Lake Oswego:
Dr. Sabrina J. Marcus, DC
15110 SW Boones Ferry Road
Suite# 380
Lake Oswego, OR 97035

Portland:
Dr. Sabrina J. Marcus, DC
2262 N. Albina Avenue
Suite# 129
Portland, OR 97227

Patient Information

Date______________________

Name____
Last First M.I. Preferred Name

Street____

City________________ State_____ Zip_________ Email__________________________

Best Phone Number (_____) _____ - _______ Please circle one: cell home work

Date of Birth_________________ Gender________ Occupation_____________________

Employer's Name and Address____

Preferred time/method of contact____

How did you hear about our center?____

Is your visit due to a Motor Vehicle Accident or Worker's Comp claim? Yes / No

If yes, please list the name and phone number of your claim representative below:

____

In Case of Emergency:

Contact________________________ Relationship_______________________________

Phone (______) _______ - _______ Alternate Phone (______) ______-_______

Address____

______________________________________ ____________________

Signature / Signature of Guardian Date

Wildflowers
CHIROPRACTIC

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Patient Intake

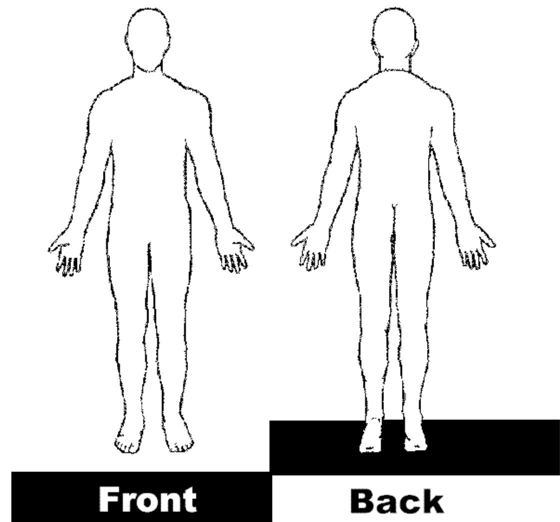
Name_________________________________ Age______ Date of visit____________________

What is the reason for your visit?____

____.

Please indicate where you are experiencing symptoms by **circling** and **labeling** the diagram below with the appropriate letter abbreviation to correspond with the area.

D=dull pain
S=stiffness/soreness
P=sharp or shooting pain
B=burning pain
N=numbness
T=tingling
W=weakness



For areas where pain is experienced, please provide additional information below:

Area Affected	Please rate **level of pain** with **0-10** where **0=NO pain** and **10=the worst pain you can imagine**	How often? (Hourly, daily, weekly, monthly, etc.)	How long does it last?

Do your symptoms affect your ability to perform daily activities? Yes / No

Activity Affected	Please rate **level of functioning** with **0-10** where **0=zero functioning** and **10=the best functioning of your life** PSFS

____ ____________________

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Financial Policy

Wildflowers Chiropractic is included in many, though not all insurance networks. As such, we may be considered an Out of Network Provider for your care. **Please provide us with a copy of your health insurance card and driver's license** so that we may assist you in determining your benefits and the reimbursements available for the care we provide. Quotes relating to your benefits will be rendered as they are communicated to us by your insurance company and do not guarantee their reimbursement. Ultimately, you are responsible for knowing your benefits and for payment to us for the care you receive.

Auto Injuries / Personal Injuries / Worker's Compensation Injuries:
If your injuries are connected with an auto accident, personal injury case, or injury sustained while on the job, Wildflowers Chiropractic will help you to determine whether your insurance will reimburse Wildflowers Chiropractic for the work performed here on your behalf. **Please provide us with a copy of your personal health insurance card and driver's license** so that we may assist you, as well as with the name and phone number of your claims representative.

I have read this financial policy. I understand that all charges billed to me from Wildflowers Chiropractic are my responsibility to pay in full. Efforts will be made to obtain financial reimbursement from all applicable insurance companies or third party agencies, but ultimately it is my responsibility to pay for all services rendered me.

If I am a patient who does not have chiropractic and/or physical therapy benefits through insurance, there are discounts available for services if paid at the time of service. A delay of payment may forfeit the time of service discount. It is my responsibility to pay for all services rendered me.

I understand that I may be assessed a $75.00 charge for any appointment missed or not cancelled more than 24 hours in advance of appointment time. If I miss or do not cancel 3 appointments more than 24 hours in advanced notice within the course of my treatment, my service provider will have the right to refuse additional appointments with me and the doctor/ patient relationship may be terminated.

I understand that any check returned for insufficient funds will be assessed a $75.00 fee and it is at the service provider's discretion whether to accept checks from me in the future.

