Contour Chiropractic Clinic PC 10150 NW Glencoe Rd, OR 97133 PH:(503)336-3335 F:(503)336-3648

Patient Registration Form

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Physical Address (if different): _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Alternate Phone: _____
Email Address: _____
Birthdate: _____ Age: _____ Sex: Male ☐ Female ☐
Social Security Number: _____ Status: Married/Partner ☐ Divorced ☐ Single: ☐
Driver's License Number: _____ Height: _____ Weight: _____
Emergency Contact: _____ Phone: _____ Relation: _____
Permission to discuss personal info with them in case of emergency? Yes ☐ No ☐
Referred by: _____

Responsible Party/Legal Guardian (If applicable)

Last Name: _____ First Name: _____ Middle Name: _____
Relation to Patient: _____ Phone: _____

Employment Information

Employer: _____ Job Title: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Ext: _____
Have you lost any time since the accident? Yes ☐ No ☐ If yes, how much money? _____
Are you able to perform your regular duties without limitations? Yes ☐ No ☐
If no, are you on light duty or another job classification, etc.? _____
Are you being compensated for time loss? Yes ☐ No ☐
Have you reported this accident to your employer? Yes ☐ No ☐
Will this accident affect your ability to maintain your current job? Yes ☐ No ☐

Insurance Information

Please select one: Medical ☐ Auto ☐ Work Claim ☐ None ☐
Company: _____ Phone: _____
Claim Number: _____ Claim Representative: _____
Company Address: _____
City: _____ State: _____ Zip Code: _____
Accident Date: _____ Time of Accident: _____ AM or PM
Address where accident took place: _____
City & County: _____ State: _____ Zip Code: _____

Vehicle Information

Were you the driver or a passenger? _____ If passenger where were you seated? _____
Is the vehicle register to you? Yes ☐ No ☐
If not, who is the vehicle registered to? _____
Address: _____ Phone: _____
Is it a private or company car? _____ Model/Year/ Make: _____
Owner's insurance company & address: _____
Policy number: _____ Insurance adjuster: _____ Phone: _____

