

Please check all that apply. Do you have any of the following? (Avg. time to complete: 30 seconds)

- yes no Diabetes
 Would you like to get rid of your diabetes? yes no
- yes no Sleep Apnea and/or CPAP machine
 Would you like to get rid of your Sleep Apnea? yes no
- yes no Fibromyalgia
 Would you like to get rid of your Fibromyalgia? yes no
- yes no I.B.S. (Or other digestive issues, GERD, constipation, etc)
 Would you like to get rid of your IBS? yes no
- yes no Neuropathy (or Peripheral Neuropathy)
 Would you like to get rid of your Neuropathy? yes no
- yes no High Blood Pressure
 Would you like to get rid of your High Blood Pressure? yes no
- yes no Overweight
 Would you like to be your ideal weight? yes no
- yes no Arthritis
 Would you like to get rid of your Arthritis? yes no
- yes no Pain- either neck, back and/or headaches
 Would you like to get rid of your pain? yes no
- yes no Thyroid issues (hypo/hyperthyroidism or Hashimoto's)
 Would you like to get rid of your pain? yes no
- yes no Other Concerns: _____
 Would you like to get rid of this concern? yes no

Would you like information on the items you marked "yes" on above? yes no

Would you like a consultation on how to get rid of the item(s) you checked yes so you can reduce or eliminate the need for drugs/surgery? yes no

Phone Number: _____

Email (please print clearly) _____

Staff use only:	Initials
Clarified request with patient:	_____
Emailed/delivered requested information:	_____
Scheduled (yes/no)	_____
Patient Case Type	_____

MEDICAL HISTORY

Patient Name: _____ DOB _____ Date: _____
 Phone #: _____ May we leave confidential voicemails at this number? Y / N Sex: Male Female
 How did you hear about us? _____ Current Job/Occupation: _____
 Reason for today's visit: _____ Emergency Contact: _____ Phone: _____
 Marital Status: _____ Have you ever received medical treatment under a different last name? Y / N If yes, list name: _____

PAST MEDICAL HISTORY: Have you had any of the following conditions?

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Brain or Nerve Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Blood Clots or Phlebitis | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Heart Disease/Problems | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Cholesterol Problems | <input type="checkbox"/> Kidney Disease/Stones | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Abnormal Skin Test | <input type="checkbox"/> Acid Reflux or Hiatal Hernia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Environmental Allergies | <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> Other: _____ |

LIST ALL CURRENT MEDICATIONS (Including non-prescription and vitamins)

Name	Dosage	Route	Frequency

LIST ALL MEDICATION ALLERGIES (Including reaction): _____

LIST ALL HOSPITALIZATIONS FOR MAJOR ILLNESSES OR SURGERIES:

Date	Operation/Hospitalization	Complications

Date	Severe Accidents and Injuries

FAMILY HISTORY:

Age at death	Age if alive	General Health; Major health problems:
Mother _____	_____	_____
Father _____	_____	_____
Sibling _____	_____	_____
Sibling _____	_____	_____

FAMILY HISTORY OF ANY OF THE BELOW CONDITIONS: (Check any boxes that apply)

- | | | | | | |
|--|-----------------------------------|---|---------------------------------------|---------------------------------|-------------------------------------|
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Cancer | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> TB | <input type="checkbox"/> Alcoholism |

SOCIAL HISTORY:

Alcohol use: # of drinks per day: _____ What age did you start drinking? _____ Year Quit: _____
 Tobacco use: Type: _____ # Per day: _____ What age did you start? _____ Year Quit : _____
 Coffee use: # of drinks per day: _____ Energy Drink use: # of drinks per day: _____ History of Drug abuse: Yes / No

 Flu Vaccine Y N Date: _____ Typical breakfast: _____
 Tetanus Booster Y N Date: _____ Typical lunch: _____
 Pneumonia Y N Date: _____ Typical dinner: _____
 Hepatitis B Y N Date: _____ Typical snacks: _____
 How often do you exercise? _____
 Date of last colonoscopy: _____ What is your workout? _____

Patient Name: _____

REVIEW OF SYMPTOMS: (Please check each item “yes” or “no” as they relate to your health)

