Wellness Doctor, Inc.
1693 SW Chandler Ave, Ste 280 Bend, OR 97702
P: 541-318-1000 * F: 541-318-7050 * E: Appointments@BendWellnessDoctor.com

GENERAL INTAKE

*Remember to bring completed paperwork: (If paperwork is not completed, arrive **30 min prior** to appt.)

First Name: _____MI: ____ Last Name:_____ SS#: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____ Carrier Company (text reminders): _____

Sex: __M__F DOB:___/___/_____ Age: ____Marital Status: __S__ M__D __W __P (partner)

E-mail: _____

Occupation: _____ Employer: _____ Work Phone: _____

Emergency Contact: _____Phone: _____ Relationship: _____

Do you give permission for our office to update your general medical practitioner with the progress of your condition? ___Yes ___No

Name of Medical Doctor/Facility: _____ Phone: _____

Who may we thank for your referral? _____

In compliance with the governmental EHR incentive program and CMS requirements, we ask the following:
Race (select one): __American Indian or Alaska Native __Asian __Black or African American
__Native Hawaiian or Pacific Islander __White __Other __I decline to answer

Ethnicity (select one): __Hispanic __Not Hispanic or Latino __I decline to answer

PRIMARY INSURED INFORMATION
If you are the responsible party, mark "self."

Person responsible for patient's charges: __Self __Spouse __Parent __Other: _____
Name: _____ Address: _____
City/State/Zip: _____
Sex: ___M ___F DOB: ___/___/_____ Age: ____ SS#: _____
Phone number: _____ Employer: _____ Occupation: _____

RESPONSIBLE PARTY INFORMATION
(If different than above)
Name: _____ Address: _____
City/State/Zip: _____
Sex: ___M ___F DOB: ___/___/_____ Age: ____ SS#: _____
Phone Number: _____ Employer: _____ Occupation: _____

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PROBLEM #1

Describe:

_____

When did it start? _____ Was there a cause? _____

Symptoms are- **Getting worse** **Improving** **Not changing**

Frequency is- **Constant** **Frequent** **Intermittent** **Occasional**

How would you describe your symptoms? (circle all that apply) **Achy, Burning, Dull, Sharp, Stiff, Throbbing, Shooting, Electrical, Sharp with Motion, Deep, Other**: _____

How severe are your symptoms? 0 (none) to 10 (worst imaginable) _____

When does it feel worse? _____ Better? _____

Are there any other symptoms you feel are related to this complaint?

_____

Have you been treated for this in the past? **YES** **NO** When? _____Where? _____

PROBLEM #2

Describe:

_____

When did it start? _____ Was there a cause? _____

Symptoms are- **Getting worse** **Improving** **Not changing**

Frequency is- **Constant** **Frequent** **Intermittent** **Occasional**

How would you describe your symptoms? (circle all that apply) **Achy, Burning, Dull, Sharp, Stiff, Throbbing, Shooting, Electrical, Sharp with Motion, Deep, Other**:

_____

How severe are your symptoms? 0 (none) to 10 (worst imaginable) _____

When does it feel worse? _____ Better? _____

Are there any other symptoms you feel are related to this complaint?

_____

Have you been treated for this in the past? **YES** **NO** When? _____Where? _____

Problem #3_____ **Problem #4**_____

Current Medication/Supplements:	**Dose:**	**Reason:**

Past Injuries, Surgeries, or Accidents:

Year:	Treatment:	Outcome:

Special Imaging and/or Tests (MRI, CT, X-Ray, Etc.):

Year:	Test:	Findings:

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MEDICAL HISTORY

Check any that apply:

- ☐ Arthritis
- ☐ Allergies/Hay Fever/Asthma
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Autoimmune_____
- ☐ Blood Pressure problems
- ☐ Bronchitis
- ☐ Cancer_____
- ☐ Carpel Tunnel Syndrome
- ☐ Celiac Disease
- ☐ Chronic Fatigue Syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Contact Lenses
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular Disease
- ☐ Drug Addiction
- ☐ Eating Disorder_____
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, Ears, Nose, Throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food Intolerance_____
- ☐ Gastroesophageal Reflux Disease
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Infection, Chronic
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome
- ☐ Kidney or Bladder Disease
- ☐ Liver or Gallbladder Disease (stones)
- ☐ Mental Illness
- ☐ Migraine Headaches
- ☐ Neurological problems (Parkinson's/Paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Seasonal Affective Disorder
- ☐ Skin problems
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Ulcer
- ☐ Varicose Veins
- ☐ Other: _____

