SCHLENKER CHIROPRACTIC

Chiropractic • Sports Medicine • Massage

PATIENT INFORMATION

Patient Name_____ Today's Date _____

Birthdate_____ Sex: M / F Marital Status: Married / Single / Other Student: Y / N

Weight_____lbs Height_____ Smoking Status: Current Smoker / Former Smoker / Non Smoker

If a smoker, Frequency_____ Start Date_____ End Date_____

Address_____ City_____ State____ ZIP_____

Home Phone _____ Cell _____ Work _____

E-mail Address_____ Please contact me at: Home / Cell / Work / E-mail

Number of Children_____ How did you hear about our office?_____

If a Minor (under 18 years old), name and address of responsible parent/guardian:

Name_____ Birthdate _____

Address_____ City_____ State____ ZIP_____

Home Phone _____ Cell _____ Work _____

EMPLOYMENT INFORMATION

Employer_____ Professional Title_____

Address_____ City_____ State____ ZIP_____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact_____ Relationship_____

Home Phone _____ Cell _____ Work _____

Please have insurance card available for receptionist to make a copy for your file.

INSURANCE INFORMATION

Insurance Company_____

Primary Insured_____Relationship to Insured: Self / Spouse / Child / Other_____

Member ID_____ Group No_____ Insurance Phone No_____

CHIEF COMPLAINT

Current Condition/Problem_____

_____

Any radiating symptoms? What/Where?_____

_____

When did this condition occur? _____

Please describe what happened:_____

_____

Since onset, is the condition getting: Better Worse Same

Anything similar ever happened before? If yes explain: _____

_____

Is Condition: Job Related____ Auto Related____ Home Injury____ Fall____ Other____

Other Doctors seen for this condition: Yes / No Who? _____

Type of Treatment_____ Results_____

Last Chiropractor seen_____

Have you been treated for any health conditions in the last year? Y / N If yes, please explain:

_____

PAST HEALTH

Other Conditions (current/past)_____

Surgeries_____

Fractures/Broken Bones_____

Major Trauma/Car Accidents_____

Medications/Supplements_____

Last Doctor Seen_____

Last Physical_____

Xrays/MRI/CT_____

FAMILY HISTORY

Please list family members affected by the following:

Cancer_____

Diabetes_____

Heart Disease_____

Osteoporosis_____

Genetic Diseases_____

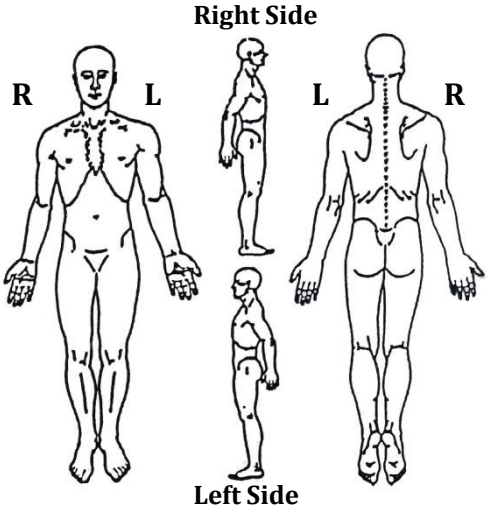
Please UNDERLINE conditions you have had PREVIOUSLY and CIRCLE conditions you have NOW

DIABETES	CANCER	HEART DISEASE
LOW BACK PAIN	PAIN BETWEEN SHOULDERS	NECK PAIN
ARM PAIN	JOINT PAIN/STIFFNESS	WALKING PROBLEMS
NUMBNESS	PARALYSIS	DIFFICULTY CHEWING/CLICKING JAW
DIZZINESS	FORGETFULNESS	CONFUSION/DEPRESSION
FAINTING	CONVULSIONS	COLD/TINGLING EXTREMITIES
ALLERGIES	LOSS OF SLEEP	FEVER
HEADACHES	SINUS TROUBLE	DIGESTIVE DISTURBANCES
LOSS OF CONSCIOUSNESS	ARTHRITIS	OSTEOPOROSIS

Mark the exact location of your symptoms on the diagram:

A = Ache
P = Pins & Needles
B = Burning
S = Stabbing
N = Numbness
O = Other

Comments:



Please indicate how your pain affects you in the six categories of daily living listed below. PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES HOW MUCH YOUR PAIN AFFECTS YOUR TYPICAL ACTIVITIES. **"0" signifies that your pain does NOT affect your activity level and "10" signifies that ALL activities in which you would normally be involved have been disrupted or prevented by your pain.**

1. Completing Family/Home Responsibilities. Ex. Chores and duties around the house (laundry) and errands or favors for other family members (driving the kids to school).

