Family Chiropractic
at Northwest Wellness Center

Date:_____

Children's Intake

13 Years old and under

ABOUT THE CHILD

Name:_____ Home Phone:_____ Age:_____ Birthdate:_____

Address:_____ City/State/Zip:_____

Gender: □ M □ F Other:_____ Height:_____ Weight:_____

Parent's Names:_____ Parent's Employer:_____

Parent's Work Phone:_____ Parent's Cell:_____

Parent's E-mail:_____

Health Insurance

Insurance Company:_____ ID Number:_____ Group Number:_____

Policy Holder's Name:_____ Policy Holder's Date of Birth:_____

REASON FOR THE VISIT

Describe the purpose of this visit:_____

_____

Is the purpose of this appointment related to: □sports □auto □fall □home injury □chronic discomfort □prevention/wellness □other

Explain:_____

When did this condition begin?:_____

Has this condition: □ become worse □ stayed constant □ comes and goes

Does this condition interfere with: □ sleep □ school □ daily routine □ other activities

Explain:_____

Has this condition occurred before? Yes □No Explain:_____

Have you seen other doctors for this condition? □Yes □No Dr.'s Name(s):_____

Type of treatment:_____ Results:_____

MOTHER'S PREGNANCY & LABOR

During pregnancy, did the mother:

...Take any medication? □Yes □No

Explain:_____

...Smoke or consume alcohol? □Yes □No

...Experience any illness? □Yes □No

...Explain:_____

Approximately how long did labor last? _____hours

Was labor chemically induced? □Yes □No

Was labor Doctor assisted? □Yes □No

Was a C-Section performed? □Yes □No

Were forceps or vacuum extraction used? □Yes □No

Did the delivery doctor pull or twist the baby during delivery? □Yes □No

Was the delivery premature? □Yes □No

If "Yes", at _____ month and _____ weight

Check any of the following if the child experienced it immediately after birth:

□Respiratory problems □Jaundice □Feeding problems □Displaced or broken bones

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis.

□Vision Problems	□Ear Problems
□Headaches	□Tubes in the Ears
□Attention Problems	□Frequent Colds
□Hyperactivity	□Pink Eye
□Allergies	□Colic
□Breathing Problems	□Digestive Problems
□Asthma	□Skin Problems
□Irritability	□Constipation
□Sleeping Disorders	□Drug Reactions
□Bed Wetting	□Food Reactions
□Other	□Environmental Reactions

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Wilsonville, OR 97070 | P 503.682.3811 | F 503.682.0416 | Nwwellnesscenter.org

Name and Date:_____

□ Other condition(s) Explain:_____

_____

CHILD'S CURRENT HEATH STATUS

Is your child accident prone? □Yes □No
Has your child:
...been hospitalized? □Yes □No
...had a severe fall? □Yes □No
...been in a car accident? □Yes □No
...ever taken antibiotics? □Yes □No
If "Yes", explain_____
Is your child currently taking any medication?
□Yes □No If "Yes", explain_____
Does your child have difficulty interacting with schoolmates or friends? □Yes □No
Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? □Yes □No
What changes (if any) in your child's health or behavior would you like accomplished?_____
How many hours a day does your child sit?_____
Hours/day watching TV or playing video games?_____
Does your child play sports/what kind?_____
Is your child a picky eater? Explain_____

GOALS FOR MY CHILD'S CARE

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, others for correction of whatever is malfunctioning in their bodies and some for prevention and wellness. Your Doctor will weigh your needs and desires when recommending your child's Chiropractic care program. Please check the type of care desired.

□ **Relief**-Symptomatic relief of pain or discomfort.

□ **Corrective**-Correcting and relieving the cause of the problem as well as the symptoms.

□ **Comprehensive**-Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

□ **Prevention and Wellness**-Regardless of symptoms we help your child reach their highest health potential by addressing lifestyle issues.

□ I want the Doctor to select the type of care appropriate for my child.

