Wellness Doctor, Inc.
61555 Parrell Rd. Bend, OR 97702
P: 541-318-1000 * F: 541-318-7050 * E: Appointments@BendWellnessDoctor.com

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

First Name: _____ MI: _____ Last Name: _____

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

Gender: ___M ___F ___Trans Age: _____ DOB: _____ Marital Status: __S __M __W __D __P

Cell Phone: _____ Cell phone carrier (for appt text reminders):_____

E-mail: _____ Occupation/Employer: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Primary Care Doctor: _____ Who may we thank for your referral?_____

PRIMARY INSURED INFORMATION

If you are the primary insured, mark "self" and move down to "Payment Information".

Primary insured: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

First Name: _____ MI: _____ Last Name: _____

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

Gender: ☐M ☐F DOB: _____Cell Phone: _____ E-mail: _____

PAYMENT INFORMATION

Please check the following payment methods that apply: ☐ Cash (Time of Service) ☐ Health Insurance

☐ Workers Compensation ☐ Auto Insurance (auto injury) Date of auto injury/accident: _____

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 cancel 24 hours before their scheduled appointment or whose appointment needed to be rescheduled by our office will NOT be subject to a cancellation fee. Thank you, in advance, for giving us 24 hours' notice.

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 text or phone call from our reception staff and a cancellation fee will not be applied.

Signature of Patient or Responsible Party _____

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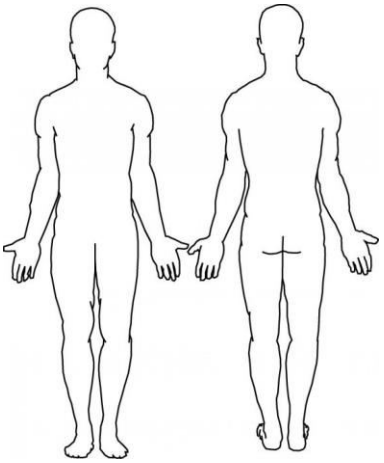

SYMPTOM SURVEY

1. What is your ***Primary*** complaint? _____
2. Was there trauma or a known cause? ☐YES ☐NO
   If yes, describe: _____
3. When did your symptoms begin? _____
4. How often do the symptoms bother you?
   ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional
5. Has this condition bothered you before? ☐YES ☐NO
6. Would you describe it as (circle all that apply): **SHARP, SHOOTING, ACHY, ELECTRICAL, DEEP, DULL, ACHING, STIFF, THROBBING, NUMBNESS, TINGLING, CRAMPING, OTHER:** _____
7. How severe is you pain/discomfort from **0 (*none*) to 10 (*worst imaginable*)**? _____
8. What makes it worse? _____What relieves it? _____
9. Any other symptoms associated with this complaint? _____
10. Treated for this in the past? ☐YES ☐NO When?_____Where?_____

Problem #2 _____ Was there trauma or a known cause? ☐YES ☐NO
If yes, describe: _____
When did your symptoms begin? _____
How often do the symptoms bother you? ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional
Has this condition bothered you before? ☐YES ☐NO
Would you describe it as (circle all that apply): **SHARP, SHOOTING, ACHY, ELECTRICAL, DEEP, DULL, ACHING, STIFF, THROBBING, NUMBNESS, TINGLING, CRAMPING, OTHER** _____
Where is you pain/discomfort from 0 (*none*) to 10 (*worst imaginable*)? _____
What makes it worse? _____What relieves it? _____
Any other symptoms associated with this complaint? _____
Treated for this in the past? ☐YES ☐NO When?_____Where?_____

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

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

Year: _____ Test: _____ Findings: _____
Year: _____ Test: _____ Findings: _____
Year: _____ Test: _____ Findings: _____

Other:_____

What do your DAILY ACTIVITIES consist of?

☐ Heavy Labor ☐ Prolonged Sitting
☐ Light Labor ☐ Prolonged Standing
☐ Repetitive Movements ☐ High Mental Stress

Do you EXERCISE on a regular basis? ☐YES ☐NO
How often?_____ How long?_____
What types?_____
Do you SLEEP WELL at night? ☐YES ☐NO

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MEDICAL HISTORY

Past or Present Concerns:

__ Arthritis
__ Allergies/Hay Fever/Asthma
__ Alcoholism
__ Alzheimer's/Dementia
__ Autoimmune _____
__ Blood Pressure problems
__ Bronchitis
__ Cancer_____
__ Carpal Tunnel Syndrome
__ Celiac Disease
__ Chronic Fatigue Syndrome
__ Cholesterol, High
__ Circulatory Problems
__ Colitis
__ Contact Lenses
__ Dental problems
__ Depression
__ Diabetes
__ Diverticulitis
__ 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)
__ Lyme Disease
__ Seasonal Affective Disorder
__ Migraine Headaches
__ Neurological Problems_____
__ Obesity
__ Osteoporosis
__ Pneumonia
__ Migraine Headaches
__ Skin problems
__ Sinus problems
__ Stroke
__ Thyroid problems
__ Ulcer
__ OTHER _____

Medical (Men)
__ Benign Prostatic Hyperplasia
__ Prostate Cancer
__ Decreased Sex Drive
__ Infertility
__ Sexually Transmitted Disease
__ OTHER_____

Medical (Women)
__ Menstrual Irregularities
__ Endometriosis
__ Infertility
__ Fibrocystic Breasts
__ Fibroids/Ovarian Cysts
__ Premenstrual Syndrome
__ Pelvic Inflammatory Disease
__ Vaginal Infections
__ Decreased Sex Drive
__ C-Section
__ Menopause
__ Breast Cancer

