausea	Vision problems	Nystagmus		
VBA Maneuver		R rot	Dizziness	Nausea	Vision problems	Nystagmus	Ipsilateral VBA or carotid insufficiency	
		L rot	Dizziness	Nausea	Vision problems	Nystagmus		