

CHIROPRACTIC REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
 I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient

3

PHONE NUMBERS

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

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

5

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

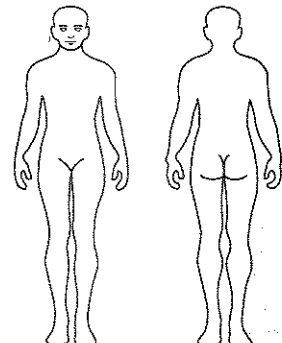
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



6

HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | |
|---------------------|--|------------------|--|---------------------|--|----------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | |
| | | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking Packs/Day _____
 Alcohol Drinks/Week _____
 Coffee/Caffeine Drinks Cups/Day _____
 High Stress Level Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

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MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

**Bend Whole Health
Dr. Daniel J Bourque D.C.**

PATIENT GUIDELINES

Chiropractic is a partnership approach between the Doctor and the Patient to reach a desired level of health. Here are some ways to help obtain the best results from your Chiropractic care.

1. Start with the End in Mind: Finish what you start! Understand the benefits of finishing the program and the consequences in stopping prematurely. Know your time commitment and investment before you start. Stopping corrective care before you finish is a loss of both time and money, i.e. an expense. NOT an investment.
2. Maintain your Spine: We are serious about what we do because it is very effective when it is done correctly. Once correction of your spine is achieved it needs to be maintained.
3. Consistency for Best Results: Stay consistent with your adjustments. Keep your appointments and follow the schedule exactly as the doctor has outlined for you. Nerve and muscle memory needs to be retrained through repetitive inputs in order for there to be enough change to correct your spine. This takes consistent repetition similar to learning piano, golf, etc. This is the way to achieve the results that millions of other chiropractic patients have enjoyed.
4. Missed Appointment Guidelines: Missing appointments will slow your progress. If you must miss an adjustment, you should make it up within one week, if possible. If you miss too many adjustments and do not make them up, we will have to stop your care to **protect your investment** until you can do the program correctly.

YOU MUST CALL to reschedule an appointment. Being consistently late or **missing appointments without calling is unacceptable**. A simple call to change or miss an appointment would reflect the same courtesy and respect to us that we deliver to you.

5. Spinal Care Classes:
6. Family Policy: We make it a policy to check your family within the first two weeks of your care, and we allow them a physical exam at **no charge**. Since spinal alignment is for **wellness**, we feel it is necessary to check family members for spinal misalignment regardless if you/they decide to accept care or not.
7. Communicate: Communicate with us if you have any questions or concerns. Any question or concern can usually be worked out. We are here to help you.
8. Payment Policies: We've worked very hard to create payment plans that are extremely affordable for you and your family. If you are committed to getting the care you need, we are committed to helping you.
9. Helping Others: If you understand Chiropractic, then share your experience with others. Educating others about the importance of spinal misalignment and maintenance of the spine could change the lives of people you care about!

My signature below indicates I have read and understand the above guidelines.

Patient Signature: _____ Date: _____

Print Name: _____

CONDITIONS AND FAMILY HISTORY

SYMPTOMS

Check symptoms you currently have or have had in past year.

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> fainting | <input type="checkbox"/> chills | <input type="checkbox"/> convulsions | <input type="checkbox"/> depression | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> loss of weight | <input type="checkbox"/> fatigue | <input type="checkbox"/> loss of sleep | <input type="checkbox"/> headache | <input type="checkbox"/> fever |
| <input type="checkbox"/> weight gain | <input type="checkbox"/> neuralgia | <input type="checkbox"/> nervousness | <input type="checkbox"/> night sweats | <input type="checkbox"/> wheezing |
| <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> gall bladder problems | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> liver problems | <input type="checkbox"/> nausea | <input type="checkbox"/> stomach pain | <input type="checkbox"/> poor appetite | <input type="checkbox"/> poor digestion |
| <input type="checkbox"/> asthma | <input type="checkbox"/> crossed eyes | <input type="checkbox"/> deafness | <input type="checkbox"/> earache | <input type="checkbox"/> ear discharge |
| <input type="checkbox"/> ear noises | <input type="checkbox"/> enlarge thyroid | <input type="checkbox"/> frequent colds | <input type="checkbox"/> hay fever | <input type="checkbox"/> hoarseness |
| <input type="checkbox"/> tremors | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> hay fever | <input type="checkbox"/> sinusitis | <input type="checkbox"/> sore throat |
| <input type="checkbox"/> tonsillitis | <input type="checkbox"/> pain in eyes | <input type="checkbox"/> poor vision | <input type="checkbox"/> nasal obstruction | |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> chronic cough | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> spitting blood | <input type="checkbox"/> spitting phlegm |
| <input type="checkbox"/> backache | <input type="checkbox"/> foot problems | <input type="checkbox"/> pain bet shoulders | <input type="checkbox"/> painful tailbone | <input type="checkbox"/> stiff neck |
| <input type="checkbox"/> weakness | <input type="checkbox"/> swollen joints | <input type="checkbox"/> spinal curvature | <input type="checkbox"/> twitching | <input type="checkbox"/> ankle swelling |
| <input type="checkbox"/> heart trouble | <input type="checkbox"/> high blood pressure | | <input type="checkbox"/> low blood pressure | |
| <input type="checkbox"/> strokes | <input type="checkbox"/> pain over heart | <input type="checkbox"/> poor circulation | <input type="checkbox"/> rapid heart | <input type="checkbox"/> slow heart |
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> dryness | <input type="checkbox"/> eczema | <input type="checkbox"/> hives | <input type="checkbox"/> itching |
| <input type="checkbox"/> sensitive skin | <input type="checkbox"/> cramps | <input type="checkbox"/> excessive flow | <input type="checkbox"/> hot flashes | <input type="checkbox"/> painful cycle |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> numbness | <input type="checkbox"/> vomiting | <input type="checkbox"/> varicose veins |

FAMILY HISTORY

Check the conditions as they pertain to your immediate family.