CONSTITUTIONAL:	Yes	No	RESPIRATORY:	Yes	No	HEMATOLOGY/LYMPH:	Yes	No
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	Gums bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>
			Chills	<input type="checkbox"/>	<input type="checkbox"/>			
EYES:			GASTROINTESTINAL			MUSCULOSKELETAL:		
Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Change in BM's	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
EAR, NOSE, THROAT:			Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	SKIN:		
Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Rash/Sores	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Black or bloody BM	<input type="checkbox"/>	<input type="checkbox"/>	Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>				Itching/Burning	<input type="checkbox"/>	<input type="checkbox"/>
Nasal stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY:			NEUROLOGICAL:		
Frequent sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Burning/frequency	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Strength	<input type="checkbox"/>	<input type="checkbox"/>
			Nighttime	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR:			Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Erectile dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal discharge	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Bladder leakage	<input type="checkbox"/>	<input type="checkbox"/>			
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>				FEMALES ONLY:		
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC:			Are you pregnant?	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to become pregnant?	<input type="checkbox"/>	
Difficulty lying flat	<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	Date of last period:	_____	
Swelling ankles	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Date of last pap:	_____	
			Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Last mammogram:	_____	
ENDOCRINE:						Last DEXA scan:	_____	
Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>				Age of onset periods:	_____	
Heat/cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>				Periods Regular?	Yes / No	
PMS	<input type="checkbox"/>	<input type="checkbox"/>				Are you on Replacement Hormones?	Yes / No	
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>						
Decreased sex drive	<input type="checkbox"/>	<input type="checkbox"/>						

How often do you take antibiotics? _____ Less than once a year _____ 2-3 times per year _____ 4 times or more per year/Long course

Patient Signature

Date

Please complete this page if you are receiving any of the following services:

Chiropractic, Physical Therapy, Massage Therapy, Exercise Therapy

Patient Name: _____ DOB _____ Date: _____

Have you had previous chiropractic care? Yes / No If Yes, when?: _____

Current Complaint: _____ How long have you had this condition? _____

Is this condition due to: A work injury? Yes / No An auto accident? Yes / No Other Injury? Yes / No

How did this condition occur? _____

What aggravates this condition? _____ What helps your symptoms? _____

Have you had similar conditions in the past? Yes / No Other Complaints: _____

Other physicians seen for this condition: _____

Any recent illnesses or infections? Yes / No If yes, please explain: _____

Have you been on antibiotics in the last two months? Yes / No Levaquin or Cipro? Yes / No

Any fractures in last 6 months? Yes / No Any joint replacements? Yes / No Any rib injuries? Yes / No

Have you had: any spinal surgeries? Yes / No If yes, please explain: _____

What are the physical demands of your job or hobbies?: _____

How many days per week do you exercise? _____ What type of exercise? _____

Sleep position (most common)? Side ___ Back ___ Stomach ___ Recreational activities? _____

Are you currently pregnant? Yes / No Do you have breast implants? Yes / No Have you had a hysterectomy? Yes / No

Are you on replacement hormones? Yes / No

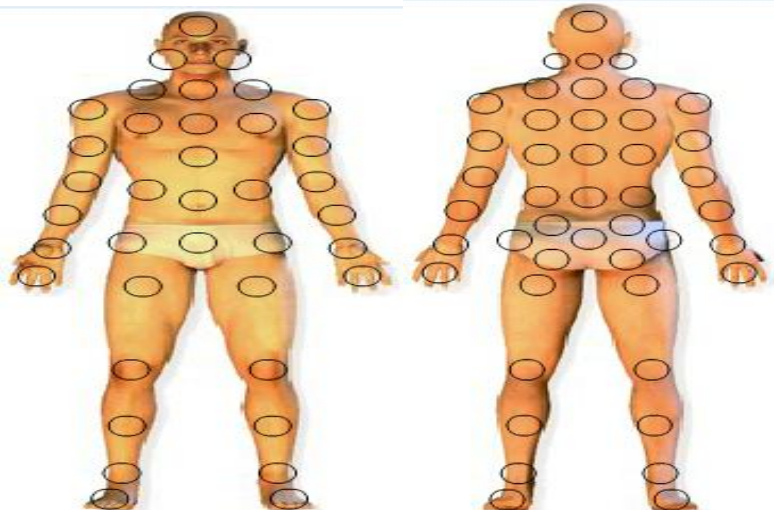
What aspect of your health are you most unhappy with? _____

QUADRUPLE VISUAL ANALOGUE SCALE

No pain	1 – What is your level of discomfort RIGHT NOW?										Worst possible pain	
	0	1	2	3	4	5	6	7	8	9	10	
No pain	2 – What is your TYPICAL or AVERAGE level of discomfort?										Worst possible pain	
	0	1	2	3	4	5	6	7	8	9	10	
No pain	3 – What is your level of discomfort AT ITS BEST (How close to “0” does your pain get)?										Worst possible pain	
	0	1	2	3	4	5	6	7	8	9	10	
No pain	4 – What is your level of discomfort AT ITS WORST (How close to “10” does your pain get)?										Worst possible pain	
	0	1	2	3	4	5	6	7	8	9	10	
Never	5 – What percentage of the time are you in pain)?										Constantly	
	0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	

Please indicate the areas of your pain on the following figures:

Additional information you would like us to know:





PATIENT REGISTRATION

Patient Name: _____ Date of Birth: _____
Last First Middle

ADDRESS: _____

Street # or P.O. Box City State Zip

E-Mail ADDRESS: _____ Social Security#: _____ Marital Status: _____ Sex: _____

Home Phone #: _____ Cell #: _____ Work #: _____

Employer _____ Occupation _____

HAVE YOU EVER RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME? Yes ___ No ___ IF YES, UNDER WHAT NAME? _____

