

- **Whom may we thank for referring you to PANGEA?**

APPLICATION FOR CARE AT PANGEA CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 E-mail Address: _____ Home Phone: _____ Mobile Phone: _____
 Marital Status: Single Married Do you have Insurance: Yes No Work Phone: _____
 Social Security #: _____ Are you Pregnant Yes No If yes, due date _____
 Employer: _____ Occupation: _____
 Spouse's Name _____ Spouse's Employer _____
 Children Names and ages: 1) _____ 2) _____ 3) _____ 4) _____ 5) _____
 Name & Number of Emergency Contact: _____ Relationship: _____
 *May we text you appointment reminders? Yes No *Are you active or military veteran? Yes No

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: **Primary:** _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **1 to 10** with **10 being the worst pain** and **zero being no pain**, rate your above complaints by **circling the number**:

Primary or chief complaint PAIN/DISCOMFORT LEVEL:

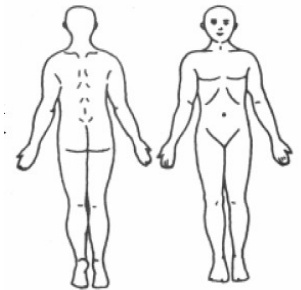
o Right now:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
o On average:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
o At its best:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
o At its worst:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:

R = Radiate B = Burning D=Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingle O=Other



When did the primary problem begin? _____ When is the problem at its worst? AM PM mid-day late PM

How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

How did the injury happen? _____

Condition has been treated by anyone in the past? No Yes **If yes**, when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ N/A

What **relieves** your symptoms? _____

What makes your symptoms feel **worse**? _____

LIST RESTRICTED ACTIVITY:

1) _____ 3) _____

2) _____ 4) _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No Yes **If yes**, how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: No Yes **If yes**, please state what type of treatment: _____

Who provided it: _____ **How long ago?** _____ What were the results. Favorable Unfavorable → please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

Have you been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past** or **C** for

Currently:

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability
___ Cancer ___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Vascular Disease

Other serious conditions _____

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

INJURIES	→
SURGERIES	→
MEDICATIONS	→
DISEASES	→

SOCIAL HISTORY

- 1. **Smoking:** cigars pipe cigarettes How often? Daily Weekends Occasionally Never
- 2. **Alcoholic Beverage:** consumption occurs Daily Weekends Occasionally Never
- 3. **Recreational Drug use:** Daily Weekends Occasionally Never
- 4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect? (See ADL form)

FAMILY HISTORY:

- 1. Does anyone in your family suffer with the same condition(s)? No Yes
If yes whom: grandmother grandfather mother father sister(s) brother(s) son(s) daughter(s)
Have they ever been treated for their condition? No Yes I don't know
- 2. **Any other hereditary conditions the doctor should be aware of?** No Yes: _____

I hereby authorize payment to be made directly to Pangea Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Pangea Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

Pangea Chiropractic

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name _____

Patient Signature _____

Date _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health 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 of our office that are involved in your care and treatment for the purpose 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 protected 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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

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 as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements

of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization. Your Rights. Following is a statement of your rights with respect to your protected health information.

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 reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of 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.

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 complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before January 1st 2014

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our FHPAA Compliance Officer in person or by phone at our Main Phone Number

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ **Signature** _____ **Date** _____

Pangea Chiropractic 409 NE Greenwood Ave. Ste#120 Bend, OR 97701

PANGEA CHIROPRACTIC

Automobile/PI Accident or Work Comp Questionnaire

Patient's Name

Date of Birth

HR#:

Dear Patient:

This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.

Thank you.

Please answer all questions completely.

Please explain in detail how your accident happened: _____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

Did you require post-accident hospitalization? Yes No

Check symptoms you have noticed since the accident:

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Head Seems to Heavy | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Neck Stiff |
| <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Constipation | <input type="checkbox"/> Tension | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Fever | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Stomach Upset | | |

Symptoms other than above: _____

Where were you taken after the accident? _____

Hospitalized? Yes No If yes, admitted? _____ How long? _____

Name of Hospital: _____

Name of Doctor(s): _____

What treatment was given? _____

Was any other doctor consulted after your accident? Yes No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? Yes No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this accident? Yes No

Since this injury are your symptoms ... Improving? Getting worse? Same?

Driver of other vehicle (if any):

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable):

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? Yes No

If so, his/her name and address _____

You were heading North/ East/ South/ West on _____ (street or highway)

Other vehicle was heading North/ East/ South/ West on _____ (street or highway)

Were police notified? Yes No

Were you knocked unconscious? Yes No If yes, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side _____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts _____

Patient Signature _____

Date _____

Doctor Signature _____

Date _____

ACTIVITIES OF LIFE

Name: _____

Date: _____

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

List Prescription & Non-Prescription drugs you take:

Patient signature: _____

Date: _____

Continued on Back.....

Please mark P for in the Past or C for Currently have:

- | | | |
|---|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Double Vision | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Irritable | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis (A,B,C) |
| <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Digestive Problems | |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Colon Trouble | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Diarrhea/Constipation | |
| <input type="checkbox"/> Pain w/Cough/Sneeze | <input type="checkbox"/> Menopausal Problems | |
| <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Menstrual Problem | |
| <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> PMS | |
| <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Bed Wetting | |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Learning Disability | |

Something not listed: _____