Vehicle A (vehicle you were in)**:**

Name of the driver in vehicle A: _____

Address of driver: _____ Phone: _____

Is it a private or company car? _____ Company name: _____

Driver's insurance company & address: _____

Policy number: _____ Insurance adjuster: _____ Phone: _____

Make/Year/Model of vehicle A: _____

Number of people in vehicle A:_____ Names: _____

Vehicle B (other vehicle involved)**:**

Name of the driver in vehicle B: _____

Address of driver: _____ Phone: _____

Is it a private or company car? _____ Company name: _____

Driver's insurance company & address: _____

Policy number: _____ Insurance adjuster: _____ Phone: _____

Make/Year/Model of vehicle B: _____

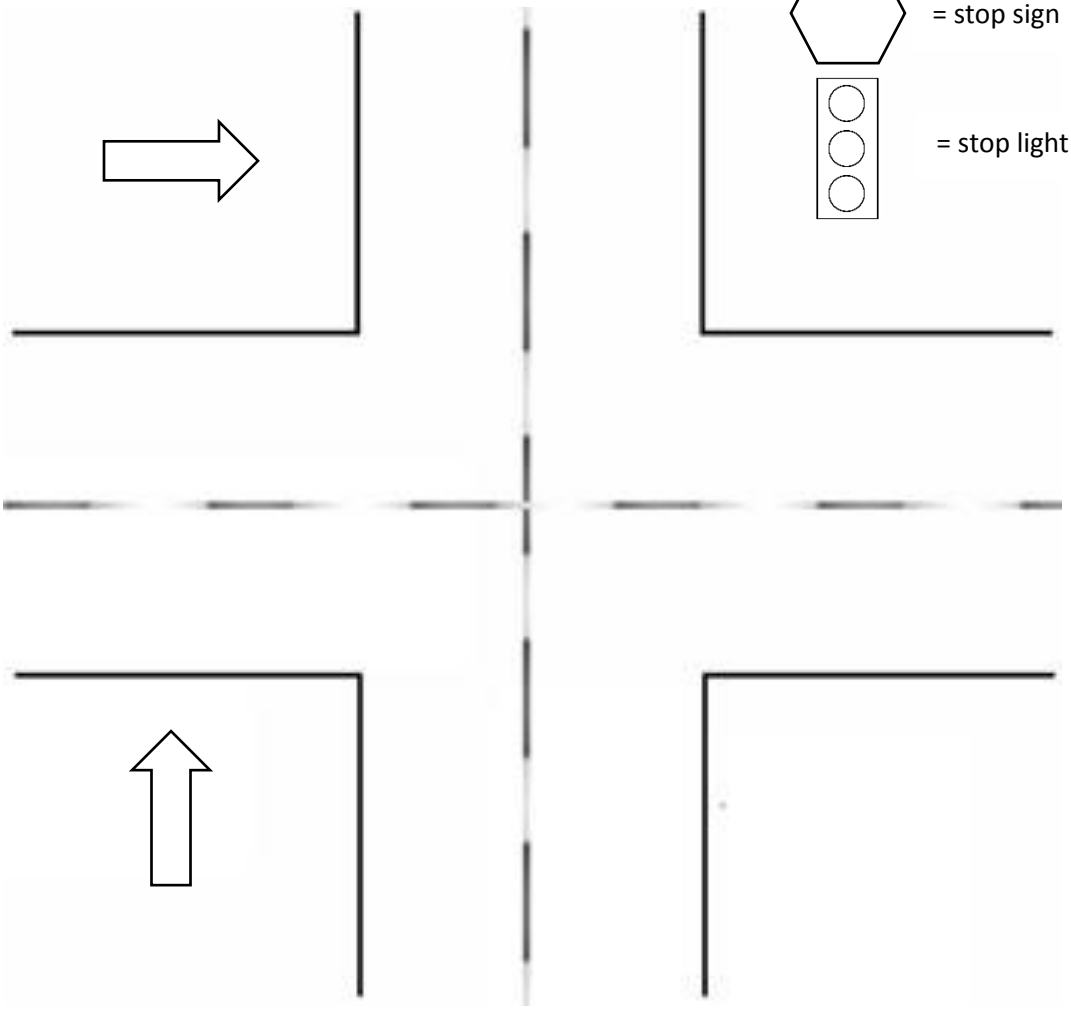
Number of people in vehicle B:_____ Names: _____

On the drawing below draw in where the vehicles were in relation to each other

1. Draw signs or lights if present and where located
2. Use arrows to indicate the direction of travel for each vehicle
3. Please indicate the name of the streets as indicated by arrows

A = vehicle you were in

B = other vehicle involved



Accident Information

Please describe to the best of your ability what happened during this accident: _____

_____

_____

_____

Road conditions at time of accident: Wet ☐ Dry ☐ Icy ☐ Loose gravel ☐ Other: _____
Visibility at time of accident: Clear ☐ Cloudy ☐ Foggy ☐ Other: _____
Type of road surface: _____ Any obstructions (ex: parked car, etc.): _____
Did the police come to the accident scene? Yes ☐ No ☐ Were there citation(s) given? Yes ☐ No ☐
If yes, to whom? _____ For what reason was the citation given? _____
Did any person involved require an ambulance? Yes ☐ No ☐ If, yes whom? _____
Were you taken to the hospital? Yes ☐ No ☐ If yes, Hospital name: _____
How did you get to the hospital? _____
While at the hospital what tests or x-rays were performed? _____
Who was the attending physician? _____
Were you given special instructions? _____ Medications? _____
Have you been seen by anyone else? Yes ☐ No ☐ If yes, whom? _____
For what reason and what treatment was rendered? _____
Were any of the involved vehicles modified in any way (ex: jacked up, etc.)? Yes ☐ No ☐
If yes, In what way? _____
Were you wearing a seat belt? Yes ☐ No ☐ Shoulder harness? Yes ☐ No ☐
Did they hold during impact? Yes ☐ No ☐
Was there a headrest? Yes ☐ No ☐ How far did the headrest come up on your neck/back? _____
If turning were hand signals or turn signals used? Yes ☐ No ☐
How were you seated in the vehicle (straight ahead, turned, etc.): _____
Were you aware of the approaching collision or did it catch you by surprise (explain): _____

