Timberline Chiropractic Center
(503) 826.1400 * 37587 Hwy 26 * Sandy OR 97055
Dr. Anna Farrer

CONFIDENTIAL PATIENT INFORMATION

Date _____

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email _____

Occupation _____ Employer _____ Work Phone ( ) _____

_ Male _ Female Date of Birth _____ Marital Status _____ # Children __

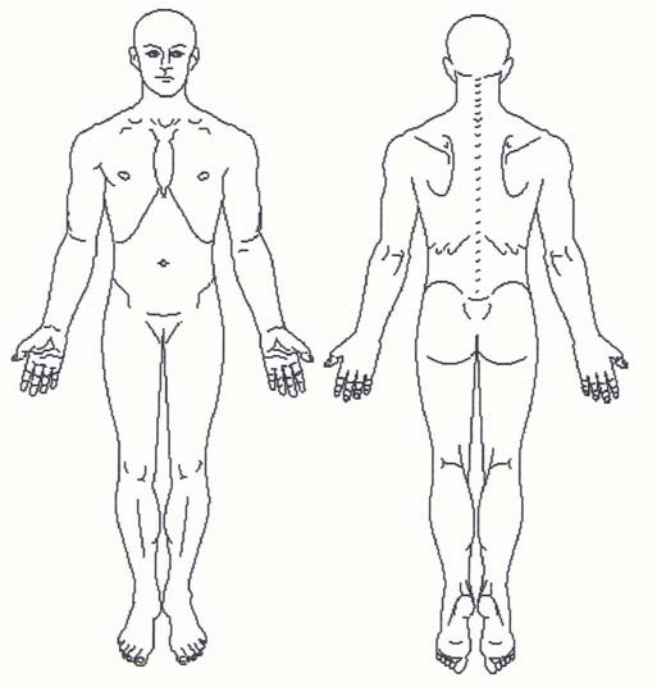
Emergency Contact Name _____ Phone _____

How did you hear about Timberline Chiropractic Center? _____

Please list the primary reason for your appointment today, including a DESCRIPTION of any symptoms you may be experiencing _____

_____

_____



Please mark the areas in which you are experiencing symptoms using the following letters:

A = ache

B = burning

S = sharp

N = numbness

P = pins & needles

O = other

Name _____

Please fill out the following information regarding your symptoms, if applicable:

Severity 1 2 3 4 5 6 7 8 9 10 (1=least, 10=greatest)

Onset _Gradual _ Sudden Date /time of onset _____

Where were you when your symptoms began? _____

What activities (if any) were you performing when your symptoms began? _____

_____

Have you experienced these symptoms in the past? _ Yes _ No If yes, when? _____

How long have you been experiencing your symptoms? _____

Symptoms _ Come and go _ Are constant

What percentage of the day do your symptoms occur? 0% 25% 50% 75% 100%

Symptoms are worse in the _ Morning _ Afternoon _ Evening _ Night _ No Change

Please indicate the following activities that make your symptoms **worse** (Mark "W") or **better** (Mark "B"):

_____coughing
_____sneezing
_____straining at stool
_____lying down
_____turning in bed
_____sitting
_____getting up from a seated position
_____standing
_____walking
_____turning head
_____bending
_____reaching
_____lifting
_____driving
_____applying cold
_____applying heat
_____stretching
_____exercise
_____taking medication
_____other

Over the past (hours/days/weeks/months/years) symptoms are

_ Rapidly getting worse
_ Gradually getting worse
_ Staying about the same
_ Getting better

List the other health professionals seen for your present symptoms _____

_____

What other remedies have you tried for your present symptoms _____

_____

Symptoms developed from _ Job related injuries _ Auto Accident _ Other

Name _____

Please indicate the following conditions that apply to you or an immediate family member (spouse, child, parent, or grandparent) by marking the appropriate box. (S=Self, F=family)

_____ADD/ADHD	_____diabetes	_____muscular dystrophy
_____allergies	_____dislocation	_____nausea
_____anemia	_____dizziness	_____neck pain
_____anxiety	_____ear infections	_____numbness
_____arthritis	_____epilepsy	_____osteoporosis
_____asthma	_____fracture	_____polio
_____back pain	_____headaches	_____reproductive issues
_____bladder issues	_____heart issues	_____seizures
_____bone disorder	_____hepatitis	_____sinus issues
_____bowel issues	_____high blood pressure	_____sleep issues
_____cancer	_____HIV/AIDS	_____STD
_____chest pain	_____hormone issues	_____stroke
_____circulation issues	_____indigestion	_____thyroid issues
_____colic	_____joint disorder	_____tuberculosis
_____concentration issues	_____kidney disorder	_____vision issues
_____concussion	_____menstrual issues	_____other:
_____depression	_____multiple sclerosis	_____

Please list all previous surgeries/hospitalizations (including tooth extraction, ceserian section, tubal ligation, hysterectomy, etc.)

_____ Date _____

_____ Date _____

_____ Date _____

Please list all current medications (including birth control pills, etc.)

_____

_____

Please list all previous traumas (including auto accidents, injuries, serious illnesses, etc.)

_____ Date _____

_____ Date _____

_____ Date _____

Name _____

Have you been under chiropractic care before? _ Yes _ No If yes, when? _____

Please list your current medical providers:

_____

_____

Are you currently pregnant _ Yes _ No Date of first day of last menstrual period _____

Please briefly describe your diet _____

Please indicate if you use the following by marking the box with an "X":

_ Tobacco Frequency _____

_ Alcohol Frequency _____

_ Recreational Drugs Frequency_____

Please describe your exercise regimen _____

Please list your hobbies/interests_____

_____	_____	_____
Signature	Name	Date

FINANCIAL POLICY

I understand and agree that insurance policies are an arrangement between me and an insurance carrier. Furthermore, I understand that Timberline Chiropractic Center will call my insurance company to receive a verification of my benefits, and will provide me with an explanation of the information they receive. I understand that the quote given by the insurance company in regards to my benefits is an estimate, and not guaranteed until the insurance company processes the claim. I understand that Timberline Chiropractic Center will make every possible effort to inform me in a timely manner when my benefits have changed or expired, and that it is my responsibility to provide Timberline Chiropractic Center with any changes in my insurance information. I understand that Timberline Chiropractic Center reserves the right to forward any or all medical records as requested by the insurance carrier in order to meet the requirements for reimbursement as set by the insurance carrier. I agree to pay all portions of my account for which I am responsible, including co-pays, on the day that I receive treatment. I understand that Timberline Chiropractic Center does not carry accounts within the office, but does accept Visa and Mastercard, in addition to cash and checks.

_____	_____	_____
Signature	Name	Date