

**For Office use only:**

WL sent:

TYL sent:

# Patient Registration Form

**Patient Information:**

	_____	_____	_____
	First Name	Middle Name	Last Name
If patient is a minor, Parent or Guardian Name:	_____		
Billing Address	_____		
	Street		
	_____		
	City	State	Zip code
Phone	_____		
	Home	Work	Mobile
	_____		
	Birth Date	Email	(Please understand that email is not a secure form of communication. Email communications can be intercepted and privacy breached.)
	_____		
	Social Security Number	Gender	
	_____		
	Employer Name & Phone Number		
	_____		

**Insurance Information:**

	_____		
	Company Name		
	_____		
	Member ID # or Claim #	Policy #	Phone #
	_____		
	Billing Address		
	_____		
What type of insurance is this?			
	<input type="checkbox"/> employer sponsored health	<input type="checkbox"/> motor vehicle accident	<input type="checkbox"/> worker's compensation
			<input type="checkbox"/> other

**Contact Information:**

	_____	_____	_____
	Emergency Contact Name	Relationship	Phone #
Is it okay to leave <b>appointment</b> information <i>with another family member or friend?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If Yes, whom?	_____		
	Name	Relationship	
Is it okay to leave <b>medical</b> information <i>with another family member or friend?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If Yes, whom?	_____		
	Name	Relationship	
Is it okay to leave <b>appointment</b> information on your <i>home or mobile voice mail?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is it okay to leave <b>medical</b> information on your <i>home or mobile voice mail?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is it okay to contact you at your place of employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is it okay to leave <b>appointment</b> information on your <i>voice mail at your place of employment?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is it okay to leave <b>medical</b> information on your <i>voice mail at your place of employment?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
What is the best number to use for the confirmation call?	_____		
How did you hear about our clinic? Or who referred you?			
<input type="checkbox"/> family member: _____	<input type="checkbox"/> employer	<input type="checkbox"/> Dr. Guthrie's website	
<input type="checkbox"/> friend: _____	<input type="checkbox"/> yellow pages	<input type="checkbox"/> other website: _____	
<input type="checkbox"/> attorney: _____	<input type="checkbox"/> sign on building		
<input type="checkbox"/> physician: _____	<input type="checkbox"/> insurance company	<input type="checkbox"/> other reference: _____	
If you indicated, family member or friend, is it okay to send them a thank you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

# Patient Health Questionnaire

Describe your symptoms:

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When did your symptoms start? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (date)

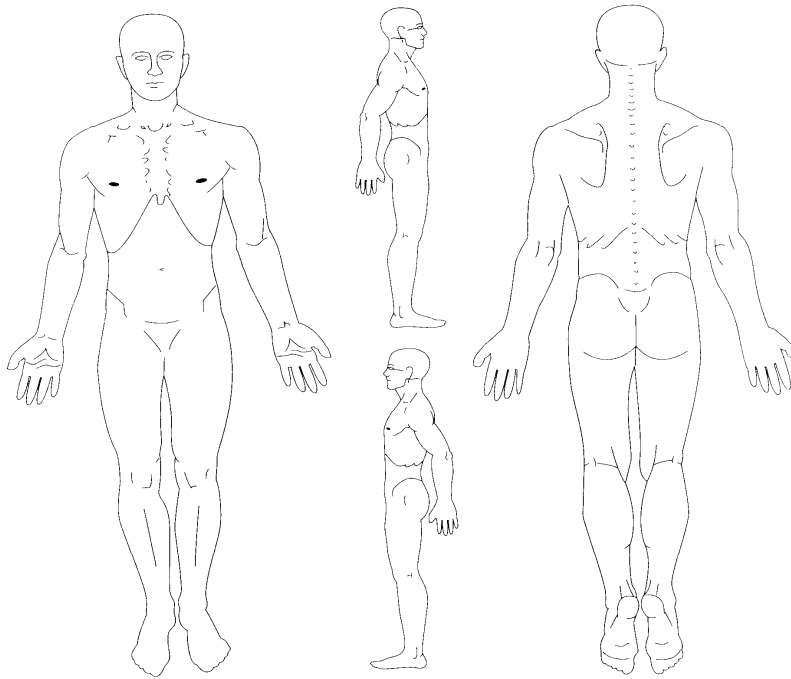
How did your symptoms begin?

