

PATIENT REGISTRATION AND HISTORY

Complete ALL portions of this form. Please Print Clearly.

**IF THIS VISIT IS DUE TO A RECENT MOTOR VEHICLE COLLISION OR WORK INJURY,
***** PLEASE STOP HERE AND NOTIFY RECEPTION. *******

Purpose of this appointment _____

How did you hear about us? Live nearby Phone Book Internet Promotion other _____
 Referred by _____

Patient Information

Patient's Name _____ **Today's Date** _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Age _____ Birth Date _____ Male Female e-mail _____

Marital Status: Single Married Widowed Sep Div Ages of Children _____, _____, _____, _____

Occupation _____ Work # _____ ext _____

Employer _____ How long? _____ SS # _____

Full Time Part Time Hours/week _____ Driver's License # _____

Spouse's Name _____

Occupation _____ Work # _____ ext _____

Employer _____ Cell Phone _____

Person to contact in case of emergency other than the above Home Phone _____

Relationship _____ Work Phone _____

The patient is a minor and I am his/her legal guardian. Permission is herewith given by me to the practitioners of this clinic, and whomever they may designate, to examine and render care to the above named patient.

_____ Print Name

_____ Relationship

_____ Signature

_____ Date

Method of Payment

Who is responsible for this account? _____ Method: Insurance Personal Payment

Name of Insured _____ Relationship to patient: _____

Name of Primary Insurance Co _____ Plan Name: _____

Billing Address _____ Policy/Group # _____

City _____ State _____ Zip _____ Insured's ID #: _____

Phone _____ ext _____ Effective Date of Insurance: ____/____/____

Insured's Employer: _____ Insured's Birth date: ____/____/____

Name of Secondary Insurance Co _____ Plan Name: _____

Name of Insured _____ Policy/Group # _____

List other sources of insurance: (union, school, etc.) _____

Clinic Policy Requires that Payment Arrangements be Made on the First Visit

GENERAL REPRESENTATION AND AGREEMENT

By my signature below, I herewith represent and certify that:

- (1) I am requesting that consultation, examination and treatment be provided to me by Dr. D. James Aungst for valid health concerns. (The use of "Dr. Aungst" herein includes Dr. Aungst, his business entities and/or any of his/its employees, associates or affiliates.)
- (2) The symptoms, complaints, conditions and health history that I have provided on my intake forms, and will provide verbally and/or on any subsequent forms, are and will be true, accurate and complete according to my best beliefs.
- (3) Dr. Aungst can rely upon said representations to provide appropriate care and to submit appropriate and accurate insurance claims, medical reports and billings for services rendered on my behalf.
- (4) I am in no way involved in or attempting to file, or have Dr. Aungst file or be involved in, a fraudulent claim against an insurance company, business or individual.
- (5) I am not personally, nor am I an agent or employee of any group or agency, desiring or intending to investigate, entrap or take advantage of Dr. Aungst for any purpose. I am not representing other interests and have presented myself only in order to receive treatment for legitimate health reasons.
- (6) I am personally and legally liable for any suits, judgments or legal proceedings, including legal fees, which are brought against Dr. Aungst as a result of any false, misleading or incomplete statements or information provided, now or in the future.
- (7) In the event I have a dispute with Dr. Aungst about the quality of service or any aspect of my dealings with Dr. Aungst, I agree that such dispute shall be submitted to arbitration, according to Title 3, Sections 36.310 et seq of the Remedial Code, Oregon Rules of Civil Procedure, before an arbitrator to be selected by Dr. Aungst. Arbitration shall occur in Multnomah County, Oregon, may be compelled by petition of either party to the court, and any award resulting from such arbitration shall become binding on the parties upon confirmation by the court. This arbitration clause shall not prevent Dr. Aungst from taking any action in any court to collect a debt owed by the undersigned. In the event of arbitration and/or litigation, the prevailing party shall recover reasonable attorney fees from the adverse party.

