2915 SE Belmont St., Suite 1
Portland, OR 97214
503.505.9677
elementalmedicinepdx.com

New Patient Registration

Name_____ Today's Date _____
LAST FIRST MI

Address_____
STREET APT# CITY STATE ZIP CODE

Date of Birth _____ Age_____ Home Phone (____)____-_____

Work Phone (____)_____-_____ Cell Phone (____)_____-_____

E-mail Address _____

Emergency Contact _____ Relationship _____ Phone(__)____-_____

Employer _____ Occupation _____

Is this visit routine/accident/illness/other? _____
If accident; Date and brief description_____

Responsible Party Information

Name (Guarantor) _____
LAST FIRST MI

Date of Birth _____ Relationship to Patient _____

Address _____
STREET APT# CITY STATE ZIP CODE

Employer _____ Phone (____)____-_____

Address _____
STREET APT# CITY STATE ZIP CODE

Name of Insurance _____ ID # _____ Grp# _____

Contact Preference

How would you like to be contacted by Dr. Ebling? Please indicated in order of preference(#1-4); E-mail____ Home Phone____ Cell Phone____ Work Phone_____

If I do not reach you, can I leave a message with the office name at your work? Yes/No
If I do not reach you, can I leave a message with the office name at your home? Yes/No
Is it OK to leave a detailed message? Yes / No (If No, I will simply ask for a return phone call to discuss the details of my call.

Do I have your permission to send an email regarding news in the field or information related to the practice? Yes / No (you can opt out at any time).

Please notify me if there are any changes to your contact information or to your insurance at your earliest convenience. Thanks!

In the event that you need to cancel or re-schedule an appointment, kindly give 24 hours notice. A $50 fee will be assessed with less than 24 hours notice.

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Acknowledgement and Understanding of Financial Policy

Please initial each item below. If you have questions, do not hesitate to ask.

_____ I understand that full payment is due at time services are rendered unless prior arrangements have been made.

_____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me by Dr. Carrie Ebling at Elemental Medicine.

_____ After verification of insurance benefits, Elemental Medicine will accept payment directly from your carrier. **Your insurance is an agreement between you and your insurance company. Elemental Medicine does not promise that your insurance company will pay all charges relative to your care even after verification has been made. Therefore, all charges disputed by your carrier will be your personal responsibility, to be paid in full by you no more than 90 days from date of notification from your carrier.**

_____ I agree to pay all Uncovered Services at the time of the visit (i.e. deductible, co-payment etc.)

_____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

_____ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, Private insurance, and all other health plans to Elemental Medicine, 2915 SE Belmont St, Suite 1, Portland, OR 97214.

_____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

_____ I understand and agree that **I will be charged $50** in the event that I neglect to provide **24 hours notice of cancellation** if I am unable to make my scheduled appointment time. I also understand this fee will *not* be covered by my insurance, if any is available.

_____ _____
Patient Name / Patient Signature Date

_____ _____
Guarantor Signature Relationship to Patient

Authorization to Treat a Minor

As a parent or legal guardian, I hereby authorize treatment for the following:

_____ ____/_____/_____ _____
Patient's Full Name Date of Birth Age

This authorization will be effective as of _____ and expires on _____

Signature _____ Witnessed by _____
Parent or Guardian

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Confidential Patient Health Questionnaire

Name_____Date of Birth _____ Today's Date _____
LAST FIRST MI

How did you find our office? ☐Friend ☐Flyer ☐Web ☐Other_____
Have you been treated by a Chiropractor before?_____
Please list practitioner names and specialties of your other health care providers:
_____
Do I have your permission to contact them to coordinate your care? ☐Yes ☐No
List any medications/vitamins/supplements (prescribed, or over-the-counter) with the dosage, and the duration you have been on them:_____
_____ _____
Name / Dose / Duration Name / Dose / Duration Name / Dose / Duration
Do you have any diagnosed health conditions?_____
Please describe your reason for seeking care today. _____
_____
Date problem began:_____Is this ☐Work related ☐Auto related ☐Other _____
Does it seem to be getting ☐ Worse ☐ Better or ☐ Staying the same?
It interferes with:☐ Sitting ☐ Work ☐ Sleep ☐ Walking ☐ Hobbies ☐ Leisure ☐Other