VACCINATIONS

Have you chosen to vaccinate your child? □Yes □No If "Yes", check all vaccinations the child has received.
□DPT □MMR □Polio □Chicken Pox □Hepatitis □Flu □Gardasil □Other
Describe any and all reactions to vaccine(s):_____

AUTHORIZATION TO CARE FOR A MINOR CHILD

I hereby authorize David Duemling, D.C., P.C., C.C.W.P. and whomever he may designate as his assistants, including but not limited to his Associate Chiropractor and Chiropractic Assistants, to administer Chiropractic care, to work with my child (name)_____through the use of adjustments and procedures to the spine as the Doctor deems appropriate.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. The doctor's office may bill my insurance as a courtesy to me and will prepare any necessary reports and forms (fees may apply) to assist in making collection from the insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment of all fees for service including legal fees, collection agency fees, and any other expenses incurred in collecting my account. I also understand and agree that if I suspend or terminate care, any fees for services rendered to me will be immediately due and payable. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Name (Print):_____

Parent or Legal Guardian (Print):_____

Parent or Legal Guardian (Signature):_____ Date:_____

Family Chiropractic
at Northwest Wellness Center

Neck Index

Patient Name:_____ **Date:** _____

This questionnaire will give your provider and insurance company information about how your neck condition affects your everyday life. Please answer every section by marking the ONE statement that best applies to you. If two or more statements in one section apply, please mark ONE that most closely describes your problem.

Pain Intensity
- o I have no pain at the moment.
- o The pain is very mild at the moment.
- o The pain comes and goes and is moderate.
- o The pain is fairly severe at the moment.
- o The pain is very severe at the moment.
- o The pain is worst imaginable at the moment.

Sleeping
- o I have no trouble sleeping.
- o My sleep is slightly disturbed (less than 1 hour sleepless).
- o My sleep is mildly disturbed (1-2 hours sleepless).
- o My sleep is moderately disturbed (2-3 hours of sleepless).
- o My sleep is greatly disturbed (3-5 hours of sleepless).
- o My sleep is completely disturbed (5-7 hours of sleepless).

Reading
- o I can read as much as I want with no neck pain.
- o I can read as much as I want with slight neck pain.
- o I can read as much as I want with moderate neck pain.
- o I can't read as much as I want because of moderate pain in my neck
- o I can hardly read at all because of sever neck pain.
- o I cannot read at all because of neck pain.

Concentration
- o I can concentrate fully when I want with no difficulty.
- o I can concentrate fully when I want with slight difficulty.
- o I have a fair degree of difficulty concentrating when I want.
- o I have a lot of difficulty in concentrating when I want to
- o I have a great deal of difficulty concentrating when I want.
- o I cannot concentrate at all.

Headaches
- o I have no headaches at all.
- o I have slight headaches which come infrequently.
- o I have moderate headaches which come infrequently.
- o I have moderate headaches which come frequently.
- o I have severe headaches which come frequently.
- o I have headaches almost all the time.

Work
- o I can do as much work as I want.
- o I can only do my usual work but no more.
- o I can only do most of my usual work but no more.
- o I cannot do my usual work.
- o I can hardly do any work at all.
- o I cannot do any more at all.

Personal Care
- o I can look after myself normally without causing extra pain.
- o I can look after myself normally but is causes extra pain.
- o It is painful to look after myself and I am slow and careful.
- o I need some help but I manage most of my personal care.
- o I need help every day in most aspects of self care.
- o I do not get dressed, I wash with difficulty and stay in bed.

Lifting
- o I can lift heavy weights without extra pain.
- o I can lift heavy weights but it causes extra pain.
- o Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., On a table)
- o Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- o I can only lift very light weights.
- o I cannot lift or carry anything at all.

Driving
- o I can drive my car without any neck pain.
- o I can drive my car as long as I want with slight neck pain.
- o I can drive my car as long as I want with moderate neck pain.
- o I cannot drive my car as long as I want because of moderate neck pain.
- o I can hardly drive at all because of severe neck pain.
- o I cannot drive my car at all because of neck pain.

Recreation
- o I am able to engage in all my recreation activities without neck pain.
- o I am able to engage in my usual recreation activities with some neck pain.
- o I am able to engage in most, but not all my usual recreation activities because of neck pain.
- o I am able to engage in a few of my usual recreation activities because of pain in my neck.
- o I can hardly do any recreation activities because of neck pain.
- o I cannot do any recreation activities at all.

