



Active Living Chiropractic P.C



5289 NE Elam Young Parkway Suite 130
Hillsboro, OR 97124
Phone: 503-718-7991

7303 SW Beaverton Hillsdale Hwy
Portland, OR 97225
Phone: 503-297-3825

ACUPUNCTURE CLIENT INTAKE FORM

Please complete this questionnaire carefully. The information you provide will assist me in creating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Name _____ Date of Birth _____ Today's Date _____

Address _____ Phone # _____

City _____ State _____ Zip Code _____ E-mail Address _____

Occupation _____ How you heard about us _____

Emergency Contact: _____ Phone # _____ Relationship _____

Insurance: _____ ID# _____ Group# _____

MAIN COMPLAINT (symptoms, diagnosis, duration of condition):

SURGERIES (please include date of procedure):

SIGNIFICANT TRAUMA (auto accident, fall, psychological, abuse, etc.):

YOUR BIRTH HISTORY (prolonged labor, forceps delivery, etc.):

ALLERGIES (drug, food, environmental):

DIET: Vegetarian Y/N _____ Meals/day _____ Snacks _____ Caffeinated drinks/day _____ Alcohol Drinks/Week _____

MEDICATIONS (type, dose, frequency):

VITAMINS/SUPPLEMENTS/HERBS (type, dose, frequency):

EXERCISE: days/week _____ length of workout _____ type of activity _____

PATIENT NAME _____

M F

DATE _____

PERSONAL HISTORY

PLEASE CHECK ANY CONDITIONS OR SYMPTOMS YOU MAY HAVE NOW

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver/gallbladder disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Hypoglycemia/hyperglycemia | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Elevated blood cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Food allergies/intolerance | <input type="checkbox"/> diverticulitis/irritable bowels |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Raynaud's disease |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid imbalance | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Fibromyalgia/polymyalgia | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Chronic pain condition | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Gastritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility | <input type="checkbox"/> Emphysema |

FAMILY MEDICAL HISTORY

PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOUR IMMEDIATE FAMILY

- | | | | |
|--|------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Other | | | |

PLEASE CHECK IF YOU HAVE HAD ANY OF THESE SYMPTOMS IN THE LAST 3 MONTHS

GENERAL

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed/bruise easily | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Peculiar tastes/smells | <input type="checkbox"/> Dental/gum problems |
| <input type="checkbox"/> Muscle weakness/fatigue | <input type="checkbox"/> Strong thirst | | |

SKIN AND HAIR

- | | | | |
|--|--------------------------------------|--|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/allergic dermatitis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Moles |
| <input type="checkbox"/> Skin discolorations | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing |

HEAD, EARS, NOSE, AND THROAT

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Migraines | <input type="checkbox"/> Eye glasses/contacts |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Jaw clicks/locks | <input type="checkbox"/> Sores on lips/tongue |

CARDIOVASCULAR

- | | | | |
|--|---|---|------------------------------------|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Palpations at rest | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Varicose/spider veins | <input type="checkbox"/> Pressure in chest | |

RESPIRATORY

- | | | | |
|---|--|---|-------------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Difficult to inhale/exhale | <input type="checkbox"/> Production of phlegm | | |

GASTROINTESTINAL

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bloating/Edema | <input type="checkbox"/> Chronic use of laxatives | <input type="checkbox"/> Loose stools (>2/day) | <input type="checkbox"/> Abdominal pain/cramps |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Hernia | |

UROGENITAL

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Scanty flow | <input type="checkbox"/> Copious flow |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Urinary tract infections | <input type="checkbox"/> Burning urination |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Dribbling after urination |

Do you wake to urinate? Yes No

What time(s): _____

What color is your urine? _____

Any other problems with your genital or urinary system? _____

GYNECOLOGICAL/REPRODUCTIVE

- | | | | |
|-------------------------------|---|--|--|
| No. of pregnancies _____ | Age of first menses _____ | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Breast lumps |
| No. of births _____ | Date of last menses _____ | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Fibrocystic breast tissue |
| No. of miscarriages _____ | Date of last Pap/pelvic _____ | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Fibroid tumors |
| No. of premature births _____ | <input type="checkbox"/> Painful menses | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Infertility |
| No. of abortions _____ | <input type="checkbox"/> Irregular menstruation | <input type="checkbox"/> Difficult intercourse | <input type="checkbox"/> Endometriosis |

Are you pregnant? Yes No

Do you practice birth control? Yes No

What type? _____

How long? _____

MUSCULOSKELETAL

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Carpal tunnel |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Sprains/strains | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Rotator cuff | <input type="checkbox"/> Back pain- upper | |
| <input type="checkbox"/> Back pain- lower | <input type="checkbox"/> Back pain- middle | | |

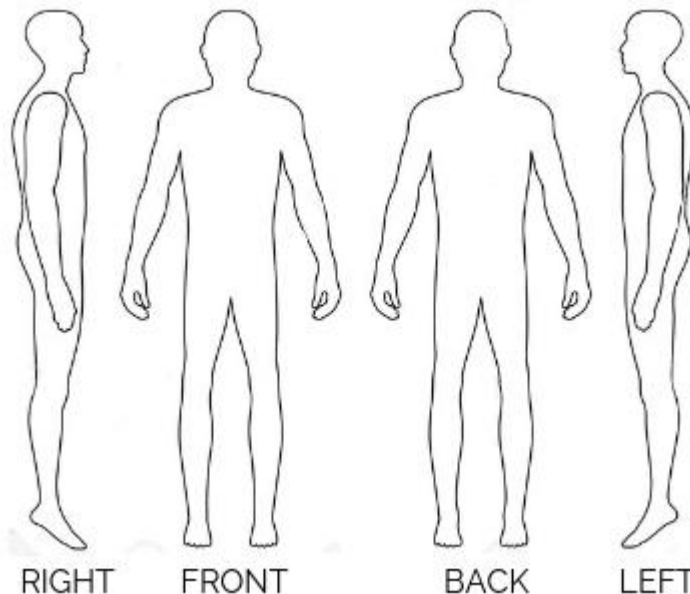
NEUROPSYCHOLOGICAL

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Vertigo/dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety/panic attacks | <input type="checkbox"/> Bad temper/irritable | <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> Seasonal affective disorder |

