Chiropractic Intake

Kwan-Yin Healing Arts Center
2330 NW Flanders, Suite 101
Portland, OR 97210
(503) 701-8766

Thank you for scheduling with us, we strive to provide the best possible integrative care for our clients. Here at the clinic we have a team of Naturopathic Doctors, Oriental Medical Practitioners, Licensed Acupuncturists, Body Workers, Psychologists, Medical Doctors, Physical Therapists and Chiropractic Physicians. During your initial evaluation your practitioner will do their best to do a thorough evaluation and give you a treatment plan. You can assist us in that by making sure you have fully completed the intake paperwork enclosed. The advantage of the integrative office is that there are many modalities that can provide input should any of us find the need for assistance.

We are located just west of the intersection of NW 23rd on NW Flanders (between 23rd & 24th Ave.). Parking is available in the main and lower lot; please do not park below the building in the covered area. Wheelchair access for the first floor is located through the main level parking lot. Please come a few minutes early and enjoy a cup of tea before your appointment.

Please be aware that we ask patients to give us 48 hours notice if they need to reschedule or cancel an appointment. Late cancellation or missed appointments will incur a fee, as we are unable to reschedule the appointment with another patient without sufficient notice.

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It will be a pleasure to support you on your path towards wellness.

PATIENT NAME:____ PATIENT DOB:_________________________

Informed Consent for Chiropractic Treatment

The State of Oregon requires that every patient be informed of the risks of, and the alternatives to, treatment prior to beginning said treatment. The following is the above named chiropractor's informed consent. We intend this consent form to cover the entire course of treatment for your present condition, and for any future conditions for which you seek treatment at this office.

The nature of Chiropractic treatment: The doctor will use his hands or a mechanical device in order to adjust the position of your joints. You may hear a "click" or "pop", similar to when a joint is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, massage, or traction, as well as exercise/nutritional instruction may be employed.

Possible risks and probability: There are inherent risks in any and all treatment delivered by any health care provider, ranging from administering a single aspirin to complicated brain surgery. Chiropractic is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic treatment. The risk is very minor to almost nonexistent in any treatment of extremities. The risks involved in treatment of the spine (excluding the neck) increase. A list from the least to most serious would include: muscular strain (rare), ligamentous sprain (rare), and injury to intervertebral discs, nerves or spinal cord (very rare). The risks involved in the treatment of the neck would include any of the proceeding risks, but also include the remote possibility of cerebrovascular injury, or stroke (very, very rare – chances are from one in one million to one in ten million.) A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary physical therapy procedures could produce skin irritation, burns, or other minor complications (rare).Other treatment options that could be considered may include the following: Over the counter analgesics. The risks of these medications include irritation to stomach, liver, kidneys, and other side effects in a significant number of cases.

Medical Care: Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of the drugs include numerous undesirable side effects, usually more serious than those listed above, and the patient dependence increases in a significant number of cases. Surgery, in conjunction with medical care, adds the risks of adverse reaction to anesthesia (which includes death) as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Concerns or questions: We at Kwan Yin Healing Arts Center have gone to great lengths to make your health and safety our top priority. We will be glad to explain any concern about treatment.

I have read the above explanation of Chiropractic treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment, I have feely decided to undergo treatment, and hereby give my full consent to treatment.

______________________________ __________ ____________________________

Signature of patient or Guardian | Date | Print Patient Name

PATIENT NAME:______________________________ PATIENT DOB:____________________

Comprehensive Health Profile

Kwan-Yin Healing Arts Center
2330 NW Flanders Suite 101, Portland, OR 97210
www.kwanyinhealingarts.com (503) 701-8766

Basic Information

Name ____ ____ __________________ Date __________________

Address____

City ____ State ______________ Zip code ______________

Telephone # (home)_________________________ _________ (work) ______________________________

(cell)____________________________________ Email Address __________________________________

Age _______ Date of Birth __________ Gender _______

Relationship Status: Single Married Partnership Separated Divorced Widowed

Live with: Spouse Partner Parents Children Friends Alone Roommates

Occupation __________________________ Hours per week ____ Retired ____________

How did you hear about our clinic?____

Emergency Contact: Name________________________________ Relationship________________________ Phone __________________________________

Are you currently under the care of a medical professional? Y N

If yes, whom and where from?____

If no, when and where did you last receive medical or health care and for what reason? ___________
____

PERSONAL HEALTH HISTORY

Patient's Name ___________________________________ DOB ________________ Date _______________

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

O F C

Muscle / Joint

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Neck pain, stiffness
☐ ☐ ☐ Pain between shoulders

General

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Nervousness, depression
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

Cardiovascular

☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heartbeat
☐ ☐ ☐ Slow heartbeat
☐ ☐ ☐ Swelling of ankles

Genitourinary

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Lack of kidney control
☐ ☐ ☐ Kidney infection
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostate trouble
☐ ☐ ☐ Pus in urine