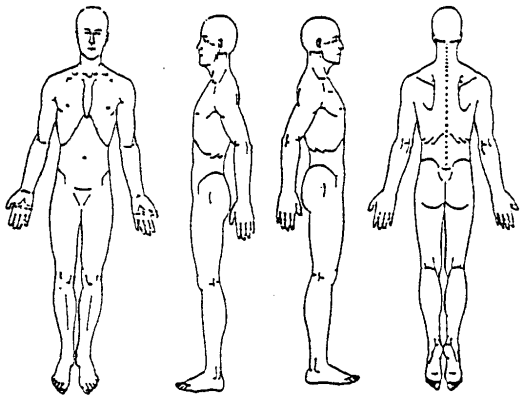
Mark current problems on these pictures:

Check all that apply:
☐Sharp Pain ☐Stabbing Pain ☐Ache
☐Weak ☐Numb ☐Throbbing ☐Shooting
☐Burning ☐Tingling ☐Decreased motion

What is the frequency of your problem?
☐ Constant (75%-100%) ☐ Frequent (50%-75%)
☐ Occasional (25%-50%) ☐ Intermittent (<25%)

Are your symptoms worse…
☐ In the morning ☐ In the afternoon ☐ At night

Do your symptoms wake you up? ☐Yes ☐No



Please circle the current level of discomfort your problem causes you, when it is at its worst
none 1 2 3 4 5 6 7 8 9 10 worst ever

What makes your problem better? ☐Nothing ☐Lying Down ☐Walking ☐Standing ☐Sitting ☐Exercise ☐Rest
What makes your problem worse? ☐Nothing ☐Lying Down ☐Walking ☐Standing ☐Sitting ☐Exercise ☐Rest

Have you experienced a similar problem in the past? ☐ Yes ☐ No
Did you seek care in the past? ☐ Yes ☐ No. From whom? _____

Physical activity at work: ☐ Sitting 50%+ of day ☐Light labor ☐ Heavy labor ☐ Repeated motion

Occupation: _____ ☐FT ☐PT Has your work changed due to this condition? ☐Yes ☐No
What is your current work status?
☐ FT, no restrictions ☐ PT, no restrictions ☐ Off work due to injury ☐ Unemployed
☐ FT, with restrictions ☐ PT, with restrictions ☐ Homemaker ☐ FT student ☐ Retired

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LIFESTYLE

	YES	Notes, if YES
Do/did you smoke/use any tobacco?	☐	
Do/did you drink alcohol?	☐	
Do/did you use drugs?	☐	
Do you consume caffeine?	☐	
Do you consume sugar / sugary drinks?	☐	
Do you eat a lot of vegetables?	☐	
Do you eat fast/processed foods?	☐	
Do you drink a lot of water?	☐	

What is your current level of stress? ☐Little to none ☐Minimal ☐Moderate ☐Severe
General Physical Activity: ☐ No regular exercise ☐ Light exercise ☐ Moderate ☐ Strenuous

HEALTH HISTORY

Please check all symptoms you have ever had, even if they do not seem related to your current problem

