Patient #:

Renewal Centers Chiropractic Care Patient Registration

Renewal Centers • Jonathan Hansel ND, DC • 1240 NE Burnside, Gresham, OR 97030

Full Name:

Home Phone: Date of Birth: Male ☐ Female ☐

Cell Phone: Last 4 digits of Social Security

Address: Apt #:

City: State: Zip:

Emergency Contact:

Phone: Relationship:

How did you hear about us?

What are you being seen for today?

List all medications you are currently taking.

Do You Have Allergies to Medication?

Prefered pharmacy? Location:

Consent for Chiropratic Care

Chiropractic and Naturopathic examination and therapeutic procedures (including but not limited to spinal adjustment, ultrasound, heat/cold application, manual muscle therapy, and vitamin/mineral injections, given intramuscularly or intravenously), are considered safe and effective methods of care. With any procedure that is intended to help, occasionally complications may arise. While the chance of experiencing complications is small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statement regarding treatment side-effects. I also understand that by signing below, I am giving my consent for care/treatment by the staff of Renewal Centers. No guarantee or warranty of a specific result has been made or implied.

Print Name:

Sign Name: Date:

For Internal Use Only : BP Pulse Temp Height Weight

Patient #:

Renewal Centers Chiropractic Care Intake Registration

Renewal Centers • Jonathan Hansel ND, DC • 1240 NE Burnside, Gresham, OR 97030

Name:

Home Phone:

Date of Birth:

Male ☐
Female ☐

How did you hear about our clinic?

Occupation:

Primary Care Provider DR.

Phone:

What symptoms prompted your visit today?

How long have you had these symptoms?

Have you seen a doctor before for this problem? ☐ Yes ☐ No

If yes, doctors name and diagnosis?

When was the last time you had a complete physical?

Findings?

If you are a female are you currently pregnant? ☐ Yes ☐ No

List all medication currently taking (prescription, over the counter, and herbal):

List any prescribed medication you've had an adverse reaction to in the past. Indicate the drug name, when you took it and the reaction you had:

List all known allergies:

How many times have you been treated with antibiotics in the past 5 years?

Blood type:

Medical History

	Age	Health problems	Cause of Death	Age of Death
Father				
Mother				
Siblings				
Children				
Grandparents				

Please check only those that pertain to you personally:

- ☐ Alcohol abuse
- ☐ Female Gynaecological problems
- ☐ Skin problems
- ☐ Allergies
- ☐ Gallstones
- ☐ Stroke
- ☐ Anaemia
- ☐ Gum/Teeth problems
- ☐ Suicide
- ☐ Asthma
- ☐ Heart attack
- ☐ Thyroid problems
- ☐ Arthritis
- ☐ Heart problems
- ☐ Tuberculosis
- ☐ Back, Muscle, Joint pain
- ☐ High blood pressure
- ☐ Ulcers
- ☐ Bladder/Urinary problems
- ☐ Kidney problems
- ☐ Venereal disease
- ☐ Candida
- ☐ Measles
- ☐ Chronic fatigue
- ☐ Epilepsy
- ☐ Depression
- ☐ Liver problems
- ☐ Diabetes
- ☐ Overweight
- ☐ Chronic sinusitis
- ☐ Rheumatic fever
- ☐ Psychological problems
- ☐ Cancer
- ☐ Lung problems
- ☐ Pneumonia
- ☐ Gout
- ☐ Mononucleosis
- ☐ Eczema
- ☐ Bowel disease
- ☐ Influenza
- ☐ Hay fever
- ☐ Constipation
- ☐ Rheumatism
- ☐ Pleurisy
- ☐ Hives
- ☐ Malaria
- ☐ Chronic swollen glands
- ☐ Hypoglycaemia

Renewal Centers Chiropratic Patient History

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Please check any conditions you are currently experience or have previously experienced.

- ☐ Allergies
- ☐ Asthma
- ☐ Arthritis
- ☐ Blood Thinners
- ☐ Bone/Joint Disease
- ☐ Broken Bones
- ☐ Bleeding Abnormalities
- ☐ Communicable disease
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Cystic acne
- ☐ Diabetes
- ☐ Depression
- ☐ Dizziness
- ☐ Digestive Problems
- ☐ Dark Spots/Skin Injury
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ HighLow Blood Pressure
- ☐ Herpes Simples-Fever, Cold/Sore
- ☐ HIV
- ☐ Insomnia
- ☐ Kelliod/Thick Scarring
- ☐ Lupus-Auto Immune
- ☐ Leg Ulcer/Phlebitis
- ☐ Neuromuscular Disorder
- ☐ Osteoporosis
- ☐ Open Cuts/Sores
- ☐ Pregnant
  How many times? ☐
- ☐ Breasts Feeding
- ☐ Psoriasis/ Vitiligo
- ☐ Pulmonary Embolism/Blood Clot
- ☐ Seizures
- ☐ Scoliosis
- ☐ Scars - Turn White/Brown
- ☐ Skin Disease
- ☐ Transplant
- ☐ Treated With Accutane
- ☐ Trauma/Abuse
- ☐ Waxing/Plucking/Electrolysis (within four weeks)
- ☐ Weakness
- ☐ Varicose Veins