UNDERSTANDING AND AGREEMENT:

I understand that I am personally responsible for the payment of all services and material items provided on my behalf regardless of insurance or third party payment arrangements, that insurance coverage is an agreement between myself and the insurance company and that payment for services rendered (including costs for material items and insurance or attorney reports and correspondence) is between myself and Dr. Aungst. As such, I understand that I am ultimately responsible for payment of all services rendered on my behalf should my insurance company fail to pay Dr. Aungst, or my attorney fail to release payment in full for all such services.

I authorize and direct my insurance company and/or attorney to make payment directly to Dr. Aungst for services rendered and permit Dr. Aungst to endorse co-issued remittances for the conveyance of credit to my account. I understand that any amount paid to Dr. Aungst will be credited to my account upon receipt.

I herewith authorize the release of any information to my attorney, insurance company and/or claim representative that will assist in the payment of my claim and/or charges, and state that my signature below will serve as that authorization needed for computer generated and/or electronic billings.

I hereby state and agree that a photocopy or faxed copy of this document will be deemed as valid and binding as the original copy on all parties involved.

I agree to pay a finance charge in the amount of 1.5% per month on any unpaid balance beginning 30 days following the last date of service and/or product purchase.

Patient's Printed Name

Date

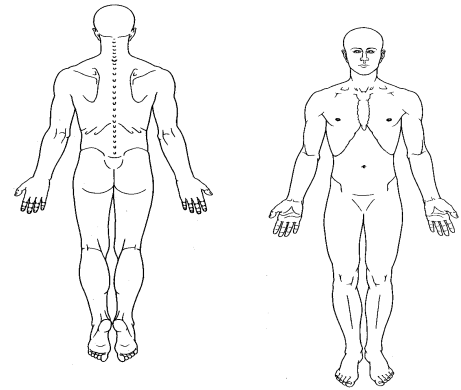
Patient's Signature / Responsible Party

Witness

List your health concerns in order of importance:

Please draw in areas of complaint

Symptom	Rate Severity 1 to 10	Date of Onset
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____



History of primary complaint:

Describe what #1 is like (sharp, dull, shooting, tingling, numb, etc.):

Did this result from a recent or previous injury or trauma? _____

If not, how do you think this came about? _____

Have you had this or a similar problem before? Y N If yes, when was the very first time? _____

Is this condition getting worse? Yes No Staying the same Comes and goes Worse in AM PM

Does it travel from one area to another? Yes No Describe _____

What initiates it? _____ What makes it worse? _____

What percent of the time does it bother? ____ % How long does it last at a given time? _____

Does it affect your: Work Sleep Daily Routine Relationships Recreation Other _____

Are you able to obtain any relief on your own? Yes No By what means? _____

Have you been treated by another for this condition? Yes No Date Last Treated _____

If yes, name of doctor/health care facility: _____

What was done? Medication Surgery Chiropractic Physical Therapy Other _____

Duration of care _____ Frequency of care _____ Results: Good Fair Poor

Is there any family history of this? Mother Father Sister Brother Children

Activities and Lifestyle:

Work activity: Mainly Sitting Mainly Standing/Walking Light Labor Heavy Labor _____

Regular exercise: None Light Moderate Heavy ____ times weekly

Rest: Do you wake up refreshed? Yes No In what sleep position do you typically wake up? Back Side Stomach

Coffee/Caffeine consumption: Never Not for ____ years ____ cups per day

Alcohol consumption: Never Not for ____ years ____ drinks per day/week

Tobacco consumption: Never Not for ____ years ____ packs per day For how long? _____

Do you consume just water? Yes No ____ glasses/day How many bowel movements each day? _____

Are you on any particular diet? Yes No Describe _____

What vitamins/minerals/herbs do you take? _____

Current medications (including non-prescription):

Name of Medication	Reason for taking	When you began taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any known allergies / sensitivities _____

Past Injuries and Surgeries:

Description	Dates
Sports / Work / Auto Accidents _____	_____
Falls _____	_____
Head Injuries _____	_____
Fractures / Dislocations _____	_____
Surgeries _____	_____

Your Health History (circle “C” if the problem is a **current** one and “P” if you’ve only had it in the **past**)

