Balance Health & Injury Clinic, PC
1217 NE Burnside Rd, STE 301 ◆ Gresham, OR 97030 ◆ PH 503.492.2625

Today's date:

Patient Information

Name: _____

DOB: ____/____/____ (MM/DD/YYYY) Gender: M F ❑ Married ❑ Single ❑ Other

Address: _____

_____
City State Zip

Primary Phone: _____ ❑ Mobile

Secondary: _____ ❑ Mobile

eMail: _____

Your Auto Insurance Information

Insurance Company: _____

Claim Number: _____

Insured Name: _____

Other Party's Insurance Information (if known)

Insurance Company: _____

Claim Number: _____

Other Driver Name: _____

Detailed Information (new patients only)

Employer: _____

Occupation: _____

Work Phone: _____ Ext

Emergency Contact:

Name: _____

Relationship: _____ Phone: _____

Referred by: _____

Accident Information

Date of Accident? ____/____/____ (MM/DD/YYYY)

State Accident Occurred In: _____

Time of Accident: _____(❍AM / ❍PM)

Who was the driver of your vehicle: _____

Type of Accident: ❍ head-on-collision ❍ broad side collision
❍ rear-end collision ❍ front impact
❍ multiple vehicle _____
❍ other (describe) _____

Accident Questionnaire

Describe what occurred to you upon impact: _____

_____

Where were you seated: Front ❍ Left (driver) ❍ Center ❍ Right Rear ❍ Left ❍ Center ❍ Right

Were seat belts worn? ❍ Yes / ❍ No Did you wear the shoulder belt? ❍ Yes / ❍ No

Does your car have headrests? ❍ Yes / ❍ No If Yes; ❍ Bottom of head ❍ Top of head ❍ Middle of neck

Were you moving at time of accident? ❍ Yes / ❍ No If Yes; How fast? ____mph; was vehicle braking? ❍ Yes / ❍ No

How fast was other vehicle moving? _____ mph Did you brace for impact? ❍ Yes / ❍ No

What was your head/body position? ❍ turned ❑left / ❑right ❍ body straight in sitting position
❍ head looking back ❍ body rotated ❑left / ❑right
❍ head straight forward ❍ other: _____

During the accident, did you hit your head/body inside the car? _____

As a result of the accident, were you? ❍ rendered unconscious ❍ dazed, circumstances vague ❍ other: _____

Could you move all parts of your body? ❍ Yes / ❍ No If no; what and why? _____

Were you able to get out of car unaided? ❍ Yes / ❍ No If no; why not? _____

What bleeding cuts did you experience? _____

What bruises did you experience? _____

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Accident Questionnaire

Describe how you felt…(please be as specific as possible):

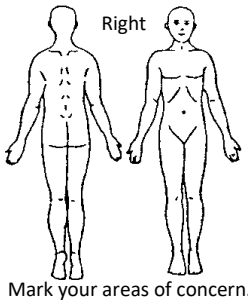
Immediately after the accident: _____

_____

Later the same day: _____

During the first night: _____

The following day: _____



Mark your areas of concern.

Check all symptoms apparent SINCE the accident, circle severity as appropriate and describe pain (i.e., dull, sharp, stabbing, aching, throbbing, burning, radiating, pressure, etc.):

Head pain feels _____ 0 1 2 3 4 5 6 7 8 9 10

Neck pain feels _____ 0 1 2 3 4 5 6 7 8 9 10

Mid back pain feels _____ 0 1 2 3 4 5 6 7 8 9 10

Low back feels _____ 0 1 2 3 4 5 6 7 8 9 10

❑ Loss of smell	❑ Loss of taste	❑ Loss of memory	❑ Fatigue
❑ Numbness in fingers	❑ Numbness in toes	❑ Cold hands	❑ Cold feet
❑ Eyes sensitive to light	❑ Pain behind eyes	❑ Dizziness	❑ Fainting
❑ Irritability	❑ Nervousness	❑ Shortness of breath	❑ Ringing/buzzing in ears
❑ Depression	❑ Anxiety	❑ Difficulty sleeping	❑ Loss of balance
❑ Diarrhea	❑ Constipation	❑ Chest pain	❑ Cold sweats

❑ Other _____

Since the onset, have your symptoms been getting: ❑ Better ❑ Worse ❑ No Change

Do your symptoms interfere with: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Recreation