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Please indicate on the diagram below where the following symptoms are located:

Using these symbols: Numbness (o) Burning (x) Stabbing(/) Pins & Needles (#) Dull Pain (+)



How often do you experience your symptoms?

- constantly (76-100% of the day)
- frequently (51-75% of the day)
- occasionally (26-50% of the day)
- intermittently (0-25% of the day)

What describes the nature of your symptoms?

- |                                    |                                     |  |                                     |
|------------------------------------|-------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> radiating | <input type="checkbox"/> cramping   | <input type="checkbox"/> sharp with movement | <input type="checkbox"/> tender     |
| <input type="checkbox"/> pulsing   | <input type="checkbox"/> nauseating | <input type="checkbox"/> aching              | <input type="checkbox"/> throbbing  |
| <input type="checkbox"/> stinging  | <input type="checkbox"/> pinching   | <input type="checkbox"/> pinprick            | <input type="checkbox"/> tingling   |
| <input type="checkbox"/> sharp     | <input type="checkbox"/> lingering  | <input type="checkbox"/> unbearable          | <input type="checkbox"/> flickering |
| <input type="checkbox"/> deep      |                                     |  |                                     |

How are your symptoms changing?

- getting better
- not changing
- getting worse
- sometimes better & worse

During the past 4 weeks, indicate the average intensity of your symptoms (0 = no pain & 10 = unbearable pain):

- |                                   |                            |  |                            |
|-----------------------------------|----------------------------|--|----------------------------|
| <input type="checkbox"/> 0 - none | <input type="checkbox"/> 1 | <input type="checkbox"/> 2               | <input type="checkbox"/> 3 |
| <input type="checkbox"/> 4        | <input type="checkbox"/> 5 | <input type="checkbox"/> 6               | <input type="checkbox"/> 7 |
| <input type="checkbox"/> 8        | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 - unbearable |                            |

## Patient Health Questionnaire cont...

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework)?

- not at all                       a little bit                       moderately                       quite a bit  
 extremely

What is your occupation? \_\_\_\_\_

What are your occupational activities/exposures?

- lifting more than 30 lbs                       prolonged sitting                       chronic interpersonal conflicts                       money worries  
 dust, fumes, noise                       chemicals on skin                       major "deadlines"                       job insecurity/dissatisfaction

What is your current work status?

- full-time                       part-time                       unemployed                       off work due to injury/illness  
 over-time

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- all of the time                       most of the time                       some of the time                       a little of the time  
 none of the time

What is the most important thing you are prevented from doing? \_\_\_\_\_

In general would you say your overall health right now is...

- excellent                       very good                       good                       fair  
 poor

Who have you seen for this episode of your symptoms?

- no one                       chiropractor                       medical doctor                       physical therapist  
 other: \_\_\_\_\_

What treatment did you receive for your symptoms?

- adjustments                       physical therapy                       medication                       surgery  
 other: \_\_\_\_\_

What tests have you had for your symptoms?

- x-rays                       MRI                       CT scan                       other: \_\_\_\_\_

Have you had similar symptoms in the past?

- no                       yes (when? \_\_\_\_\_)

If you have received treatment in the past for the same or similar symptoms, who did you see?

- this office                       other chiropractor                       medical doctor                       physical therapist  
 other

Please put a check mark in the column which best describes your ability at this time:

	not limited	mildly limited	very limited	unable
lifting				
standing				
sitting				
walking				
sleeping				

Habits:

- caffeine used occasionally                       caffeine used often                       cigarettes used occasionally                       cigarettes used often  
 alcohol used occasionally                       alcohol used often                       tobacco chewed occasionally                       tobacco chewed often  
  
 exercise occasionally                       exercise often                       eat processed/restaurant food occasionally  
 eat processed/restaurant food often  
  
 sleep less than 6 hours                       sleep 6-8 hours                       sleep more than 8 hours                       take naps

Is your current weight a concern for you?     Yes                       No

<b>For Office use only:</b> P = Past C = Current
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## Medical & Social History

