BACKS ON BURNSIDE

chiropractic and massage

Name:_________________________ **Date:**_______________

Address:_________________________ City:_______________ State:______ Zip:____________

Telephone: _______________ Social Security #:_______________ Age:___ Birth date: ___/___/___ Sex:M / F

Occupation:_______________ Employer:_______________ Wk. Ph:_____________ Cell Ph.:_____________

Address: _________________________ City:_______________ State:_______ Zip:____________

Spouse's Name:_______________ Occupation:_______________ Employer:_______________

Subscriber's Name:_______________ Subscriber's SS# :_______________ Subscriber's DOB: __/__/___

Health Plan: _______________ ID#:_______________ Group#:_______________

WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP)? _________________________

WHO REFERRED YOU TO THIS CLINIC? _________________________

PLEASE DESCRIBE YOUR CURRENT PROBLEM._________________________

____

HOW DID YOUR PROBLEM BEGIN? _________________________

DATE PROBLEM BEGAN: ____/____/____ IS THIS ☐ WORK RELATED ☐ AUTO RELATED ☐ N/A?

WHAT TREATMENT HAVE YOU HAD FOR THIS CONDITION? (surgery, medications, therapy, chiropractic, etc.)

____

HAVE YOU HAD X-RAYS, MRI OR OTHER TESTS FOR THIS CONDITION? WHAT TESTS AND WHEN?_______________

____

How bad is your pain? (Circle the number.)
0 1 2 3 4 5 6 7 8 9 10

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Have you had spinal x-rays, MRI, CT scan for your area(s) of comlaint? ☐ Yes ☐ No

Date(s) taken:_________________________ What areas were taken?:_________________________

Please check all of the following that apply to you:

☐ Recent fever
☐ Diabetes
☐ High blood pressure
☐ Stroke (date)_______________
☐ Corticosteroid use (cortisone, prednisone, etc.)
☐ Taking birth control pills
☐ Dizziness/Fainting
☐ Numbness in groin/buttocks
☐ Cancer/Tumor (explain)_______________
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain)_______________
____

☐ Prostate problems
☐ Menstrual problems
☐ Urinary problems
☐ Currently pregnant, # weeks___________
☐ Abnormal weight ☐ Gain ☐ Loss
☐ Marked morning pain/stiffness
☐ Pain unrelieved by position or rest
☐ Pain at night
☐ Visual disturbances
☐ Surgeries: _______________
____
☐ Medications: _______________
____

Family History: ☐ Cancer ☐ Diabetes ☐ High blood pressure
☐ Heart problems/Stroke ☐ Rheumatoid arthritis/Auto-immune disease _______________

I certify to the best of my knowledge, the above information is complete and acurate. If the health plan nformation is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my massage therapy provider or a clinical peer employed by my health plan may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my massage therapy provider and/or my health plan to contact my physician, if necessary. **Patient Signature:**_________________________ **Date:**_______________

Gail Karvonen, D.C. • Megumi Moskowitz, D.C.
2303 E. Burnside, Portland, OR 97214 • phone: 503.287.7733 • fax: 503.281.7703