What makes your pain worse? _____

What makes your pain better? _____

Have you missed work? ❍ Yes / ❍ No ❍ Unable to work since accident

❍ Full-time off work From _____ To _____

❍ Part-time off work From _____ To _____

Did you seek medical attention soon after the accident? ❍ Yes / ❍ No

If yes, how did you get there? ❍ I drove ❍ Ambulance ❍ Someone else drove me

❍ Police ❍ Other: _____

Urgent Care / Hospital / Doctor seen: _____ Date: _____

Examined? ❍ Yes / ❍ No X-rays taken? ❍ Yes / ❍ No If yes, area: _____

What treatment did you receive? ❑ Bed rest ❑ Brace ❑ Physiotherapy ❑ Pain medication ❑ Other _____

How did treatment help? _____ Last treatment date: _____

Describe physical complaints you had prior to accident: _____

Surgical History	Allergies or Reactions to Medication
List with year:	

Current Medication/Supplements

Please list all medications or supplements with dose and frequency:

Personal Health Information

Health Habits

Alcohol: _____glasses / day week month
Caffeine: _____glasses / day week month
Tobacco: _____packs / day week month
Stress: None Moderate Daily Heavy
Exercise: None Moderate Daily Heavy

Work Activity

❑ Sitting
❑ Standing
❑ Computer
❑ Light Labor
❑ Heavy Labor
❑ Hazards
❑ Repetitive

Female Health

Date of last menses: _____ ❑ Menopause
Age of first period: _____ ❑ PMS
Menses: ❑ Spotting ❑ Light ❑ Heavy
❑ Irregular ❑ Painful ❑ Clots ❑ Absent
Are you currently pregnant? ❑ Y ❑ N
Are you currently breast feeding? ❑ Y ❑ N
# of pregnancies: _____ # of live births: _____

Any additional information we need to know about your accident and/or your health prior to this accident:

Informed Consent

I hereby request and consent to the performance of acupuncture, chiropractic, naturopathy, and/or massage treatments and other procedures within the scope of practice of my provider on me (or on the person named below, for whom I am legally responsible) by the practitioner I see now or other practitioners who now or in the future treat me while employed by, working or associated with or serving as back-up for my practitioner, including those working at the clinic or office listed above, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, chiropractic, naturopathy moxibustion, cupping, electrical stimulation, ultrasound, Tui-na (oriental manual therapy), massage, herbal medicine, exercise and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I have been informed that chiropractic therapy is a generally safe method of treatment, but that it may have some side effects including non-painful cavitations or “popping” and soreness in the area following treatment. The cavitation or “popping” commonly occurs during an adjustment and is caused by the joint fluid converting from a liquid to a gas and is a normal side effect of the treatment. Unusual risks of chiropractic treatments include soft tissue injury, physical therapy burns, rib fracture and very rare disc herniation and stroke. I understand that while this document describes the major risks of chiropractic treatment, other side effects and risks may occur.

I have been informed that naturopathy is a generally safe method of treatment, but that it may have some side effects, including bruising, non-painful cavitations or “popping” and soreness in the area following treatment, dizziness, or fainting. Unusual risks of joint mobilization include soft tissue injury, physical therapy burns, rib fracture and very rare disc herniation and stroke Bruising is a common side effect of cupping or instrument assisted soft tissue manipulation. Bruising, soreness, or allergic reaction may be side effects of blood draws, IV transfusions, or injections. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I have been informed that massage therapy is a generally safe method of treatment, but that it may have some side effects, including bruising, soreness, and the possible aggravation of symptoms after treatment.

The herbs and nutritional supplements that have been recommended are traditionally considered safe when prescribed by competently trained practitioners. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

Clinic Policies and Procedures

Insurance billing: We will bill your insurance for you. You are responsible for any amounts applied to your deductible.

Appointment changes: your appointment time is reserved specifically for you. In the event of a missed appointment, you may be charged a fee.

Closure due to inclement weather: in the case of inclement weather please call the clinic prior to your appointment. Our status will be noted on our voicemail.

Insurance Assignment and Release

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of treatment, and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I, the undersigned, hereby instruct and direct my insurance company to pay by check, made out and mailed directly to the above named office, the professional and medical expense benefits allowable and otherwise payable to me under my current policy agreement as payment toward the services rendered. I understand that I am financially responsible for all charges for services provided me (or my dependent). A photocopy of this assignment shall be considered as effective and valid as the original.

Responsible party name: _____ Signature: _____ Date: _____