**Medical Conditions:**

- |                                       |   |  |  |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> arthritis    | <input type="checkbox"/> cancer                       | <input type="checkbox"/> diabetes      | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> psychiatric illness          | <input type="checkbox"/> skin disorder | <input type="checkbox"/> stroke        |
| <input type="checkbox"/> anemia       | <input type="checkbox"/> epilepsy, seizures           | <input type="checkbox"/> AIDS          | <input type="checkbox"/> blood clots   |
| <input type="checkbox"/> osteoporosis | <input type="checkbox"/> auto-immune condition: _____ |  |  |

**Medications:**

**What for:**

**Rx Doctor:**


**Digestive, inflammatory and allergic conditions:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> gas                  | <input type="checkbox"/> bloating               | <input type="checkbox"/> constipation             | <input type="checkbox"/> diarrhea                        |
| <input type="checkbox"/> IBS                  | <input type="checkbox"/> fibromyalgia           | <input type="checkbox"/> chronic fatigue syndrome | <input type="checkbox"/> multiple chemical sensitivities |
| <input type="checkbox"/> severe allergies     | <input type="checkbox"/> ankylosing spondylitis | <input type="checkbox"/> crohns disease           | <input type="checkbox"/> ulcerative colitis              |
| <input type="checkbox"/> rheumatoid arthritis |   |   |  |

**Allergies:**

- |                               |   |  |                                       |
|-------------------------------|---|--|---------------------------------------|
| <input type="checkbox"/> eggs | <input type="checkbox"/> fish & shellfish | <input type="checkbox"/> milk or lactose | <input type="checkbox"/> peanut       |
| <input type="checkbox"/> soy  | <input type="checkbox"/> sulfites         | <input type="checkbox"/> wheat/gluten    | <input type="checkbox"/> other: _____ |

**Surgeries:**

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> back or neck surgery | <input type="checkbox"/> abdominal surgery | <input type="checkbox"/> other: _____ |
|---|--|---------------------------------------|

**Antibiotic Use:**

- |                                 |                                  |   |
|---------------------------------|----------------------------------|---|
| <input type="checkbox"/> recent | <input type="checkbox"/> chronic | <input type="checkbox"/> increased abdominal symptoms after use |
|---------------------------------|----------------------------------|---|

**For Women only:**

- |  |  |                                    |                              |
|--|--|------------------------------------|------------------------------|
| <input type="checkbox"/> pregnancy (current)           | <input type="checkbox"/> endometriosis | <input type="checkbox"/> menopause | <input type="checkbox"/> PMS |
| <input type="checkbox"/> pelvic inflammatory condition | <input type="checkbox"/> other: _____  |                                    |                              |

**For Men only:**

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> prostate problem | <input type="checkbox"/> sexual dysfunction | <input type="checkbox"/> other: _____ |
|---|---|---------------------------------------|

**Jaw conditions:**

- |                                   |   |                                     |   |
|-----------------------------------|---|-------------------------------------|---|
| <input type="checkbox"/> jaw pain | <input type="checkbox"/> jaw locking (open or closed) | <input type="checkbox"/> jaw noises | <input type="checkbox"/> oral surgeries |
| <input type="checkbox"/> braces   |   |                                     |   |

**Family History:**

- |  |  |                                    |
|--|--|------------------------------------|
| <u>Parent:</u>                         | <u>Sibling (brother or sister):</u>    | <u>Abuse:</u>                      |
| <input type="checkbox"/> cancer        | <input type="checkbox"/> cancer        | <input type="checkbox"/> physical  |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> heart disease | <input type="checkbox"/> emotional |
| <input type="checkbox"/> arthritis     | <input type="checkbox"/> arthritis     | <input type="checkbox"/> sexual    |
| <input type="checkbox"/> other: _____  | <input type="checkbox"/> other: _____  |                                    |

**Number of Children:** \_\_\_\_\_

- |                                  |                                     |                                    |                                 |
|----------------------------------|-------------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> infants | <input type="checkbox"/> youngsters | <input type="checkbox"/> teenagers | <input type="checkbox"/> adults |
|----------------------------------|-------------------------------------|------------------------------------|---------------------------------|

**Recreational activities/exposures:**

- |   |  |                                  |   |
|---|--|----------------------------------|---|
| <input type="checkbox"/> dancing        | <input type="checkbox"/> walking       | <input type="checkbox"/> running | <input type="checkbox"/> aerobics class |
| <input type="checkbox"/> weight lifting | <input type="checkbox"/> swimming      | <input type="checkbox"/> skiing  | <input type="checkbox"/> skating        |
| <input type="checkbox"/> biking         | <input type="checkbox"/> sports: _____ |                                  |   |

**Supplements/Vitamins:**

**What for:**


## Medical Authorization

I, the undersigned, as patient (or as parent or guardian of the patient), so hereby authorize the attending physician/practitioner to medically manage the treatment of the afore named patient and to provide such medical treatment, which, in the physician/practitioners judgment is deemed necessary for the benefit of the patient. And further, I authorize Dr. Guthrie to contact my other healthcare providers regarding issues of care related to safety or continuity.