Family Health History- Parents/Grandparents/Siblings:
__ Autoimmune
__ Arthritis
__ Alcoholism
__ Alzheimer's/Dementia
__ Celiac Disease
__ Migraine Headaches
__ Eating Disorder_____
__ Genetic Disorder
__ Glaucoma
__ Heart Disease
__ Cancer _____
__ Neurological Disorders_____
__ Obesity
__ Osteoporosis
__ Stroke
__ Mental Illness
__ Diabetes

Medications/Supplements

Med/Sup	Dosage	Reason

Traumatic Injury/Surgery

Year	Trauma/Surgery

Do you have a **Primary Care Provider?** ☐YES ☐NO
When was your **Last Physical**?_____

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MSQ -MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

Name: _____ Date: _____**Height_____ Weight**_____

Point Scale	**0** - Never or almost never have the symptom **1** - Occasionally have it, effect is not severe **2** - Occasionally have it, effect is severe	**3** - Frequently have it, effect is not severe **4** - Frequently have it, effect is severe

Head	____ Headaches ____ Faintness ____ Dizziness ____ Insomnia ____ **TOTAL**
Eyes	____ Watery or itchy eyes ____ Swollen, reddened or sticky eyelids ____ Bag or dark circles under eyes ____ Blurred or tunnel vision (does not include near or far-sidedness) ____ **TOTAL**
Ears	____ Itchy Ears ____ Earaches, ear infections ____ Drainage from ear ____ Ringing in ears, hearing loss ____ **TOTAL**
Nose	____ Stuffy Nose ____ Sinus problems ____ Hay fever ____ Sneezing attacks ____ Excessive mucus formation ____ **TOTAL**
Mouth/ Throat	____ Chronic coughing ____ Gagging, frequent need to clear throat ____ Sore throat, hoarseness, loss of voice ____ Swollen or discolored tongue/gums/lips ____ Canker sores ____ **TOTAL**
Skin	____ Acne ____ Hives, rashes, dry skin ____ Hair loss ____ Flushing, hot flashes ____ Excessive sweating _____ **TOTAL**
Heart	____ Irregular or skipped heartbeat ____ Rapid or pounding heartbeat ____ Chest pain ____ **TOTAL**
Lungs	____ Chest congestion ____ Asthma, bronchitis ____ Shortness of breath ____ Difficulty breathing ____ **TOTAL**
Digestive Tract	____ Nausea, vomiting ____ Diarrhea ____ Constipation ____ Bloated feeling ____ Belching, passing gas ____ Heartburn ____ Intestinal/stomach pain ____ **TOTAL**
Joints/ Muscle	____ Pain or aches in joints ____ Arthritis ____ Stiffness or limitation of movement ____ Pain or aches in muscles ____ Feeling of weakness or tiredness ____ **TOTAL**
Weight	____ Binge eating/drinking ____ Craving certain foods ____ Excessive weight ____ Compulsive eating ____ Water retention ____ Underweight ____ **TOTAL**
Energy/ Activity	____ Fatigue, sluggishness ____ Apathy, lethargy ____ Hyperactivity ____ Restlessness ____ **TOTAL**
Mind	____ Poor memory ____ Confusion, poor comprehension ____ Poor concentration ____ Difficulty in making decisions ____ Stuttering or stammering ____ Slurred speech ____ Learning disabilities ____ **TOTAL**
Emotions	____ Mood swings ____ Anxiety, fear, nervousness ____ Anger, irritability, aggressiveness ____ Depression ____ **TOTAL**
	<10 – Optimal **10-50 – Mild Toxicity** **50 – 100 Moderate Toxicity** **>100 – Severe Toxicity** **GRAND TOTAL: _____**

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INTERESTS AND GOALS

To allow us to better address your healthcare goals & priorities, please check what applies 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 therapists 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 specific condition. Areas of focus include: weight management, athletic performance, food sensitivities/allergies, Celiac and IBD, cancer, and digestive health.

___ **Infrared Sauna:** We offer the highest quality Full Spectrum Infrared Sauna therapy with our Sunlighten Sauna. Some of the many benefits include: Detoxification, Weight Loss, Pain Relief, Anti-Aging, Immune Enhancement, Relaxation, Cardiovascular and Skin Health.

___ **Pulsed Electromagnetic Field (PEMF) Therapy:** Through improving the cell membrane potential via charging the cells of the body, improved circulation, oxygen uptake, mitochondrial function, nutrient uptake, and elimination of cellular waste, this modality proves to be quite an impressive therapy. Recommended for improving athletic performance/recovery, strains/sprains/broken bones, post-surgery, neurological complaints, concussions, and in conjunction with Functional Medicine.

Specific Health Goals:

__ Have More Energy	__ Improve Strength	__ Improve Concentration
__ Sleep Better	__ Improve Flexibility	__ Improve Memory
__ Be Free of Pain	__ Improve Balance	__ Neurological Support
__ Improve Immunity	__ Reduce Weight	__ Reduce Depression
__ Heart Health	__Sport Specific _____	__ Reduce Stress

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

The Nature of Chiropractic Manipulation: The doctor will often 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, soft tissue therapies, corrective exercises, or active stretching may also be utilized.

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, dislocation 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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Financial Policy

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, co-insurance, 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 an 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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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: _____

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MASSAGE PATIENT WAIVER FORM

Please read and initial the following information if you think you would like/need massage at our clinic.

___ 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, or 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 (ex. pregnancy). 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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