MEDICAL (Men)

- ☐ Benign Prostatic Hyperplasia
- ☐ Prostate Cancer
- ☐ Decreased Sexual Drive
- ☐ Infertility
- ☐ Sexually Transmitted Disease

MEDICAL (Women)

- ☐ Menstrual Irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic Breasts
- ☐ Fibroids/Ovarian Cysts
- ☐ Premenstrual Syndrome (PMS)
- ☐ Pelvic Inflammatory Disease
- ☐ Vaginal Infections
- ☐ Decreased Sexual Drive
- ☐ C-Section
- ☐ Surgical Menopause
- ☐ Menopause
- ☐ Breast Cancer

FAMILY HEALTH HISTORY/PARENTS AND SIBLINGS:

- ☐ Autoimmune
- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Celiac Disease
- ☐ Cancer_____
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Infertility
- ☐ Mental Illness
- ☐ Migraine Headaches
- ☐ Neurological Disorders (Parkinson's/ Paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide
- ☐ Other: _____

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Name: _____ Date: _____

Point Scale: Rate each of the following based upon your typical health profile for the past 2-4 weeks.
0-Never or almost never have the symptom 1-Occasionally have it, effect not severe 2-Occasionally have it, effect is severe
3-Frequently have it, effect not severe 4-Frequently have it, effect is severe

HEAD: ___Headaches ___Faintness ___Dizziness ___Insomnia ___**TOTAL**	**DIGESTION:** ___Nausea, vomiting ___Constipation ___Belching, passing gas ___ Intestinal/stomach pain ___Diarrhea ___Bloated feeling ___Heartburn ___**TOTAL**
EYES: ___Watery or itchy eyes ___Swollen, reddened or sticky eyelids ___Bags or dark circles under eyes ___Blurred or tunnel vision (Does not include near or far-sightedness ___**TOTAL**	**JOINTS/MUSCLE:** ___Pain or aches in the joints ___Stiffness or limitation of movement ___Feeling of weakness or tiredness ___Pain or aches in muscle ___Arthritis ___Pain or aches in muscles ___**TOTAL**
EARS: ___Itchy ears ___Earaches, ear infections ___Drainage from ear ___Ringing in ears, hearing loss ___**TOTAL**	**WEIGHT:** ___Binge eating/Drinking ___Excessive weight ___Water retention ___Craving certain foods ___Compulsive eating ___Underweight ___**TOTAL**
NOSE: ___Stuffy nose ___Hay fever ___Excessive mucus ___Sinus problems ___Sneezing attacks ___**TOTAL**	**ENERGY/ACTIVITY** ___Fatigue ___Hyperactivity ___Apathy, lethargy ___Restlessness ___**TOTAL**
MOUTH/THROAT ___Chronic fatigue ___Gagging, frequent need to clear throat ___Sore throat, hoarseness, loss of voice ___Swollen or discolored tongue/gums/lips ___Canker sores ___**TOTAL**	**MIND:** ___Confusion, poor comprehension ___Difficulty making decisions ___Stuttering or stammering ___Learning disabilities ___**TOTAL**
SKIN: ___Acne ___Hair loss ___Excessive sweating ___Hives, rashes, dry skin ___Flushing, hot flashes ___**TOTAL**	**EMOTIONS:** ___Mood swings ___Anxiety, fear, nervousness ___Anger, irritability, aggressiveness ___Depression ___**TOTAL**
HEART: ___Irregular or skipped heartbeat ___Rapid or pounding heartbeat ___Chest pain ___**TOTAL**	**LUNGS:** ___Chest Congestion ___Shortness of breath ___Asthma, bronchitis ___Difficulty breathing ___**TOTAL**

GRAND TOTAL_____

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What Are Your Goals and Interests for Care at Wellness Doctor?

To allow us to better address your healthcare goals and priorities, please check all boxes that apply to you and your interests.

What types of care are you open to?