_____
How was your head positioned at impact (turned right/left/straight etc.)? _____
Were you trying to grab/restrain anyone (explain)? _____
If you were the driver, did you have time to brace yourself? Yes ☐ No ☐
Was your foot on the brake? Yes ☐ No ☐ Was the car stopped or rolling? _____
If you were the passenger, did you have time to brace yourself? Yes ☐ No ☐
What was the estimate speed of your vehicle at time of impact? _____
Was your car slowing down, gaining speed, or steady? _____
What was the estimate speed of the other vehicle at time of impact? _____
Describe where your vehicle was hit? _____
Did you lose consciousness (blackout) upon impact? Yes ☐ No ☐ If yes, how long? _____
If knocked out were you aware of your surroundings? Yes ☐ No ☐
Was one or both shoe(s) knocked off due to impact? Yes ☐ No ☐
At the point of impact did you see stars, bright white lights, or feel a blinding or explosive sensation to your head? _____
What bleeding cuts did you receive during the accident? _____
What areas of your body were bruised? _____
Were you thrown around inside the vehicle? Yes ☐ No ☐
Did any part of you hit the vehicle? Yes ☐ No ☐ If yes, which part(s)? _____
What part of the vehicle did you hit? _____
Did you have any broken bones? Yes ☐ No ☐ If yes, explain? _____
Did any objects in the car hit you? _____
What position were you in following the impact? _____
Were you able to get out of the vehicle by yourself? Yes ☐ No ☐
Were you able to walk unaided? Yes ☐ No ☐

Did any of the following parts of the vehicle brake during the accident?
Windshield ☐ Right/left window ☐ Steering wheel ☐ Your seatbelt ☐ Your seat rail ☐
Other: _____

Describe any pain or discomfort immediately following the accident: _____

_____

Describe any pain or discomfort later that same day: _____

_____

Describe any pain or discomfort the following day: _____

_____

Were you dizzy? Yes ☐ No ☐
Did you feel disoriented? Yes ☐ No ☐
Did you have any vision problems? Yes ☐ No ☐
Did the airbag deploy? Yes ☐ No ☐

What has been the progression of symptoms from the time of the accident until now (ex: aches, pains, new limitations)? _____

What symptoms have improved since the accident? _____

Do you have good recall of the accident and the time immediately following? Yes ☐ No ☐

Have you been in any previous auto accident (list year, injuries, and explain what happened)?

_____

_____

Are there any residuals, pains, or discomforts from a previous accident that were bothering you before or that have worsened after this accident (explain)? _____

_____

Do you have any congenital defects or illness that have worsened since the accident? Yes ☐ No ☐
If yes, explain: _____

Are any prior accidents still under litigation? Yes ☐ No ☐
If yes, what is your attorney's name, address, & number? _____

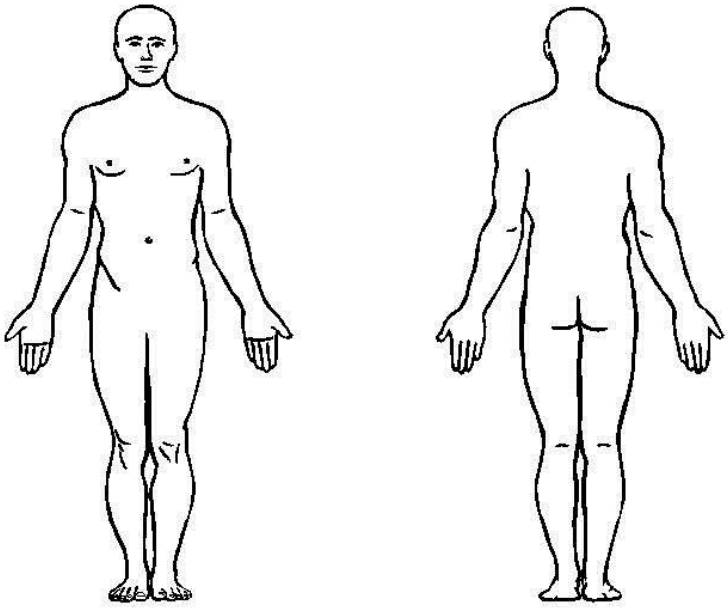
Have you contacted an attorney concerning this new accident? Yes ☐ No ☐
If yes, what is your attorney's name, address, & number? _____