Pain level rating- On a scale of 0-10 with 0=no pain and 10= worst pain you have ever experienced, where is your neck pain **currently?**

At its best:____ **At its average:**____ **At its worst:**_____

Neck Pain Score **(office use only)** ☐

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Back Index

Patient Name:_____ **Date:** _____

This questionnaire will give your provider and insurance company information about how your back condition affects your everyday life. Please answer every section by marking the ONE statement that best applies to you. If two or more statements in one section apply, please mark ONE that most closely describes your problem.

Pain Intensity
- o The pain comes and goes and is very mild.
- o The pain is mild and does not vary much.
- o The pain comes and goes and is moderate.
- o The pain is moderate and does not vary much.
- o The pain comes and goes and is very severe.
- o The pain is very severe and does not vary much..

Sleeping
- o I get no pain while in bed.
- o I get pain while in bed but it doesn't prevent me from sleeping well.
- o My pain reduces my normal sleep is by less than 25%
- o My pain reduces my normal sleep is by less than 50%
- o My pain reduces my normal sleep is by less than 75%
- o Pain prevents me from sleeping at all.

Sitting
- o I can sit in any chair as long as I like.
- o I can only sit in my favorite chair as long as I like.
- o Pain prevents me from sitting more than 1 hour.
- o Pain prevents me from sitting more than ½ hour.
- o Pain prevents me from sitting more than 10 minutes.
- o I avoid sitting because it increases pain immediately.

Standing
- o I can stand as long as I want without pain.
- o I have some pain while standing but it does not increase with time.
- o I can't stand for longer than 1 hour without increasing pain.
- o I can't stand for longer than ½ hour without increasing pain.
- o I can't stand for longer than 10 minutes without increasing pain.
- o I avoid standing because it increases pain immediately.

Walking
- o I have no pain while walking.
- o I have some pain while walking but it doesn't increase with time.
- o I can't walk for more than 1 mile without increasing pain.
- o I can't walk for more than ½ mile without increasing pain.
- o I can't walk for more than ¼ mile without increasing pain.
- o I can't walk at all without increasing pain.

Personal Care
- o I don't have to change my way of washing or dressing in order to avoid pain.
- o I don't normally change my way of washing or dressing even though it causes some pain.
- o Washing and dressing increases the pain but I manage not to change my way of doing it.
- o Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- o Because of the pain I'm unable to do some washing and dressing without help.
- o Because of the pain I'm unable to wash and dress without help.

Lifting
- o I can lift heavy weights without extra pain.
- o I can lift heavy weights but it causes extra pain.
- o Pain prevents me from lifting heavy weights off the floor.
- o Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- o Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- o I can only lift very light weights.

Traveling
- o I get no pain while traveling.
- o I get some pain while traveling but none of my usual forms of travel make it worse.
- o I get extra pain while traveling but it doesn't cause me to seek alternate forms of travel.
- o I get extra pain while traveling which causes me to seek alternate forms of travel.
- o Pain restricts all forms of travel except that done while lying down.
- o Pain restricts all forms of travel.

Social Life
- o My social life is normal and gives me no extra pain.
- o My social life is normal but increases the degree of pain.
- o Pain has no significant affect on my social life apart from limiting my energetic interests (e.g., dancing)
- o Pain has restricted my social life and I do not go out very often.
- o Pain has restricted my social life to my home.
- o I have hardly any social life because of pain.

Changing Degree of Pain
- o My pain is rapidly getting better.
- o My pain fluctuates but overall is definitely getting better
- o My pain seems to be getting better but improvement is slow.
- o My pain is neither getting better or worse.
- o My pain is gradually worsening.
- o My pain is rapidly worsening.

Pain level rating- On a scale of 0-10 with 0=no pain and 10= worst pain you have ever experienced, where is your back pain **currently**?