- | | | | | |
|---------------------|---------------------------------|---------------------------------|-------------------------------------|------------------------------------|
| Diabetes | <input type="checkbox"/> mother | <input type="checkbox"/> father | <input type="checkbox"/> brother(s) | <input type="checkbox"/> sister(s) |
| Heart problems | <input type="checkbox"/> mother | <input type="checkbox"/> father | <input type="checkbox"/> brother(s) | <input type="checkbox"/> sister(s) |
| Kidney problems | <input type="checkbox"/> mother | <input type="checkbox"/> father | <input type="checkbox"/> brother(s) | <input type="checkbox"/> sister(s) |
| Cancer | <input type="checkbox"/> mother | <input type="checkbox"/> father | <input type="checkbox"/> brother(s) | <input type="checkbox"/> sister(s) |
| Headaches | <input type="checkbox"/> mother | <input type="checkbox"/> father | <input type="checkbox"/> brother(s) | <input type="checkbox"/> sister(s) |
| Back Pain | <input type="checkbox"/> mother | <input type="checkbox"/> father | <input type="checkbox"/> brother(s) | <input type="checkbox"/> sister(s) |
| Obesity | <input type="checkbox"/> mother | <input type="checkbox"/> father | <input type="checkbox"/> brother(s) | <input type="checkbox"/> sister(s) |
| Stroke | <input type="checkbox"/> mother | <input type="checkbox"/> father | <input type="checkbox"/> brother(s) | <input type="checkbox"/> sister(s) |
| High blood pressure | <input type="checkbox"/> mother | <input type="checkbox"/> father | <input type="checkbox"/> brother(s) | <input type="checkbox"/> sister(s) |

LIFESTYLE

How many hours per day do you use a computer at work or home 1 2-3 4-5 more than 5

How many hours per day do you ride in a car or other vehicle 1 2-3 4-5 more than 5

What is the age of your mattress? _____ Comfortable Uncomfortable

What type of pillow do you use? _____ Comfortable Uncomfortable

Are you wearing: heel lifts sole lifts inner soles arch support

INFORMED CONSENT TO CHIROPRACTIC CARE

DANIELS CHIROPRACTIC

Daniel J. Bourque, D.C.

2207 N.W. Awbrey Rd.

Bend, OR 97701

Telephone: (541) 389-1191

Patient Name _____ Birthdate _____

Please discuss any questions or concerns with the Doctor before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that I will be receiving the following treatment:

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Witness Signature _____ Date _____

Doctor's Signature _____ Date _____

ACKNOWLEDGMENT AND CONSENT

I understand that Dr. Daniel J. Bourque of Bend Whole Health PC,
(referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. 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 the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ (Patient)	Date: _____
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-OR-

By: _____ -- (Patient representative)	Date: _____
Description of Representative's Authority: _____	



FINANCIAL POLICY

This is an agreement between Dr. Daniel J. Bourque and you, the patient.
By executing this agreement, you are agreeing to pay for all services rendered.

Payment Information

Payment for services is expected at the time of service unless we approve other arrangements in writing prior to your treatment. Accounts are considered past due if not paid by the last day of each month.

Payment Options

If you have insurance Payment for services is expected at the time of service unless we approve other arrangements in writing prior to your treatment. Accounts are considered past due if not paid by the last day of each month.

If you have no insurance Payment for services is expected at the time of service unless we approve other arrangements in writing prior to your treatment. Accounts are considered past due if not paid by the last day of each month.

Insurance Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company as a courtesy to you, or if you decide to bill your insurance company we will provide you with a form (superbill) to give to your insurance company. Although we will estimate what your insurance company may pay, it is the insurance company who makes the final decision of your eligibility. You agree and understand that you are responsible for benefits, payments, or any claim inquiries.

Monthly Statements If you have a balance on your account, we will send you a monthly statement. It will show your previous balance and any new charges to your account and if any payments, credits or write offs have been applied to your account during the month(s).
Finance Charge A finance charge may be imposed on your account which has not been paid within thirty (30) days of the date of receiving your statement. The finance charge will be computed at the rate of (2%) per month, or an Annual Percentage Rate of (18%). The minimum finance fee is \$.50 cents.
Late Fee A late fee of \$25 may be assessed on all charges that are not paid in full by the end of each billing cycle.
Returned Checks There is a \$25.00 fee for any checks returned by the bank.
Missed Appointment Fee We require 24-hour notice in order to change any appointments. There is a \$25 fee for all appointments that are missed or cancelled less than 24 hours in advance.
Past Due Accounts If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which may incur. If we have to refer collection to a lawyer, you agree to pay all lawyer's fees which we incur, as well as court costs. In case of suit, the venue will be in the Deschutes County.

Effective Date *Once you have signed this document, you agree to all of the terms and conditions contained herein. This is a legally binding agreement and will be in full effect.*

ASSIGNMENT OF BENEFITS

I hereby assign all chiropractic benefits, including alternative care health coverage to which I am entitled, to Daniel J. Bourque, DC., for services rendered and charges appropriated. If any claims are denied or unpaid due to lapse in coverage, lack of chiropractic coverage, unmet deductible, maximized benefits, or for any other reason, I am fully responsible for any outstanding balance.

By: _____
PATIENT DATE

OR

By: _____
PATIENT REPRESENTATIVE DATE