It should be understood that any nutritional protocols given by Dr. Guthrie are considered valid for only two months and follow-up consultations are strongly advised.

If a serious problem should arise and Dr. Guthrie is not available please call 911 or go to the emergency room immediately.

Risks:

In our experience, the most effective treatment for spinal joint dysfunction involves manipulation of spinal joints. Specifically, manipulation can reduce pain, tenderness, and muscles spasm, and can improve the mobility of your spine, as well as many other beneficial effects.

As with all other forms of treatment, manipulation of the spinal joints may have some unwanted side effects of which you should be made aware. Some patients will experience discomfort after a manipulation, usually a mild soreness lasting for a day. In the very rare instance (from one in one million to one in ten million) serious neurological damage may occur as a result of this type of treatment.

Here at Dr. Guthrie's office we take every precaution in our diagnosis and treatment to minimize the chance of any such unfortunate occurrences. Although we offer spinal manipulation with the utmost confidence in its proven benefits, you have the choice to decide not to have this type of treatment. There are other forms of treatment available to you here, including soft tissue, nutritional & electrical therapies, among others.

\_\_\_\_\_  
Patient Signature (or Guardian)  
**(Note: if minor then parent or guardian must sign.)**

\_\_\_\_\_  
Date

## Financial Policy

Please understand, we cannot guarantee that your insurance plan covers any of the procedures or products we offer, so we expect you to be familiar with your policy provisions and to make informed decisions about the procedures you elect. We ask that you pay your copay and for all products at the time of service. A full list of prices\* for all products and services is available upon request. As a courtesy to our patients we bill your insurance company for you. If our office has not received payment or a denial within 45 days of the date of service the charges will be made your responsibility and it will be your responsibility to contact your insurance company in regards to payment. If your insurance company (for any reason) reduces or denies payment, we will bill you for the unpaid balance.

We expect payment in full for all services and products provided. We bill every two weeks and charge a \$10 rebilling fee on any unpaid balance. In some unusual cases if you are unable to pay your balance in full we may be able to set-up a monthly payment schedule. Please contact us immediately if this becomes necessary.

There will be a **\$40 fee** for missed appointments or appointments cancelled with less than 24 hours notice. This charge is for each scheduled provider/service. Any outstanding fees must be paid before your next visit. (If you are more than 15 minutes late, your appointment is considered missed.)

**Financial Agreement:** I agree that in consideration of the medical services rendered, I hereby individually obligate myself to pay the account in full to Guthrie Chiropractic & Massage.

**Assignment of Insurance Benefits:** I hereby authorize payment directly to Guthrie Chiropractic & Massage of the group or personal benefits or any other insurance benefits otherwise payable to me, for medical services rendered by the office.

**Patient Certification, Authorization to release Medical Information:** I authorize Guthrie Chiropractic & Massage to release any medical information that may be necessary to request claim reimbursement from insurance companies to whom claims have been submitted.

**Collection fees:** I agree that if payment on this account is not made in accordance with the above mentioned terms, I will pay reasonable attorney's fees and other costs incurred for collection.

I certify that I have read and understand the above policies, and I am the patient, or am duly authorized to execute the above agreement and accept its terms.

\_\_\_\_\_  
Patient Signature (or Guardian)  
**(Note: if minor then parent or guardian must sign.)**

\_\_\_\_\_  
Date

Thank you for the trust you have placed in us.

Guthrie Chiropractic & Massage  
235 W. 10<sup>th</sup> Avenue, Eugene, OR 97401  
Ph: (541) 683-9069 Fax: (541) 431-7001

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

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{Please Print Name}

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{Signature}

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{Date}

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_

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Staff Signature

Date