# 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**

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

**FAMILY MEDICAL HISTORY**

**PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOUR IMMEDIATE FAMILY**

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ Seizures | ☐ Heart disease | ☐ Stroke |
| ☐ High blood pressure | ☐ Allergies | ☐ Cancer | ☐ Asthma |
| ☐ Other | | | |

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

**GENERAL**

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

**SKIN AND HAIR**

| | | | |
|---|---|---|---|
| ☐ Rashes | ☐ Ulcerations | ☐ Hives/allergic dermatitis | ☐ Itching |
| ☐ Eczema/Psoriasis | ☐ Dandruff | ☐ Hair loss | ☐ Moles |
| ☐ Skin discolorations | ☐ Acne | ☐ Change in skin/hair texture | ☐ Face flushing |

**HEAD, EARS, NOSE, AND THROAT**

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

**CARDIOVASCULAR**

| | | | |
|---|---|---|---|
| ☐ Chest pain | ☐ Irregular heartbeat | ☐ Palpations at rest | ☐ Fainting |
| ☐ Cold hands/feet | ☐ Swelling of hands/feet | ☐ Blood clots | ☐ Phlebitis |
| ☐ Shortness of breath | ☐ Varicose/spider veins | ☐ Pressure in chest | |

**RESPIRATORY**

| | | | |
|---|---|---|---|
| ☐ Cough | ☐ Coughing blood | ☐ Asthma | ☐ Bronchitis |
| ☐ Pneumonia | ☐ Pain with deep inhalation | ☐ Tight sensation in chest | ☐ Wheezing |
| ☐ Difficult to inhale/exhale | ☐ Production of phlegm | | |

**GASTROINTESTINAL**

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

**UROGENITAL**

☐ Pain on Urination ☐ Frequent urination ☐ Blood in urine ☐ Urgent urination
☐ Unable to hold urine ☐ Kidney stones ☐ Scanty flow ☐ Copious flow
☐ Impotence ☐ Sores on genitals ☐ Urinary tract infections ☐ Burning urination
☐ Premature ejaculation ☐ Decreased libido ☐ Prostatitis ☐ 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 _____ ☐ Ovarian cysts ☐ Breast lumps
No. of births _____ Date of last menses _____ ☐ Vaginal sores ☐ Fibrocystic breast tissue
No. of miscarriages _____ Date of last Pap/pelvic _____ ☐ Vaginal discharge ☐ Fibroid tumors
No. of premature births _____ ☐ Painful menses ☐ Vaginal dryness ☐ Infertility
No. of abortions _____ ☐ Irregular menstruation ☐ Difficult intercourse ☐ Endometriosis

Are you pregnant? ☐ Yes ☐ No
Do you practice birth control? ☐ Yes ☐ No

What type? _____ How long? _____

**MUSCULOSKELETAL**

☐ Neck pain ☐ Shoulder pain ☐ Hand/wrist pain ☐ Carpal tunnel
☐ Knee pain ☐ Sprains/strains ☐ Sciatica ☐ Foot/ankle pain
☐ Hip pain ☐ Muscle pain ☐ Muscle weakness ☐ Tendonitis
☐ Bursitis ☐ Rotator cuff ☐ Back pain- upper
☐ Back pain- lower ☐ Back pain- middle

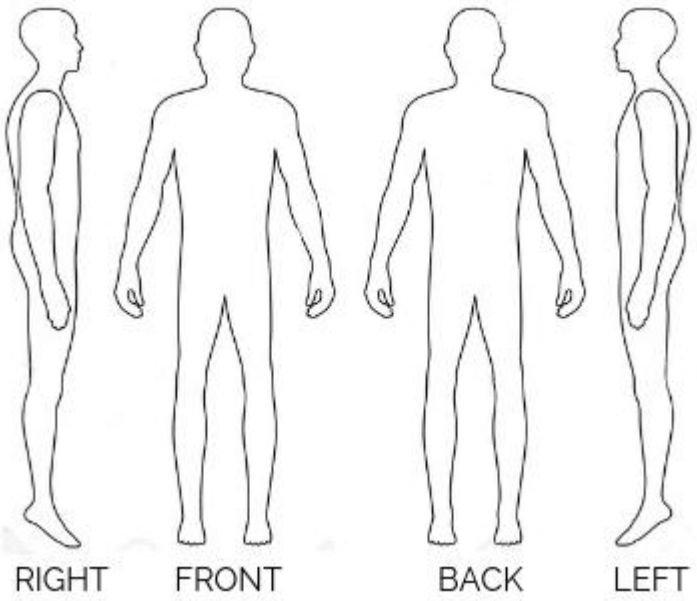
**NEUROPSYCHOLOGICAL**

☐ Seizures ☐ Loss of balance ☐ Vertigo/dizziness ☐ Areas of numbness
☐ Lack of coordination ☐ Poor memory ☐ Concussion ☐ Depression
☐ Anxiety/panic attacks ☐ Bad temper/irritable ☐ Easily susceptible to stress ☐ 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. To ensure transparent understanding of our financial policies, please review the following information.

**Office Policy and Payment Responsibility**

Health and accident insurance operate as contractual agreements between the **insured (You)** and the insurance carrier. It is the sole responsibility of the insured to verify eligibility for chiropractic health care benefits. Possession of a medical insurance member ID card does not guarantee coverage. Consequently, we are unable to determine benefits in advance or collect outstanding amounts from your insurance company. The responsible party is obligated to settle this account in full. If your insurance company fails to compensate us after billing, we require direct payment from you and we will bill your credit card on file. We will require that you settle with your insurance company directly (excluding workers 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.**

**Appointment Cancellation Policy**

If you need to reschedule or cancel your appointment, please provide 24 hours' notice so that we may help others. Cancellations, re-schedules or no-show appointments made within 24 hours of the set appointment will incur a $85.00 charge.

**Billing your insurance Carrier**

As a courtesy, we will submit your bills to your primary insurance carrier. Co-payments, co-insurance and deductibles 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.

**Credit Card Authorizations**

To facilitate a smooth payment process, please provide your credit card information below. Your card will be securely stored for any outstanding balances, co-payments, or charges related to missed appointments.

**Credit Card Number: _____**
**Expiration Date:_____/_____ CVV:_____ Zip Code:_____**
**Email Address:_____**

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

**Name:_____**

**Signature: _____**

**Date: _____**

Active Living Chiropractic P.C

# 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:** _____