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Past Health History

Name: ______________________________________

Are you experiencing any major illness at this time?____________________________________

Have you had any major surgeries or hospitalizations within your lifetime? When and for what?______________________________________
____

Have you had any accidents (car, falls, sports-related, other)?________________________________
____
____

Have you ever broken any bones? If any, which ones and how?_________________________________
____
____

What is your occupation/job?___________________
____

Is your work physically demanding? How?
____

Do you smoke or have you ever?________________
____

How much alcohol do you drink within a week?
____

Do you take any drugs, whether prescribed or not? Please list them below. ________________________
____

Do you take any Over the Counter medications?
____

Do you take any supplements?
____

Do you exercise on a regular basis? What does exercise mean to you?__________________________
____

Do you participate in any hobbies that can put a strain on your body (such as gardening, knitting, a high degree of video game play, etc.)?
____

In your diet, what types of food do you eat the most?____

In your diet, what types of food do you eat the least?____

How many hours per night do you sleep?_________

Do you wake up well-rested? YES / NO

Are you currently in a relationship which makes you feel scared or threatened? YES / NO

Are you currently experiencing a lot of stress in your life or within the past year? YES / NO

Women only:
When was the first day of your last menstrual period?_______________________________________

Are you pregnant? YES / NO

Are you taking oral contraception? YES / NO

Right to Privacy

Protecting the privacy of your protected health information is important to us. Protected health information includes both medical and individually identifiable information. We will not disclose this information without your authorization, except as required by law.

Our Notice of Privacy Practices provides information about how your protected health information may be used or disclosed. You have the right to request that we restrict how protected health information about how it is used or disclosed. Upon request, we will give you a copy of your Notice of Privacy Practices for you to review and/or make a copy for your records.

By signing this form, you consent to our use and disclosure of your protected health information as indicated in the Notice of Privacy Practices. Please note that your personal informant is not shared with third parties, such as financial, credit, or marketing companies. Use is restricted to procedures that are relevant to your care.

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Please indicate if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fracture
- ☐ Gout
- ☐ Hypertension
- ☐ Multiple Sclerosis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Ankylosing Spondylitis
- ☐ Other Rheumatic Disease
- ☐ Other Major Illness/Surgery

Please indicate if you have experienced any of the following within the past 6 months:

General:
- ☐ Headache
- ☐ Fever
- ☐ Loss of Sleep
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Thyroid Issues
- ☐ Allergies
- ☐ Excessive Urination
- ☐ Painful Urination
- ☐ Discolored Urine

Musculoskeletal:
- ☐ Neck Pain
- ☐ Pain between shoulders
- ☐ Low back Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Teeth Grinding
- ☐ Other Jaw Issues
- ☐ Foot Pain
- ☐ Walking Issues
- ☐ Spinal Curvature

Nervous System:
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Sharp/Burning Pain
- ☐ Twitching
- ☐ Seizures
- ☐ Stroke
- ☐ Stress
- ☐ Anxiety
- ☐ Depression

Gastrointestinal:
- ☐ Excessive Thirst
- ☐ Constipation
- ☐ Diarrhea
- ☐ Sexual Dysfunction
- ☐ Nausea
- ☐ Vomiting
- ☐ Poor or Excessive Appetite
- ☐ Abdominal Pain/Cramping
- ☐ Excessive Gas
- ☐ Heartburn
- ☐ Black or Bloody Stools
- ☐ Liver or Gall Bladder Issues
- ☐ Ulcers

Cardiovascular and Respiratory:
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Heart Attack
- ☐ Aneurysm
- ☐ Asthma
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Varicose Veins
- ☐ Ankle Swelling

EENT:
Any problems with:
- ☐ Ears/Hearing
- ☐ Eyes/Vision
- ☐ Nose
- ☐ Throat
- ☐ Sinuses

***Please indicate if any members of your immediate family (parents, grandparents, siblings, children) have a history of the same condition or symptom as yours.**

***Please indicate if you have ever had any prior adverse reactions to any forms of body work including chiropractic care.**

***Please list any other relevant details below:**

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Consent to Treatment

Chiropractic examination and therapeutic procedures are considered safe and effective methods of care. These include spinal adjustments, extremity adjustments, applications of ice or heat, manual muscle therapy, and therapeutic and preventative rehabilitation exercises. Occasionally, however, complications may arise. While the chances of experiencing complications are small, it is the practice of Wildflowers Chiropractic to inform our patients about possible complications. These may include, but are not limited to; soreness, inflammation, soft tissue injury or bruising, dizziness, burns, or temporary worsening of symptoms. More serious complications are extremely rare, and their association with spinal adjustments are debated. These complications include injury to arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries of the spinal discs, and bone fractures. Additional information on side effects and complications are available upon request.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me by Wildflowers Chiropractic. I have read and understand the above statements regarding possible treatment side effects, and I also understand that there is no guarantee for a specific cure or result that is implied or to be inferred pertaining to the course of treatment I receive at Wildflowers Chiropractic. I intend for this consent form to cover the entire course of treatment performed by Wildflowers Chiropractic for my present condition(s) and for any future condition(s).

____
Print Name / Name of Guardian

____ ____________________
Signature / Signature of Guardian Date