- ☐ **Chiropractic/Sports Medicine**: This approach involves addressing musculoskeletal and neurological function through addressing postural or biomechanical imbalances. Injury treatment and prevention are often achieved through joint manipulation, active and passive stretching, soft tissue techniques, traction, physical therapy modalities, and therapeutic home exercise programs.
- ☐ **Therapeutic Massage**: Several forms of deep tissue massage and other forms of body work are offered. Our licensed massage therapist offer targeted treatments for athletes, work and auto injuries, postural stress, and even pregnancy massage.
- ☐ **Acupuncture:** An Eastern approach for creating balance within the body with effective treatments for headaches, hypertension, depression, insomnia, digestive concerns, pain management, sports injuries, and general wellness.
- ☐ **Functional Medicine:** Upstream approach to getting to the root cause of many chronic conditions and health concerns including gastrointestinal dysfunction, autoimmune conditions, chronic fatigue, weight gain, mood disorders, cardiovascular health, and skin complaints. Specialty lab testing, supplements, dietary intervention and lifestyle modifications are the most commonly utilized methods with this approach to best address gut function, sensitivities, toxic burdens, hormone and immune function, and inflammation.
- ☐ **Nutrition:** Professional guidance with meal planning, shopping, and determining the best diet for an individual's specific needs or condition is where our nutritional and lifestyle education program shines. Areas of focus include: weight management, athletic performance, food sensitivities/allergies, Celiac and IBD, and digestive health.
- ☐ **Infrared Sauna**: We offer the highest quality Full Spectrum Infrared Sauna therapy with Sunlighten Sauna's. Some of the many benefits include: Detoxification, Weight Loss, Pain Relief, Anti-Aging, Immune Enhancement, Relaxation, Cardio and Skin Health.

What Type of Care are You Interested In?

- ☐ Relief/Injury Care: Symptomatic relief from chronic or acute pain, tension, and other symptoms of immediate concern.
- ☐ Preventative Care: A natural approach to health management for maintaining one's current state of health function. This proactive approach also focuses on prevention from injuries related to work, sports, and postural stressors.
- ☐ Both: You may be interested in both options or for your provider to decide.

Specific Health Goals

Energy-Vitality	Health-Fitness	Mental-Emotional
☐ Have More Energy	☐ Improve Strength	☐ Improve Concentration
☐ Sleep Better	☐ Improve Flexibility	☐ Improve Memory
☐ Be Free of Pain	☐ Improve Balance	☐ Improve Mood
☐ Improve Immunity	☐ Reduce Weight	☐ Reduce Depression
☐ Heart Health	☐ Sport Specific_____	☐ Reduce Stress
		☐ Neurological Support

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or a "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular incident could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burn or minor complications.

Other Treatment Options: May include over-the-counter analgesics, prescription medications, injections, and surgery.

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 induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

No Warranty: I understand that my doctor at Wellness Doctor, cannot make any promises or guarantees regarding a cure for or improvement of my condition. I understand that my doctor will share with me his/her opinion regarding potential results from chiropractic treatment for my condition and will discuss treatment options with me before I consent to treatment.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Printed Name: _____Signature: _____ Date: _____

CONSENT TO TREAT A MINOR

I hereby authorize Wellness Doctor to administer chiropractic care, as deemed necessary, to my child.

Name of Child: _____ Age: _____ Date: _____

Parent/Guardian Signature: _____

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MASSAGE CLIENT WAIVER FORM

Name: _____Date: _____ DOB: _____

Please read and initial the following information:

____ I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular and fascial tension, improvement of circulation and energy flow.

____ If I experience pain or discomfort during the session, I will immediately inform the Licensed Massage Therapist (LMT) so that pressure/strokes can be adjusted to my level of comfort. I will not hold Wellness Doctor or the LMT responsible for any pain or discomfort I experience during or after the session.

____ I understand that the services offered today are not a substitute for medical care. I understand that the LMT, is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe of treat physical or mental illness.

____ I affirm that I have notified the LMT of all known medical conditions, medications, and injuries.

____ I agree to inform the LMT of any changes in my health and medical condition. I understand that there shall be no liability on the LMT should I forget to do so.

____ By signing this release, I hereby waive and release Wellness Doctor and the LMT from all liability, past, present, and future relating to massage therapy and bodywork.