Have you ever been treated for emotional problems? Yes No

Have you ever been treated for substance abuse? Yes No

Any other neurological or psychological conditions? Please explain: _____

PLEASE INDICATE ANY PAINFUL OR DISTRESSED AREAS

Jade River Healing Arts Center Acupuncture
7303 SW Beaverton-Hillsdale Hwy, Suite 100, Portland OR 97225
Phone: 503-297-3825 / Fax: 503-297-3827 / www.JadeRiverPdx.com

HIPAA PATIENT CONSENT FORM

Effective January 1, 2018

I, _____, consent to the use or disclosure of my protected health information by Jade River Healing Arts Center Acupuncture, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Active Living Chiropractic, LLC, Jade River Healing Arts Center Acupuncture, dba Jade River Healing Arts Center. I understand that diagnosis or treatment of me by Jade River Healing Arts Center Acupuncture, may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or the health care operations of the practice. Jade River Healing Arts Center Acupuncture, is not required to agree to the restrictions that I may request; however, if Jade River Healing Arts Center Acupuncture, agrees to a restriction that I request, that restriction is binding.

"Protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected health information is information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information identifies me.

I understand that I have a right to review Jade River Healing Arts Center Acupuncture's Notice of Privacy Practices prior to signing this document. Jade River Healing Arts Center Acupuncture's Notice of Privacy Practices has been provided to me. The notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Active Living Chiropractic, LLC, dba Jade River Healing Arts Center Acupuncture, dba Jade River Healing Arts Center. The Notice of Privacy Practices also describes my rights and the duties of Jade River Healing Arts Center Acupuncture, with respect to my protected health information.

Active Living Chiropractic, LLC, Jade River Healing Arts Center Acupuncture, dba Jade River Healing Arts Center, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the HIPAA representative at the office and requesting a revised copy be sent in the mail or by asking for one at the time of my time of my next appointment.

_____ (initial) Jade River Healing Arts Center Acupuncture reserves the right to leave a message on the patient's home answering machine/recorder or private cell phone. As the patient, I specifically consent to this right.

_____ (initial) I understand that if I, the patient, refuse to sign this consent form, my health care information cannot be given to insurance companies, and consequently, I, the patient, will be responsible for the entire bill and will be billed accordingly.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative (print)

Description of Personal Representative Authority

Date



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Financial Agreement

Welcome To our office. Please familiarize yourself with the financial policy of our office by reading the following information on how your medical bill will be handled.

Office Policy and Payment Responsibility

Health and accident insurance are a contractual arrangement between an insurance carrier and the insured. It is solely the responsibility of the insured to verify eligibility for chiropractic health care benefits. Possession of medical insurance member ID card is **not** a guarantee of coverage. Therefore, we cannot accept responsibility for determining benefits in advance of your treatment or for collection of monies owed on your account from you insurance company. The responsible party is obligated for payment in full of this account. In the event your insurance company does not compensate us within sixty (60) days after billing, we must require you to pay us and settle with your insurance carrier directly (Not applicable to workman's compensation and personal injury claims).

In the event of non-payment, the responsible party shall bear the cost of collection and/or court costs and reasonable legal fees. **Accounts past due will be assessed a 2.0% per month service charge.**

If you are unable to keep your appointment, please allow 24 hours advance notice. Cancellations/Rescheduled appointments made within 24 hours of the set appointment will be assessed a \$50.00 charge, also No Show/Missed appointments will be assessed a \$50.00 charge.

Billing your insurance Carrier

As a courtesy to you, we will gladly submit your bills to your primary insurance carrier. **Co-payments are due and payable at the time of service.**

Insurance Authorizations and Assignment of Benefits

I authorize my insurance benefits to be paid directly to Active Living Chiropractic, P.C. I authorize the release of any medical information necessary to process this claim.

I have read this form and understand and agree to all of the above applicable policies. I authorize my insurance benefits be paid to Active Living Chiropractic, P.C.

Name: _____

Signature: _____

Date: _____



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Acupuncture Informed Consent to Treat

By signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back up for the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by licensed physician is recommended by this clinic's practitioners. I understand that methods of treatment may include, but are not limited to, Acupuncture, Moxabustion, Cupping, Electrical stimulation, TuiNa (Chinese massage), Chinese herbal medicine and nutritional counseling.

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will occasionally leave a non painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine Treatments: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.

Heat Treatments with Moxa or a TDP Lamp: These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over warming, but the rare possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by heating a small glass cup. There is a possibility of local non painful bruising from this suction. Very rarely a slight burn or blister may appear due to the heat. The skin marks from this procedure may take 3-7 days or longer to dissipate.

Gua Sha: Gua Sha is light scraping on the skin in a small area using a smooth or edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7days.

Electro-Acupuncture: A mild electric microcurrent similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pace maker or have any heart or neurological condition prior to having this treatment.

Acupressure and Massage: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage.

I understand the clinical and administrative staff may review my patient records and lab records but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment. Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as Licensed acupuncturists are not primary care physicians.

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Patient's Name: _____

Patient's Signature: _____

Date: _____