

Colling Chiropractic

Kevin Colling D.C., FAFS / 6018 SE Stark St. / Ste. 103 / Portland / OR / 97215
(503) 808-9145

Hello and Welcome to our office!

We value our time with each patient and in order to maximize your time with Dr. Colling we have sent these forms in advance of your visit. These forms are very important to the thorough care that Dr. Colling gives each and every patient. Although there are a lot of pages to complete, these questions are focused on meeting federal and state requirements, so please print clearly. Generally, it takes about 20 minutes to complete these forms. If you arrive for your appointment and your forms are not filled out completely, you will be required to finish them before Dr. Colling can begin your visit.

Thank you. We look forward to your visit. ☺

PATIENT INTRODUCTION-INSURANCE

Today's Date: _____

Last Name:		MI:	First Name:	
Home Address:		City:	State:	Zip:
Date Birth:	Age:	Tel. Home:	Tel. Work:	
Height:	Weight:	Cell Number:		
Employer's Name:		Email:		
Occupation:		Marital Status (Circle): Single, Married, Domestic Partner, Divorced, Widowed		

MEDICAL INSURANCE INFORMATION

Does your insurance plan cover Chiropractic treatment?	<input type="checkbox"/> Yes, <input type="checkbox"/> No If yes, we need a copy of the card
If yes, indicate Insurance Company Name (Need copy of card).	Insurance Name: _____ Address: _____ Telephone: _____
Are you the insured person or dependent (wife/husband/child)?	<input type="checkbox"/> Insured, <input type="checkbox"/> Dependent
If you are the insured person's dependent (spouse or child), we need the insured person's name, date of birth, social security number, and the company/business name of the insured employer in order to do billing.	Name of Insured Person: _____ Insured Date of Birth: _____ Name of Insured Employer: _____
What is your co-payment amount for each visit?	Amount: \$ _____ Percentage: % _____
Do you have a health insurance deductible for chiropractic?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Have you met deductible yet? What is your deductible \$ _____
If known, what are your chiropractic health insurance benefits annually?	Number visits per year # _____. Amount per year: \$ _____

Name and Telephone Number of your nearest adult emergency contact _____

OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES FOR AS A COURTESY. HOWEVER, IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT AND/OR DEDUCTIBLE FOR REGULAR HEALTH INSURANCE PATIENTS. PLEASE SIGN BELOW.

Patient Signature and Date	I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my medical insurance carrier.
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The 1996 Health Insurance Portability and Accountability Act (HIPAA) requires that all health care providers comply with patient privacy and security laws (45 CFR 160, 164). Patient confidentiality and privacy/security applies to any **protected health information (PHI)**. This notice explains how a patient's protected health information (PHI) may be used and what said office's responsibilities are regarding my privacy rights and protected health information. Indicate whether you are the parent or a legal guardian of the patient or minor. If you want to discuss anything privately that you do not want to be overheard by other persons in the doctor's office, please inform the staff before you see the doctor so a private room can be arranged. Please sign and date below.

Patient Signature and Date	By signing this form, I acknowledge that this office has presented me with a copy of their HIPAA privacy practices and I have been able to read the practice policies notice that is posted in Dr. Colling's office.
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LEGAL GUARDIAN/PARENT NAME/RELATIONSHIP: _____

Kevin Colling, DC, 6018 SE Stark St, Ste., 103, Portland, OR 97215

GENERAL HEALTH HISTORY (Page 1)

DESCRIBE THE REASON(S) WHY YOU HAVE COME TO OUR OFFICE (Symptoms/Injury)

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
<input type="checkbox"/>	History of poor healing or told that you have a healing disorder?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Smoke cigarettes or use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes, hypoglycemia, thyroid, kidney, liver disease, or other endocrine disorder?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart attack, heart disease or have a heart pacemaker or neck or chest shunt?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of any disease such as AIDS, Tuberculosis, ALS, Meningitis, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have problems with dizziness, blacking out, balance, fainting, or tripping?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy-Seizure-Convulsion history or any other neurological disease?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of multiple sclerosis, lupus, psoriasis, paralysis, or disease affecting nerves?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer history or cancer treatment or surgery of any type?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke history (Indicate any suspected mild strokes or transient ischemic attacks)?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have you ever been hospitalized? Why/When:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hypertension or high blood pressure? If yes, name of MD seeing:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Autoimmune disease, digestive or intestinal disease, or respiratory diseases, etc?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have any type of chest or breast implants presently (males & females)?	N/A	<input type="checkbox"/>
<input type="checkbox"/>	Women only: Check box to left if there any chance that you are currently pregnant		<input type="checkbox"/>

If you checked yes, please describe:

No, Yes **Do you have an infection, cold, virus, or other recent illness? Describe:** _____

HAVE YOU HAD PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN?