O F C

Eye, Ear, Nose and Throat

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear discharge
☐ ☐ ☐ Ear noise
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Enlarged thyroid
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Far sightedness
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Near sightedness
☐ ☐ ☐ Nose bleeds
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Sore throat
☐ ☐ ☐ Tonsillitis

Gastrointestinal

☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult digestion
☐ ☐ ☐ Bloated abdomen
☐ ☐ ☐ Excessive hunger
☐ ☐ ☐ Gallbladder trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Intestinal worms
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver trouble
☐ ☐ ☐ Nausea
☐ ☐ ☐ Pain over stomach
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting of blood

PATIENT NAME:____ PATIENT DOB:_________________________

Chiropractic Intake

O F C

Skin

- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin eruptions (rash)
- ☐ ☐ ☐ Varicose veins

Pain or numbness in

- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hand
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tailbone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

Respiratory

- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing

Women only

- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excess menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Lumps in breast
- ☐ ☐ ☐ Menopause
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal discharge

Are you pregnant? ☐Yes ☐No
If yes, how many months?____
How many children do you have?___

Check any of the following conditions you currently have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

Describe chiropractic problem:____

____

How long have you had this condition? Is it getting worse? ☐ Yes ☐ No
Does it bother your (check appropriate box): ☐ Work ☐ Sleep ☐ Other (please specify)
What seemed to be the initial cause?

PATIENT NAME:_______________________________ PATIENT DOB:_______________

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Have you seen a chiropractor before? ☐ Yes ☐ No If yes, how long ago? ________ For what reason?
Are you under the care of a physician? ☐ Yes ☐ No If yes, for what reason?

Patient's Name ____ DOB _______________
Date________________

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No If yes, for major surgery? ☐ Yes ☐ No for serious injury? ☐
Have you had any mental or emotional disorders? ☐ Yes ☐ No If yes, when?
Indicate the drugs do you now take? ☐ birth control pills ☐ tranquilizers ☐ pain killers ☐ other (specify)
Do you wear: ☐ heel lifts? ☐ sole lifts? ☐ inner soles? ☐ area supports? ☐ negative heels? ☐ platform shoes?
What is the age of your mattress? Is it ☐ comfortable? ☐ uncomfortable? Do you use a bedboard? ☐
How is most of your day spent? ☐ standing ☐ sitting ☐ walking ☐ other (specify)

Have you ever:	Yes	No	If yes, briefly explain.
- had a broken bone?	☐	☐	
- been hospitalized?	☐	☐	
- had strains or sprains?	☐	☐	
- used a cane, crutch or other support?	☐	☐	
- been struck unconscious?	☐	☐	
- been hospitalized for other than surgery?	☐	☐	
Do you:			
- take minerals, herbs or vitamins?	☐	☐	
- think you need minerals, herbs or vitamins?		☐	☐
- have any drug allergy?	☐	☐	

HABITS	None	Light	Mod	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

When did you last have:	Never	0-6 mos.	6 -18 mos.	longer
- spinal x-ray?	☐	☐	☐	☐
- spinal examination?	☐	☐	☐	☐
- physical examination?	☐	☐	☐	☐

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

____

____

____

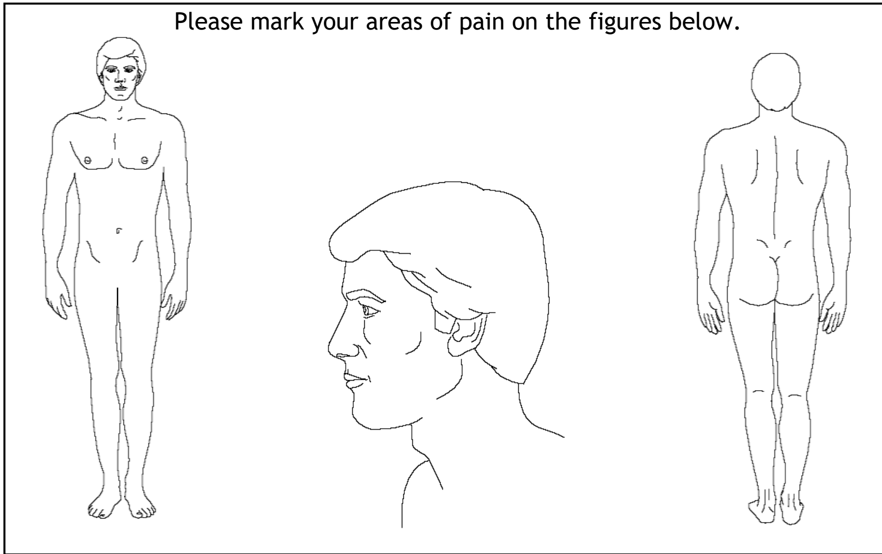
PATIENT NAME:____ PATIENT DOB:__________________________

Chiropractic Intake

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Please mark your areas of pain on the figures below.



PATIENT NAME:____ PATIENT DOB:__________________________