The Healing Arts Clinic at Multnomah Village
An Association of Independent Practitioners
Joyce D. McClure, DC, DACRB – Donald Fuegy DC
3644 SW Troy St. Suite 200 – Portland, Oregon 97219

PERSONAL HISTORY FORM

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

Name _____ □ Male □ Female Date_____

Address _____

City _____ State _____ Zip _____

Home phone _____ Business phone _____

Cell phone _____ e-mail address _____

Birth Date _____ Age _____ Spouse/Partner _____ Height_____ Weight _____

Employer _____ Occupation _____

Employment address _____

In case of emergency contact _____ Phone _____

How did you hear about our clinic? _____

Is your pain the result of a motor vehicle accident?	□ YES □ NO
If so, have you filed a legal suit?	□ YES □ NO
Is your pain the result of a work related injury?	□ YES □ NO
If so, have you filed a worker's compensation claim?	□ YES □ NO

How would you describe your chief complaint at this time?_____

_____

_____

Is there any numbness, tingling or weakness present in your hands or feet? _____

_____

When did it start? (Include month and year, day if known)_____

_____

What makes your symptoms worse? _____

_____

What makes your symptoms better? _____

_____

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Patient Name _____ Date _____

Are your symptoms: □ Intermittent □ Constant **Are they worse:** □ AM □ PM □ Same

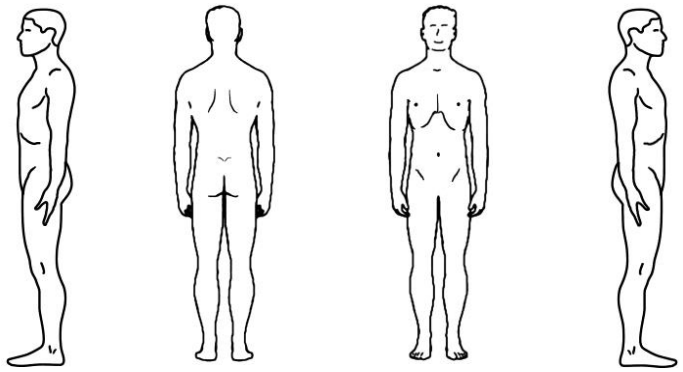
Any other times of the day or week your pain worse? _____

_____

Have you had this problem in the past? □ YES □ NO If YES, how often? _____

Location & Intensity (0=no symptoms; 10=severe pain) **Please mark areas of pain or discomfort:**

Neck _____/10
Upper Back _____/10
Mid-Back _____/10
Lower Back _____/10
Shoulder R / L _____/10
Leg R / L _____/10
Other:_____/10



Have you seen any other doctors for this condition? □ YES □ NO If yes, p**lease list:**

Doctor #1 _____ X-Ray? _____ Date of 1st visit: _____
Medications/Therapy prescribed: _____
Doctor #2 _____ X-Ray? _____ Date of 1st visit: _____
Medications/Therapy prescribed: _____
Doctor #3 _____ X-Ray? _____ Date of 1st visit: _____
Medications/Therapy prescribed: _____

Have you had previous chiropractic care? □ YES □ NO

If YES, when was the last time you were adjusted? _____

Doctor's Notes:

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Patient Name _____ Date _____

Do you exercise regularly? □ YES □ NO If yes, how many times per week? _____

If yes, what activities? _____

When you engage in the physical activity noted above, **what is the average duration of activity?**

□ Less than 10 minutes □ 10 – 20 mins □ 20 – 30 mins □ 30 – 60 mins □ over 60 mins

When you engage in the physical activity noted above, **what do you feel the level of effort is?** _____

_____

At work, how many days per week do you engage in tasks that are intense enough to cause sweating and a rapid heart rate?_____

Please rate your level of fitness (0 = very poor, 5 = average, 10 = excellent) _____

Do you have a past history of injuries involving: (dates)

ankles _____ knees _____ hips _____

wrists _____ elbows_____ shoulders_____

Please list any other accidents, injuries, surgeries and hospitalizations you have had.