Have you been seen by a doctor in the past year? Yes ☐ No ☐

If yes, please specify reason.

Have you had any surgeries, accidents, serious illness/ injuries or been hospitalized? Yes ☐ No ☐

Include year and what treatment you received.

List any medications you're currently taking or have taken in the past.

List any herbal supplements you are currently taking or have taken in the past.

Chief Complaint (describe symptoms, including location):

When did the symptoms appear?

Are symptoms progressively worse? Yes ☐ No ☐

If caused by an injury, please describe what happened:

Are symptoms progressively worse? Constant ☐ Comes and Goes ☐

Renewal Centers Chiropratic Patient History

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Symptoms interfere with: Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Activities/movements that are painful: Sitting ☐ Walking ☐ Lying Down ☐ Bending ☐

Have you been treated for this problem? Yes ☐ No ☐

If yes, by who?

What did they do/recommend?

Are there any other areas of complaint?

Have you ever had chiropractic care for other problems? Yes ☐ No ☐

If yes, for what and when?

Date of last: Physical ____ Breast Exam/Mammogram ____

Spinal X-Ray ____ Prostate Exam ____

Have you ever been involved in any auto (or other) accidents? Yes ☐ No ☐

If yes, please briefly describe each incident

Have you been treated for spinal/nerve disorder? Yes ☐ No ☐

Do you have an implant, pacemaker or IUD? Yes ☐ No ☐

If yes, please explain

Do you exercise regularly (non-job) Yes ☐ No ☐

If yes, how often and what type of exercise do you do?

How many hours of sleep do you get each night?

Is it restful? Yes ☐ No ☐

Do you sleep on your Back ☐ Side ☐ Stomach ☐

Do you smoke? Yes ☐ No ☐ How many per day?

Do you drink? Yes ☐ No ☐ How many per day/wk?

Are you currently pregnant? Yes ☐ No ☐ Date of last menstrual period

Do you take: Muscle relaxers ☐ Pain killers ☐ Birth control pills ☐ Insulin ☐ Other ☐

Do you need any information on any of our other services? Yes ☐ No ☐

If yes, which?

How would you prefer us to contact you?

Notice of Information Practices

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By signing below I consent to Renewal Centers' use and disclosure of my Protected Health Information (PHI) for the purposes of providing treatment to me, relating to payment of services rendered to me and general healthcare operations purposes of Renewal Centers. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, business management and other general operations activities. I understand that Renewal Centers' diagnosis or treatment of me may be conditional upon my consent as evidenced by my signature on this document.
I understand that I have the right to request a restriction on the use and disclosure of my PHI for the purposes of treatment, payment or healthcare operations of Renewal Centers. However, the restrictions must be agreed upon by Renewal Centers. If the restrictions that I request are agreend upon, those restrictions are then binding on Renewal Centers.

I acknowledge I have a right to review Renewal Centers' Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my PHI.

I understand that this consent to release information expires one year from the date of my signing and I have the right to revoke this consent, in writing at any time, except to the extent that a Physician or an other Renewal Centers' staff has acted in reliance on this consent.

Renewal Centers' Policy Statement

Eligibility for Service
Services are not denied to any person on the basis of race, color, gender, sexual orientation, creed, handicap, national origin, duration of residence or age.

Scope of Services
We provide chiropractic services including adjustments, heat packs, therapy, massage, electronic stimulation therapy and other conventional chiropractic and naturopathic services.

Payment of Fees
We accept Cash, Visa or MasterCard. We do not accept insurance accept for auto accident injuries. All payments are due at time of service.

Grievance Procedure
Should you ever feel that you didn't get outstanding service from us, please let the doctor or office manager know. We care and will do our best to resolve any issue that you might have.

By Signing below I an acknowledging that I have read and understand Renwal Centers' Policies and PHI practices.

Print Name: _____

Sign Name: _____ Date: _____