What is the damage estimated on your vehicle? $_____

What is the damage estimated on the other vehicle? $_____

Personal Health Information

Please mark your area of pain on the figures below



Name _____ Date _____

How is most your day spent: Standing ☐ Sitting ☐ Walking ☐ Other ☐, specify:_____
Symptoms: Come and go ☐ Constant ☐ Symptoms are worst: Morning ☐ Afternoon ☐ Evening ☐
Have you ever had this before? Yes ☐ No ☐ If yes, When? _____
Please circle the following activities that **aggravate** your condition:

Bending Reaching Lifting Sneezing Walking Lying down Standing Driving Sitting
Getting up/down Straining Coughing Turning head Twisting Work Sleep

Please circle the following activities that **relieve** your condition:

Bending Reaching Lifting Sneezing Walking Lying down Standing Driving Sitting
Getting up/down Straining Coughing Turning head Twisting Work Sleep

Please list any current medications (ex: birth control, pain killers, steroids, etc.): _____

_____
Please list any current minerals, herbs, or vitamins: _____
Please list any allergies (medication, food, herbs, etc.): _____
Currently under the care of a physician? Yes ☐ No ☐ If yes, for what reason? _____
Physician's Name: _____ Phone number: _____
Have you seen a Chiropractor before? Yes ☐ No ☐ If yes, how long ago? _____
And for what reason? _____

Please list any hospitalizations, surgeries, or major accidents:

Date	**Please Describe**

Personal/Family health history:
Please indicate the conditions by marking the "S" for self or "F" for family history of condition

S	F		S	F		S	F		S	F	
		Alcoholism			Diphtheria			Influenza			Polio
		Anemia			Eczema			Lumbago			Rheumatic Fever
		Appendicitis			Emphysema			Malaria			Scarlet Fever
		Arteriosclerosis			Epilepsy			Measles			Stroke
		Cancer			Fever Blisters			Multiple Sclerosis			Tuberculosis
		Chicken Pox			Goiter			Mumps			Typhoid Fever
		Cholera			Gout			Pacemaker			Ulcers
		Cold Sores			Heart Disease			Pleurisy			Rheumatoid Arthritis
		Diabetes			Herpes			Pneumonia			HIV/AIDS

Please circle the degree of all of your conditions: **O=occasional F=frequent C=constant**

Muscle/Joint	**General**	**Pain or Numbness**	**Eye, Ear, Nose & Throat**
O F C Arthritis	O F C Allergy	O F C Elbows	O F C Asthma
O F C Bursitis	O F C Chills	O F C Hands	O F C Colds
O F C Foot trouble	O F C Cold sweats	O F C Arms	O F C Earache
O F C Hernia	O F C Dizziness	O F C Legs	O F C Ear ringing
O F C Low back Pain	O F C Fainting	O F C Knees	O F C Blurry eyes
O F C Neck Pain, stiffness	O F C Fatigue	O F C Feet	O F C Hay fever
O F C Upper back pain	O F C Fever	O F C Hips	O F C Hoarseness
O F C Nasal obstruction	O F C Loss of balance	O F C Sciatica	O F C Sore throat
O F C Sinus infection	O F C Loss of sleep	O F C Tailbone	O F C Shortness of breathe
Cardiovascular	O F C Loss of weight	**Gastrointestinal**	O F C Trouble breathing
O F C High blood pressure	O F C Nervousness	O F C Diarrhea	**Women only**
O F C Low blood pressure	O F C Depression	O F C Nausea	O F C Cramps
O F C Cold feet	O F C Confusion	O F C ↓ appetite	O F C Heavy flow
O F C Swelling of ankles	O F C Numbness	O F C Vomiting	O F C Menopause
O F C Cold hands	O F C Tremors	**Respiratory**	O F C Painful menstruation
Skin	O F C Light sensitivity	O F C Chest pain	O F C Miscarriage
O F C Hives or allergy	O F C Noise sensitivity	O F C Coughing	Are you pregnant? ___
O F C Skin eruptions(rash)	O F C Headache	**Habits**	If, yes how many weeks? _____
O F C Varicose Veins	O F C Swollen joints	O F C Smoking	How many children do you have? _____
	O F C Poor posture	O F C Tobacco	
		O F C Alcohol	