NO. (Check box if you have no prior history of previous injury or pain) If yes, please describe below:

HAVE YOU HAD FRACTURES/BROKEN BONES IN THE PAST?

NO. (Check box if you have never had any broken bones in the past). If yes, please describe below:

HAVE YOU HAD ANY PREVIOUS SURGERIES?

NO. (Check box if you never had any surgical procedure). If yes (including silicone implants, cancer, spine, herniated discs, genetic conditions, ports in the chest/abdomen), please describe type and when:

Patient Name:	Doctor's Name: Kevin Colling, DC, FAFS
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GENERAL HEALTH HISTORY (Page 2)

No, Yes **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, rheumatoid arthritis, other forms of joint or spine arthritis, herniated discs in the spine, spinal cord disease, brain disease, nerve disease, blood vessel aneurysms, or other diseases?

If yes, please describe:

No, Yes **Have you ever been to a Chiropractor before for any condition?**

If yes, Chiropractor's Name/City : _____ Year: _____

List Problem(s) that the Chiropractor treated you for: _____

Indicate when you have your last physical examination by a medical doctor and please indicate his/her name?

Doctor:
Date:

No, Yes **Do you have any problems laying face down on an examination table** (tender breasts, chest or breast surgical implants, ports, etc)? If yes, why: _____

MEDICATION HISTORY (PRESCRIBED AND OVER-THE-COUNTER)

No, Yes **Are you taking any medications currently?** In yes, list all medications that you are taking:

No, Yes. **Have you taken any pain medications today? If yes, describe:** _____

FOOD OR MEDICATION ALLERGY HISTORY

No, Yes . Do you have allergies to any medications, foods, shellfish, seafood, etc? If yes, List:

DESCRIBE YOUR TYPICAL EXERCISE ROUTINE CURRENTLY

Describe what types of exercise you perform:

How often to do you regularly exercise?

SYMPTOM OR COMPLAINT ONSET

Suddenly, Gradually. Check box indicating if your current symptoms developed gradually or suddenly.

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

- | | | |
|--|--|--|
| <input type="checkbox"/> Excessive fatigue-malaise | <input type="checkbox"/> Bowel or bladder disorders | <input type="checkbox"/> Night pain or night time sweats |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Ovarian pain | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Low grade fever | <input type="checkbox"/> Kidney pain/painful urination | <input type="checkbox"/> Balance problems |

YES NO SLEEPING PATTERNS

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you sleep poorly at night? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you sleep on your stomach? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you consistently feel extremely tired when you wake up in the morning? |

Patient Name:

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NECK, BACK, SACRUM, PELVIS PAIN AND/OR INJURY HISTORY (Page 3)

Please print clearly. Check all boxes that apply to you and describe your "YES" responses. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.

YES NO GENERAL SPINE HISTORY (HEAD, NECK, BACK, SACRUM, AND PELVIS)

<input type="checkbox"/>	<input type="checkbox"/>	Have you been told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae?
<input type="checkbox"/>	<input type="checkbox"/>	Told that you have a bulging/herniated disc or disc degeneration in the spine?
<input type="checkbox"/>	<input type="checkbox"/>	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis in your spine or joints?
<input type="checkbox"/>	<input type="checkbox"/>	Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a previous head injury in the past (e.g., blow or fall)?
<input type="checkbox"/>	<input type="checkbox"/>	Have you injured your neck, back, sacrum or pelvis in the past?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an injection into your discs or spine (facet joints) in your back, sacrum or neck?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a stomach, intestinal, digestive, malabsorption disorder (wheat allergy, etc.), muscle disease, prostate, ovarian, or uterine problem, condition or disease that could be affecting your back?