At its best:____ **At its average:**_____ **At its worst:**_____

Back Pain Score **(office use only)** ☐

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Patient Name & Date:_____

ACTIVITIES OF LIFE

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

List all Prescription & Non-Prescription drugs you take, including dose and frequency:_____

_____

_____

List all supplements you take, including dose and frequency:_____

_____

_____

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Family Chiropractic
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CONSENT TO TREAT MINOR

Under the age of 18 years old

Patient's Name:_____ Age:_____ Birthdate:_____ Today's Date:_____

Parent/ Guardian Name(s):

_____

Email:_____

Telephone(s): **Home**:_____
Cell:_____
Work:_____

I, [print name],_____, the undersigned, being the parent and/or legal guardian of the above-referenced minor consent to and request that she / he be examined, evaluated and treated at this office within the scope of any duly licensed Doctor of Chiropractic (D.C.). Services rendered may include but are not limited to, applicable x-rays, examinations, evaluations, diagnoses, and treatment as indicated and / or recommended by and under the supervision of any licensed Doctor of Chiropractic or other qualified staff of Wilsonville Family Chiropractic at NW Wellness Center.

This consent shall be valid from this date forward until this applicable medical case is resolved or withdrawn by the undersigned. If I withdraw this consent, I, the undersigned, understand that I am responsible for, and agree to pay any and all outstanding monies due for services rendered hereunder and understand that I must notify Wilsonville Family Chiropractic at NW Wellness Center IN WRITING of my intent to withdraw consent.

_____ _____
Signature of Guardian Relationship

_____ _____
Witness Date

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WILSONVILLE FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call our office at (503) 682-3811 and ask for **Teirnie Hemelstrand**. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

*Patient initials:*_____**retaining** ***page 1 of 2***

WILSONVILLE FAMILY CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY
CONTINUED...

I have received a copy of Wilsonville Family Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____
Patient's Name DOB

_____ _____
Patient's Signature Date

_____ _____
Witness Date

Family Chiropractic
at Northwest Wellness Center

Financial Policy

1. All payments are expected at the time that services are rendered, or at the beginning of each week.
2. Co-pays are to be paid at the time of service.
3. No patient balance may ever exceed $300 at any given time.
4. All outstanding patient balance past 45 days from the date of service will automatically be charged to your credit card. We accept Visa and Master card. We request this information as a guarantee of payment. No charge will be processed without prior notification.

_____ Initials **Would you like our office to securely store your card to run your copays for you?** Yes / No

Credit Card Number:_____ Expiration Date:_____

V-Code: _____ Card Type:_____

Card Holder Name:_____

5. In the event that you discontinue care prior to the Doctor's consent, you are responsible to pay in full any and all outstanding balances within 10 days. Insurance assignment patients are required to pay all outstanding claims in full.

Appointment Policy:

The frequency of your care plan is of paramount importance to your results, so we ask that each patient assume the responsibility of strict adherence to the appointment program as it is designed by your Doctor for optimum results.

1. Regardless of how many appointments are scheduled for you each week, please note that it is the FREQUENCY of visits that count, not days on which you receive the care to maximize your results.

_____ Initials

2. Our recommendation is that you make multiple appointments, 6 or more at a time, for your convenience and ours. This will ensure you get the appointment that you want at the time that works best for you.
3. If you are unable to keep an appointment for any reason, we require you to provide us with at least 24 hours' notice to prevent incurring a fee. Emergencies are an exception.

_____ Initials

4. It is your obligation to make up a missed appointment within 7 days of any cancellation or missed appointment. Again, it is the frequency of appointments that ensure your best results.
5. We reserve the right to charge $35 for missed appointments **without 24 hours prior notification.**

Health Care Classes:

Family Chiropractic offers a variety of educational classes each month. You will find class schedules posted at the front desk, Facebook and our website **nwwellnesscenter.org**. Our health classes are complimentary, unless otherwise noted. We invite you to bring family and friends, as this is a terrific way for them to become improve their health as well. Please ask the front desk staff to reserve a place for you and your guest. We have found that patients who attend health classes save time, money, and respond better to care.

We request that you sign this form as verification that you have read, understand and agree with these policies.

Patient/Legal Guardian (Print name):_____

Patient/Legal Guardian Signature:_____ Date:_____