Consent to Treat

I, (please print full name) _____, hereby request and authorize Dr. Ann Lauzon & Dr. Jessica Garrison to perform diagnostic tests and render chiropractic adjustments and other treatments including but not limited to; heat/cold packs, traction, cold laser, electrical muscle stimulation, manual muscle therapies, ultrasound, etc. I understand that these procedures are considered to be safe and effective methods of care, however, complications may arise. While these complications are considered rare, it is the practice of Contour Chiropractic Clinic PC to make all patients aware of them. Some of these complications include but are not limited to soreness, dizziness, temporary worsening of symptoms, inflammation, burns, and etc. I extend this authorization to include other doctors or staff members that may be affiliated with this clinic. I understand that this authorization is intended to include radiographic/magnetic imaging at the doctor's discretion.

I have read and completely understand the above statements regarding chiropractic care. I also understand that there is no guarantee that chiropractic care will provide a specific cure or result.

Signature _____ Date _____

(Signature must be provided by parent/legal guardian if patient is under the age of 18)

Awareness of Privacy Practices

I, (please print full name) _____, am aware and understand the Notice of Privacy Practices of Contour Chiropractic Clinic PC. I understand that this notice describes in detail the procedures and policies regarding the protections of my health information that is received, created, or maintained by this clinic and agree to these terms. In addition, I authorize medical providers and personal of Contour Chiropractic Clinic PC to have electronic correspondence including by phone, fax, and email provided on intake.

Signature _____ Date _____
(Signature must be provided by parent/legal guardian if patient is under the age of 18)

Financial Policy

Payment at the time of service/No insurance
Payments may be made by cash, check, or credit/debit card. By paying at the time of service, you will receive a discount which is only valid when payment is received on the same day the service is provided. If you are unable to pay in full at the time of service you will be billed at the standard office rates, it is your responsibility to contact our office to arrange a payment plan.

Insurance: Medical, Auto, or Worker's Comp
As a courtesy to you, we will bill your insurance company for you. All co-payments, deductibles, and payments for services which are not covered under your insurance policy are due at the time of service unless prior arrangements have been made. Payments can be made by cash, check, or credit/debit card. Any balances which remain unpaid for 90 days or longer will be charged interest of 2.5% per month. Your insurance policy is a contract between you and your insurance company, Contour Chiropractic Clinic PC is not included in this contract. You are responsible for reviewing and understanding your insurance plan contract and coverage. This clinic will make every effort to recover our fees from all available sources. However, regardless of your insurance company's agreement with these rates, you are ultimately responsible for payment in full. Contour Chiropractic Clinic PC is not contracted with Medicare or Medicaid.

Minors
Minors will be accompanied by a parent/legal guardian for the first visit, whether minor needs to be accompanied for future visits is parent/legal guardian's choice. Payment is the responsibility of the parent/legal guardian.

Missed appointments
24-hour notice is required for cancellation of appointments with this office, cancellation by voicemail made at least 24 hours before appointment is accepted. This office reserves the right to charge standard rates for any appointments that are not cancelled with advanced notice.

Patient's Agreement
I have completely read and understand the Financial Policy of Contour Chiropractic Clinic PC. I understand and agree that I am responsible for payment for services and products provided by this clinic. I am also responsible for payment of any fees that may accumulate while trying to collect my unpaid balance; including but not limited to attorney fees.

Printed Name _____

Signature _____ Date _____
(Signature must be provided by parent/legal guardian if patient is under the age of 18)