If yes, describe and provide dates:

NECK PAIN AND/OR INJURY HISTORY

Location of your pain (left, right, middle, both sides):	
When did your neck pain begin and/or injury occur?	Date required:
Describe how or why your pain began(mechanism): Describe any neck injury (what happened):	
Describe all aggravating physical activities/motions: (What makes your neck or referring arm pain worse)	
Describe any relieving physical activities: (What activities lessen your neck/arm symptoms)	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, numbness, tingling, stiff, etc):	
Describe any symptoms that originate from your neck that radiate to your head/shoulders/arms/hands?	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your neck before?	

YES NO NECK REGION HISTORY CONTINUED

<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy when you look up or twist your head? If yes, how often:
<input type="checkbox"/>	<input type="checkbox"/>	Do you black out, lose your balance or get a headache when you look up or twist your head?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel your neck pain sends pain downwards between your shoulders or to the front of your chest?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a new type of headache or an unusually severe headache recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed your head leaning or tilting to one side recently?

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THORACIC, LUMBAR, SACRUM, PELVIS REGION HISTORY (Page 4)

Location of your pain (left, right, middle, both sides):	
When did your pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism): Describe any injury (what happened):	
Describe all aggravating physical activities/motions: (What makes your back or referring leg pain worse)	
Describe any relieving physical activities: (What activities lessen your back or leg symptoms)	
Describe any symptoms that originate from your back that radiate to your chest, hips, legs, or feet?	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, numbness, tingling, stiff, etc):	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your back before?	

YES NO THORACIC AND BACK REGION HISTORY CONTINUED

<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain that shoots or radiates outward along your rib cage?
<input type="checkbox"/>	<input type="checkbox"/>	Does your middle back or chest wall pain intensify when you take in a deep breath or cough?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a tight band-like feeling sometimes around your chest?
<input type="checkbox"/>	<input type="checkbox"/>	Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
<input type="checkbox"/>	<input type="checkbox"/>	When you move your neck around, does your middle back pain or chest pain increase?
<input type="checkbox"/>	<input type="checkbox"/>	When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get worse?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distances that is relieved by resting or sitting down? This pain resumes after walking for same distance.
<input type="checkbox"/>	<input type="checkbox"/>	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at night or while sitting.
<input type="checkbox"/>	<input type="checkbox"/>	Does either leg or foot drag on the floor when you walk?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a lot of leg cramps at night recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you recently had any urinary or bowel incontinence or had difficulty urinating?
<input type="checkbox"/>	<input type="checkbox"/>	Do your feet feel cold recently? If yes, indicate which foot or if both feet:
<input type="checkbox"/>	<input type="checkbox"/>	Have you recently noticed that either of your legs occasionally gives out on you when you walk?
<input type="checkbox"/>	<input type="checkbox"/>	Does one or both of your legs feel weak recently?
<input type="checkbox"/>	<input type="checkbox"/>	Has your anal-rectal region been completely numb?

Please print clearly

If yes, describe and indicate dates:

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Form 1010

EXTREMITY PAIN OR INJURY QUESTIONNAIRE

Please answer the following sections that apply to you. If some of the questions are unclear to you, skip ahead to the next question. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.

SHOULDER, ARM, ELBOW, WRIST AND HAND REGION

Location of your pain (left, right, middle, front, back):	
When did your pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism): Describe any injury (what happened):	
Describe all aggravating physical activities/motions: (What makes your shoulder-arm symptoms worse)	
Describe any relieving physical activities: (What lessens your shoulder-arm pain-symptoms)	
If present, describe which fingers or part of your hand you have any pain, numbness, or tingling?	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, numbness, tingling, stiff, etc):	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your shoulder, arm, or hands before?	

HIP, LEG, KNEE, ANKLE AND FOOT REGION

Location of your pain (left, right, middle, front, back):	
When did your pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism): Describe any injury (what happened):	
Describe all aggravating physical activities/motions: (What makes your hip-leg pain-symptoms worse)	
Describe any relieving physical activities: (What lessens your hip-leg symptoms-pain)	
If present, describe which toes or part of your foot you have any pain, numbness, or tingling?	
Describe how your symptoms feel (examples: dull, sharp, ache, numbness/tingling, stiff, etc):	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your hip, leg, knee, ankle, and foot before?	

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