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

Have you had X-rays taken of your spine within the last 10 years? □ YES □ NO

If yes, location and date of X-rays _____

Location and date of MRIs _____

MEN: Date of last prostate exam _____ Date of last colon exam _____

Any unusual findings? _____

WOMEN: Date of last pap smear _____ Date of last mammogram _____

Any unusual findings? _____

Do you have breast implants? □ YES □ NO Date implanted/removed _____

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Patient Name _____ Date _____

PLEASE CHECK ANY OF THE FOLLOWING YOU ARE CURRENTLY EXPERIENCING

HEAD
_____ Headache
_____ Loss of balance
_____ Dizziness
_____ Deafness
_____ Ringing in ear(s)
_____ Jaw pain
_____ Fainting
_____ Eye Pain
_____ Failing Vision
_____ Frequent nosebleeds
_____ Sinus Infection(s)

CHEST
_____ Chest Pain
_____ Difficulty breathing
_____ Asthma

ABDOMEN
_____ Difficult digestion
_____ Abdominal cramps
_____ Diarrhea
_____ Constipation
_____ Nausea
_____ Change in urinary function
_____ Change in bowel function
_____ Hemorrhoids

OTHER
_____ Fatigue
_____ Loss of sleep/insomnia
_____ Nervousness
_____ Fever
_____ Change in menstrual cycle
_____ Hot flashes

Do you or other family members have a history of any of the following?

Arthritis	☐ Family member	☐ Self	☐ Medications _____
Asthma	☐ Family member	☐ Self	☐ Medications _____
Autoimmune	☐ Family member	☐ Self	☐ Medications _____
Cancer	☐ Family member	☐ Self	☐ Medications _____
Depression	☐ Family member	☐ Self	☐ Medications _____
Diabetes	☐ Family member	☐ Self	☐ Medications _____
Fibromyalgia	☐ Family member	☐ Self	☐ Medications _____
Heart Disease	☐ Family member	☐ Self	☐ Medications _____
High Cholesterol	☐ Family member	☐ Self	☐ Medications _____
Hypertension	☐ Family member	☐ Self	☐ Medications _____
Kidney Disease	☐ Family member	☐ Self	☐ Medications _____
Mental Illness	☐ Family member	☐ Self	☐ Medications _____
Migraines	☐ Family member	☐ Self	☐ Medications _____
Stroke/TIA	☐ Family member	☐ Self	☐ Medications _____

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Patient Name _____ Date _____

PLEASE GIVE DATES FOR ANY OF THE FOLLOWING YOU HAVE HAD PREVIOUSLY:

_____ Alcoholism
_____ Allergies
_____ Anemia
_____ Arteriosclerosis
_____ Appendectomy
_____ Chemical dependency
_____ Chicken Pox
_____ Colitis
_____ Concussion/head injury
_____ Diphtheria
_____ Eating disorder
_____ Eczema
_____ Emphysema
_____ Epilepsy
_____ Fractures
_____ Glaucoma
_____ Goiter
_____ Gout
_____ Gall bladder problems
_____ HIV/AIDS
_____ Hepatitis
_____ Herniated disc
_____ Irritable Bowel Syndrome
_____ Kidney stone or infection
_____ Liver problems
_____ Measles
_____ Mumps
_____ Malaria
_____ Multiple sclerosis
_____ Numbness in hands/feet
_____ Osteoporosis
_____ Pacemaker
_____ Pinched nerve
_____ Polio
_____ Pneumonia
_____ Prostate problems
_____ Pleurisy
_____ Scarlet Fever
_____ Scoliosis
_____ Small Pox
_____ Tuberculosis
_____ Thyroid trouble
_____ Ulcers
_____ Whooping cough
_____ Weakness in arms or legs

Please list any allergies that you have _____

_____

PLEASE MARK ALL THAT APPLY:

_____ Avoid dairy
_____ Avoid wheat
_____ Avoid corn
_____ Avoid sugar
_____ Avoid night snacks
_____ Avoid nuts
_____ Drink alcohol _____ per week
_____ History of smoking ☐ current ☐ past
_____ Recreational drugs _____
_____ Caffeinated drinks _____ cups/day
_____ Soda _____ cans/day
_____ Anabolic steroids / EPO / Other

Any other health conditions you currently have? (Please list condition and any medications)

_____

_____

_____

_____

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Patient Name _____ Date _____

What medications, vitamins, supplements, herbs do you take?

Name	**Reason**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any other concerns?_____

_____

_____

_____

_____ _____

Patient Signature **Date**

Doctor's Notes:

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INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the above named doctors of chiropractic.

Though chiropractic treatments are usually beneficial and rarely cause any problem, I understand that, like many other forms of health care, there are some risks. These can include but are not limited to fractures, disc injuries, strokes, dislocations, and sprains.

Alternatives to chiropractic treatment for common musculoskeletal conditions may include physical therapy, medications such as muscle relaxers and anti-inflammatory drugs, and acupuncture.

I have had the opportunity to discuss with the doctor the purpose, benefits, and risks of the recommended chiropractic care, and alternatives to chiropractic treatment have been reviewed.

I further understand that health care providers cannot guarantee the results of treatment. I acknowledge that no guarantee of the outcome of the chiropractic care I have requested has been made. I have had ample opportunity to ask questions, and my questions have been answered to my satisfaction.