	YES	Notes
Surgery/Hospitalization	☐	
Serious injuries or traumas	☐	
Allergies	☐	
Migraine headache	☐	
Change in bowel habits	☐	
Abnormal weight gain/loss	☐	
Ulcers	☐	
Heartburn/indigestion	☐	
Cold/flu often	☐	
Sinus infection	☐	
Asthma	☐	
Chronic cough	☐	
Breathing difficulty	☐	
Dizziness/fainting	☐	
High blood pressure	☐	
High cholesterol	☐	
Visual disturbances	☐	
Aortic Aneurysm	☐	
Metal/surgical implants	☐	
Rash or hives	☐	
Slow healing	☐	
Suspicious mole(s)	☐	
Currently pregnant	☐	
Kidney infections	☐	
Bladder infections	☐	
Prostate problems	☐	
Osteoporosis	☐	
Stroke	☐	
Corticosteroid use	☐	
Cancer/tumor	☐	
Neck pain	☐	
Jaw pain	☐	
Arm/elbow/wrist pain	☐	
Shoulder pain	☐	
Mid back pain	☐	
Low back pain	☐	
Scoliosis	☐	
Hip pain	☐	
Leg pain	☐	
Knee pain	☐	
Ankle pain	☐	
Foot pain	☐	
Bursitis	☐	
Tendonitis	☐	
Numbness/tingling	☐	
Menstrual pain	☐	

FAMILY HEALTH HISTORY If a family member has or had any of the following, please check the box(s).
☐Cancer ☐High Blood Pressure ☐Heart Problems ☐Stroke ☐Diabetes ☐Other___

Patient's Signature _____ Date _____

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Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patient's privacy and strive to protect the confidentiality of your medical information. Federal legislation requires that we issue this notice of our privacy practices. You have the right to confidentiality of your medical information, and we are required by law to maintain the privacy of that information.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We may also share medical information about you to your other health care providers to assist them in treating you.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations
We may use and disclose your information for our health care operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials needed to serve you. We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law: public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, workers compensation, and law enforcement. You may revoke this authorization at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization

Your Rights
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in anticipation of, or use in, a civil, criminal, or administrative action or proceeding. A copy of your records must be requested in writing. You have the right to request a restriction of your protected health information. The physician is not required to agree to a restriction that you request. You have the right to request that we communicate with you about your medical information by different means or to a different location. This request must be made in writing. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. You may request a copy of this notice.

Questions or Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a compliant with us by notifying our privacy contact of your complaint. *We will not retaliate against you for filing a complaint.*

By signing below, I acknowledge that I have read, understand and accept the terms of this document.

Signature of Patient or Guardian_____ Date_____

Print Patient Name _____

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Informed Consent to Chiropractic Treatment

The nature of Chiropractic treatment:

The care we provide is directed toward balancing the muscles, joints and nerves of your body. To achieve this, the doctor will use his/her hands or tools to adjust your joints and align your soft tissues. You may hear a "click or pop", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, massage, traction, electric muscle stimulation, taping and exercise/nutritional instruction may also be employed.

Possible risks and alternative treatments:

There are inherent risks in any and all treatment delivered by any health care provider, ranging from administering a single aspirin to complicated brain surgery. Chiropractic is no exception. Though we take every precaution, there are some risks associated with Chiropractic. The most common is muscle soreness the first couple days after treatment. A list of rare possibilities includes muscular stain, ligamentous strain, and fractures. Injury to the intervertebral discs, nerves or spinal cord is possible, though are considered even less likely. The risks involved with treating the neck may include any of these, but also includes the remote possibility of cerebrovascular injury or stroke. Current literature states the chances of this occurring to be one in one million to one in ten million. The ancillary physical therapy procedures could produce skin irritations, burns or bruising. Other treatment options may include over the counter analgesics, which carry with them the risks of irritation to the stomach, liver, kidneys, and various other side effects.

Alternative treatments for most musculoskeletal complaints include care from an acupuncturist, naturopathic doctor, massage therapist, physical therapist, medical doctor, or surgeon, to name a few. Each of these modalities possesses their own list of possible risks and side effects. One or several of these may be recommended to compliment your Chiropractic care.

Concerns or Questions:

We hold your health and your safety as our top priority. We are glad to explain and address any concerns you may have regarding your treatment. We will only recommend treatment for you that we would feel comfortable having performed on ourselves. This consent form is intended to cover the entire course of treatment for your present conditions, and any future conditions for which you seek treatment at this office.

I have read the above explanation of Chiropractic treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment, I have freely decided to undergo treatment, and hereby give my full consent to treatment.

Signature of Patient or Guardian_____Date_____

Print Patient Name _____