0 1 2 3 4 5 6 7 8 9 10

2. Recreation. Ex. Hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

3. Social Activity. Ex. Activities which involve participation with friends and acquaintances other than family members (parties, theater, concerts, dining out, and other social functions).

0 1 2 3 4 5 6 7 8 9 10

4. Occupation. Ex. Activities that are part of or directly related to your job. This also includes non-paying jobs such as volunteer work.

0 1 2 3 4 5 6 7 8 9 10

5. Self Care. Ex. Activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.)

0 1 2 3 4 5 6 7 8 9 10

6. Life-Support Activity. Activities which support basic life behaviors (eating, sleeping, and breathing)

0 1 2 3 4 5 6 7 8 9 10

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Consent to Treatment

I wish to receive treatment and examinations provided at Schlenker Chiropractic. I understand that all diagnosis and treatment methods will be explained to me and I have the right to ask questions if further explanation is needed.

I understand that individuals respond differently to treatment and that there is no guarantee of results during any treatment. I understand the examination and treatment involve certain risks and those risks will be explained or communicated to me.

I therefore authorize Dr. Schlenker to examine and treat me to the extent that he deems suitable.

Patient's Name: _____

Signature: _____ Date: _____

The patient is unable to consent for the following reasons:

- ☐ Patient is a minor
- ☐ Other: _____

I therefore give consent on the patient's behalf.

Signed: _____ Date: _____

Relationship: _____

SCHLENKER CHIROPRACTIC
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Auto Injury • Rehab

Financial and Cancellation Policies

Thank you for choosing our office to meet your chiropractic and massage healthcare needs. It is our optimal goal to provide you and your family with the highest quality of care, while maintaining a friendly environment. In order to keep our standard of care at a level which best serves your healthcare needs, we ask you to please observe the following guidelines.

Office and Financial Polices

Our relationship is with you, not your insurance company. It is therefore your responsibility to verify if we are in-network with your insurance company. We do our best to verify your insurance benefits. Your insurance policy may not cover all services provided to you. It is your responsibility to understand your insurance benefits before your visit occurs.

The filing of insurance claims is a courtesy that we extend to our clients. All charges are your responsibility from the date that the services were rendered. We will help you by processing your insurance claims for your **primary insurance only.** We **do not** bill secondary insurance.

We require you to pay at the time we provide services to you. If your insurance covers chiropractic or massage therapy, we require you to pay your co-payment at time of service. Balances for co-insurance and deductibles are billed once your insurance company processes your claim. They are due within **30 days** of receiving your statement. For your convenience we accept cash, check, Visa, MasterCard, Discover and American Express. Awareness of the following terms can help you in understanding the cost of your services:

Co-payment: An amount owed at the time of service. It is a fixed dollar amount determined by your insurance contract.

Co-Insurance: This is an additional amount you owe after your claim has been processed. It is a percentage due determined by your insurance contract.

Deductible: Many insurance policies have an amount you owe for services before your insurance company will pay for services. After you pay your copay, and the insurance has processed the claim any remaining amount that is part of your deductible is your responsibility.

Past Due Accounts

Patients with past due accounts will be required to pay their account in full before any future appointments may be scheduled.

Late Arrival Cancellation and No-Show Policy

We seek to honor your scheduled appointment times. When a patient cancels without giving notice, we are prevented from being able to provide service to others who desire an appointment. It is your responsibility to call the office at **(503) 908-0582** within 24 hours prior to your appointment if you need to cancel. If you do not show for your appointment or you cancel your appointment with less than 24 hours' notice you will be charged based on the following fees.

- **$175.00 for a 45 minute new patient appointment**
- **$85.00 for a 30 minute Chiropractic adjustment and therapy appointment**
- **$60.00 for a 15 minute Chiropractic adjustment appointment**
- **$85.00 for a 60 minute massage appointment**
- **$120.00 for a 90 minute massage appointment**

If you arrive more than 5 minutes late for a 15 minute adjustment appointment or 15 minutes late for a 30 min adjustment or Massage appointment, we will need to reschedule your appointment.

Your signature below indicates that you have read, understand and consent to the above agreements. Your signature indicates that you accept financial responsibility and give permission for us to bill your insurance on your behalf.

_____

Print Patient's name

_____ _____

Signature of Responsible Party **Date**

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Privacy Practices Acknowledgement Form

Per HIPAA (Health Insurance Portability and Accountability Act) regulations, we will protect and keep confidential your protected health information. A full copy of the Notice of Privacy Practice is available to read upon request.

Name (printed)_____ Date of Birth_____

Signature_____ Date_____

Health and Medical Information Release Form (Optional)

I, _____, give permission to Dr. Jason Schlenker, DC, DACBSP, and staff of Schlenker Chiropractic and Associates to share my private and medical information with the below named parties:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Signature: _____ Date: _____