Patient's name (printed) Today's Date

Signature of patient or parent/guardian (if patient is a minor)

*******STOP HERE*******

Portion Below Used If Additional Information Requested and Received

I requested and received, in substantial detail, further explanation of the procedure or treatment. I was also given information about material risks of the procedure or treatment and other alternative procedures or methods. I give my permission and consent to the procedure or treatment.

Signature Today's Date

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YF FORM

NAME _____ Primary complaint _____

1. Please indicate your usual level of pain during **the past week**:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

2. Does pain, numbness, tingling or weakness extend into your leg (from the low back) &/or arm (from the neck)?

None of the time 0 1 2 3 4 5 6 7 8 9 10 All of the time

3. How would you **rate your general health**? (10-x)

Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

4. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?

Delighted 0 1 2 3 4 5 6 7 8 9 10 Terrible

5. How anxious (eg. tense, uptight, irritable, fearful, difficulty in concentrating / relaxing) you have been feeling during **the past week:**

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely anxious

6. How much you have been able to control (i.e., reduce/help) your pain/complaint on your own during **the past week:**

I can reduce it 0 1 2 3 4 5 6 7 8 9 10 I can't reduce it at all

7. Please indicate how depressed (eg. Down-in-the-dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling in **the past week:**

Not depressed at all 0 1 2 3 4 5 6 7 8 9 10 Extremely depressed

8. On a scale of 0 to 10, how certain are you that you will be doing normal activities or working in **six months**?

Very certain 0 1 2 3 4 5 6 7 8 9 10 Not certain at all

9. I can do light work for an hour?

Completely agree 0 1 2 3 4 5 6 7 8 9 10 Completely disagree

10. I can sleep at night

Completely agree 0 1 2 3 4 5 6 7 8 9 10 Completely disagree

11. An increase in pain is an indication that I should stop what I am doing until the pain decreases.

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

12. Physical activity makes my pain worse?

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

13. I should not do my normal activities including work with my present pain.

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

Please sign your name _____ Date _____

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Effective Date: September 21, 2013

Health Insurance Portability and Accountability Act (HIPAA)
Notice of Patient Privacy Policy

Joyce D. McClure DC PC, The Healing Arts Clinic, an association of independent practitioners, and its staff are dedicated to preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed as well as how you can access this information.

Under HIPAA, we are able to use or disclose to others your medical information for purposes of providing or arranging for your healthcare, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated. We in turn reserve our legal right of having 30 days to produce such information.

We have available a detailed **NOTICE OF PRIVACY PRACTICES** which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact Jennifer DeChane, Office Manager/Compliance Officer at (503) 293-3001.

I acknowledge that I have read the above and understand I may request a detailed version of privacy practices at this clinic.

_____ _____

Printed Name Date

_____

Signature

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Financial Policy

1) All payments, including co-pays, are due at the time of service, unless special arrangements have been agreed upon prior to visit.
2) We accept cash, checks, Visa, and MasterCard.
3) As a courtesy to our patients, we will bill your insurance company for you. However, an insurance contract is between you, the patient, and your insurance company, therefore,
you are financially responsible for anything your insurance does not cover.
4) All supplements/vitamins, supports and other supplies ***must*** be paid for at the time they are received.
5) You are responsible for timely payment of your account.

Workers Compensation Claims

6) All workers' compensation cases will be billed directly to the insurance company, providing the appropriate paperwork has been filled out and a claim is filed with your employer. If the claim is denied, we will bill your private insurance carrier, if you have applicable coverage. Please keep in mind that if your claim is denied, you are responsible for prompt payment of your account.

Personal Injury/Motor Vehicle Accidents

7) Personal injury and auto accident cases will be billed to your auto insurance company, providing a claim has been filed and the appropriate paperwork has been completed. This includes a Personal Injury Protection (PIP) form, and any other forms required by your insurance company.
8) We do not do third party billings to other insurance companies.
9) If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service.
10) Supplements/vitamins, supports, and other supplies may not be covered by insurance companies, and must be paid for at the time they are received. Should the insurance company cover the cost of these items, we will reimburse you for the amount paid by your insurance.

Missed Appointments

We request at least a 24-hour notice when appointments must be cancelled or rescheduled, except in the case of illness or family emergency. There is a charge of $40 for no-shows or cancellations with less than 24-hour notice.

I have read, understand, and agree to Dr. McClure's financial policy. In addition, I authorize the payment of benefits to Joyce D. McClure, D.C., P.C.

_____ _____

Patient/Guardian Signature Date