_____ _____

Patient Signature Date

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Financial Policy

Welcome! To ensure your treatments are as stress free as possible we have established a clear financial policy.

Please read and initial next to the policy that applies to you. If you have any questions don't hesitate to ask!

____ **Insurance:** We will bill your insurance as a courtesy for you. If you provide us with your current insurance information we will do our best to verify your benefits prior to receiving care, however insurance companies will never allow a quote of coverage to be a guarantee of payment. We will collect 100% of services not covered by your insurance carrier. If you have a copay, coinsurance or unmet deductible you will be responsible for payment at time of service. **We do offer services that may not be covered by your insurance and you will be responsible for the balance.** Please be aware that some patient's policies are written to where they may have a deductible for certain services and or a copay for certain services. ***Insurance is a contract between the patient and their carrier, so it is important that you take responsibility for understanding your benefits. ***

____ **Auto Accident/Personal Injury/Workman's Compensation:** Most Personal Injury and Workman's Compensation claims are covered 100%. However, it is **YOUR** responsibility to provide our office with the documentation necessary to prove a valid claim which includes your claim number, as well as the name(s) of any claims adjustor/attorney, etc. handling the case, their phone and fax number and the mailing address to send bills. Failing to provide the documentation needed will result in immediate conversion of your case to cash, and all payment will be due on receipt. We can send any unpaid claims to your personal health insurance if it was in effect during your treatment as long as you provide us with current insurance information. If you miss more than two appointments and do not call within the 24-hr. cancellation period, appointments with our facility may be terminated

____ **Cash: Payment is due at the time of service.** A prompt pay incentive discount is offered for patients that do not have insurance or choose to not use their insurance. Please speak with our front desk staff to go over those prices.

*Unpaid balances greater than 120 days will be sent to collections and you will be charged and additional 35% to cover the cost of collections. (this amount will be added to you bill) *

I have read and understand the above Financial Policy.

_____ _____

Signature of Patient or Responsible Party **Date**

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Cancellation and No Show Policy

Scheduling an appointment reserves this time especially for you and no one else. Therefore, our office requires 24 hours' notice to cancel an appointment. If 24 hours is not given, a charge of $25 will be billed to your account.

If you do not show up for your appointment, you will be responsible for a $25 no show fee.

Patients that cancels 24 hours before their scheduled appointment or whose appointment needed to be rescheduled by our office will NOT be subject to a cancellation fee.

Inclement Weather Policy

Please be aware of the local forecast and if you feel that you are unable to come in for your scheduled appointment make sure to cancel 24 hours before. The above policies will be applied.

If we close the office due to weather you will receive a phone call from our reception staff and cancellation fee will not be applied.

_____ _____

Signature of Patient or Responsible Party **Date**

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HIPAA Acknowledgement of Notice of Privacy Practices

PLEASE REVIEW THE FOLLOWING CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

*My health information may be created or received by Wellness Doctor, LLC and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

*We may use health information about you to provide you with medical treatment of services. We may disclose health information about you to doctors, nurses, technicians, office staff, personnel or anyone who is involved in taking care of you and your health.

*I understand that I have the right to receive and review a written description of how Wellness Doctor, LLC will handle my health information. This written description is known as a NOTICE OF PRIVACY PRACTICES and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of Wellness Doctor, LLC and my rights regarding my health information.

*I understand that the NOTICE OF PRIVACY PRACTICES may be revised periodically. We will not disclose your health information unless we have received written consent. I understand that a copy of summary of the most recent version of Wellness Doctor, LLC's NOTICE OF PRIVACY PRACTICES in effect will be posted in the waiting/reception area.

Special Permission Request:

I give my permission for Wellness Doctor, LLC to leave messages regarding appointments on my home/cell phone answering machine.

Initial: ____ Date: _____

I give my permission to speak with/leave messages regarding treatment, billing and regarding appointment status left with my spouse, partner, caregiver.

Initial: ____ Date: _____ Name: _____

By signing this agreement, I attest that I understand the information above. Our posted Privacy Health Information provides more detailed information about the usage and disclosure of your (PHI). You have the right to review and/or request a copy of this policy before signing this consent. This release will revoke by written permission only.

I understand that I must send a written request to Wellness Doctor, LLC to revoke this release.

Signature: _____Date: _____