<u>General</u>	<u>Muscles & Joints</u>	<u>Eyes, Ears, Nose & Throat</u>	<u>Gastrointestinal</u>
C P Anemia	C P Arthritis	C P Hearing Loss	C P Colon Problems
C P Allergy shots	C P Bursitis	C P Ear-ache / pain	C P Constipation
C P Convulsions .	C P Neck Pain / Stiffness .	C P Cataracts / Glaucoma	C P Diarrhea
C P Dizziness .	C P Shoulder Pain	C P Failing Vision	C P Gall Bladder
C P Fainting .	C P Mid-back Pain	C P Nosebleeds	C P Hemorrhoids
C P Fatigue .	C P Low Back Pain / Stiff	C P Sinus Infections	C P Hernia
C P Headaches .	C P Spinal Curvature	C P Strep Throat	C P Liver Problems
C P Migraines .	C P Herniated Disc	C P Thyroid Problems	C P Nausea / Vomiting
C P Sudden Weight Loss	C P Osteoporosis	C P Goiter	C P Poor Digestion
<u>Respiratory</u>	<u>Pain or Numbness in:</u>	<u>Skin Problems</u>	<u>Other</u>
C P Asthma	C P Head / Face / Throat .	C P Acne	C P Cancer / Malignancy
C P Bronchitis	C P Shoulders / Arms	C P Bleeding Disorders	C P Diabetes .
C P Chest Pain	C P Elbows / Hands	C P Bruise Easily	C P Chemical Dependency
C P Chronic Cough	C P Fingers / Toes	C P Allergic Reactions	C P Chicken Pox
C P Emphysema	C P Hips / Legs / Knees	C P Skin Rash or Hives	C P Measles
C P Spitting up Blood	C P Ankles / Feet	C P Surface Scars	C P Mononucleosis
C P Pneumonia or TB	C P Prosthesis	C P Deep Scars	C P Mumps
			C P Polio
<u>Cardio-Vascular</u>	<u>Genito-Urinary</u>	<u>Neurological</u>	C P Rheumatic Fever
C P Heart Disease .	C P Bedwetting	C P Alcoholism	C P Scarlet Fever
C P High B/P .	C P Frequent Urination	C P Alzheimer’s	C P Typhoid Fever
C P Low B/P	C P Painful Urination	C P Epilepsy	C P Whooping Cough
C P Rapid Heart Beat	C P Gout	C P Parkinson’s	C P Multiple Sclerosis
C P Slow Heart Beat	C P Kidney Infection	C P Seizures	C P Sexual Transmitted Disease
C P Arrhythmia .	C P Kidney Stones	C P Stroke .	C P HIV Positive
C P High Cholesterol .	C P Prostate Trouble	C P Trouble Sleeping	C P Psychiatric Care
C P Pacemaker	C P Swelling of Ankles	C P Unable to Relax	C P Tumors / Growths / Cysts

For Women Only

C P Cramps or Backache w/cycle	C P Pain with intercourse	C P Facial Hair / Thinning Hair
C P Irregular Cycle Length	C P Unable to Conceive	C P Breast Implants
C P Scanty or Excess Flow	C P Miscarriage(s)	C P Hysterectomy
C P Breast or Ovarian Cysts	C P Pelvic Inflammatory Disease	C P Use of the “Pill” or IUD
	C P PMS / Painful Menstruation	C P Menopausal

Are you pregnant at this time? Yes No Possibly Date last cycle started _____

Your Family History (some health problems result from familial tendencies)

Family Member	Illnesses	Current Age (or) age at death	Cause of Death or N/A
Mother _____	_____	_____	_____
Father _____	_____	_____	_____
Sister(s) _____	_____	_____	_____
Brother(s) _____	_____	_____	_____

<p>Have you had chiropractic care before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was your experience: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p>Duration of care _____ Frequency of care _____ Preferred style? <input type="checkbox"/> Manipulation <input type="checkbox"/> Low force</p>
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Signature of Patient / Legal Guardian _____

Date _____