How did you hear about us? _____

GUARANTOR OR CUSTODIAL PARENT (RESPONSIBLE PARTY if different from patient)

Name: _____ Date of Birth: _____ Relationship to Patient: _____
Last First Middle

ADDRESS: _____

Street # or P.O. Box City State Zip

E-Mail ADDRESS: _____ Social Security#: _____ Marital Status: _____ Sex: _____

Home Phone #: _____ Cell #: _____ Work #: _____

Employer _____ Occupation _____

EMERGENCY CONTACT: SPOUSE, PARENT, RELATIVE, CLOSE FRIEND (circle one)

Name: _____ Relationship: _____ Date of Birth: _____
Last First Middle

ADDRESS: _____

Street # or P.O. Box City State Zip

E-Mail ADDRESS: _____ Home Phone #: _____ Cell #: _____

INSURANCE INFORMATION: (Please check all that apply) (PLEASE PRESENT INSURANCE, MEDICARE OR OREGON HEALTH PLAN CARD TO RECEPTIONIST) I HAVE: Medicare _____ OHP _____ Health Insurance _____ No Insurance _____

MEDICARE: ID# _____ PRIMARY CARE PROVIDER _____

OREGEON HEALTH PLAN Yes ___ No ___

PRIMARY HEALTH INSURANCE: _____ Policy# _____ Group# _____

INSURED NAME _____ DOB _____ SEX _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ EMPLOYER ADDRESS _____

SECONDARY HEALTH INSURANCE: : _____ Policy# _____ Group# _____

INSURED NAME _____ DOB _____ SEX _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ EMPLOYER ADDRESS _____

I am receiving medical treatment as a result of an accident Yes ___ No ___ (If yes please complete accident report form)

Motor Vehicle Accident _____ Work Related Accident _____ Other Accident _____

Consent for medical treatment: _____ Date: _____

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to Complete Care for any services rendered. I understand I am financially responsible for all charges whether or not they are covered by insurance. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for services rendered. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

****YOUR EMAIL ADDRESS MAY BE USED FOR ELECTRONIC NEWSLETTERS FOR COMPLETE CARE AND DR THAD GALA, DC****

Signature _____ Date _____

Authorized Signature



FINANCIAL POLICY

Please review and initial each policy listed below.

_____ **Private Pay Primary Care (Self Pay):** I understand that if I do not have health insurance, \$125.00 minimum is due at the time of service.

_____ **Policy Benefits/Non-Covered Charges:** I understand that it is my responsibility to know my insurance policy coverage and benefits and will notify Complete Care of any insurance changes in a timely manner. (Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. Services rendered may be considered non-covered by insurance and/or may be subject to deductible in addition to a copay.) I understand that I have the right to refuse any service before they are rendered if I think that are non-covered services or not payable by my insurance.

_____ **Out-of-Network Insurance Plans:** I understand that full payment is required if I choose to be seen using an out-of-network insurance plan.

_____ **In-Network Insurance Plans:** I understand that I must provide a copy of my current insurance card in order to file an insurance claim. If I do not have my insurance card, self-payment guidelines will apply and \$125 minimum will be collected at the time of service for my primary care visit. I authorize the release of my medical information necessary to process an insurance claim on my behalf. I understand and agree to this financial policy. I request that my medical insurance carrier make any payments to Complete Care for services rendered to me.

_____ **Copayments:** I understand that all copays are due at the time of my appointment and before I see the provider.

_____ **Account Balances:** I understand that if I have a balance on my account I will receive a monthly statement until the account is paid in full. Bills are due and payable upon receipt of this monthly statement. Complete Care will bill my insurance for me if I provide the appropriate billing information. My insurance will make payment directly to Complete Care and I will be responsible for any deductible, co-payments, patient balances or co-insurances.

_____ **Managed Care (Medicaid):** I understand that my insurance coverage is based on funding levels. There are some diagnoses that are considered non-covered and my insurance will not pay for any additional visits for this condition. (We have a payment plan for any patients who would like to schedule follow-up and/or elected procedure for any non-covered conditions. If you are interested in this option please let the provider know and the process will be started. In addition, some of the medications recommended today for treatment may not be covered and can be quite expensive. We will not submit any prior authorizations for these medications.)

_____ **Medicare Patients:** Complete Care is a participating provider with Medicare. Medicare will pay 80% of what they allow, minus your annual deductible. If this has not been met, you will be responsible for the deductible and the 20% of allowable charges. Also, by signing this agreement, you authorize any holder of medical or other information regarding the patient names above to release such information to the Social Security Administration effective from this date.

_____ **Ancillary Services:** I understand that it is my responsibility to know from whom my insurance company requires me to obtain any labs, x-rays, or any other ancillary services. Please let your providers medical staff know so that they may schedule these services accordingly. If your provider orders any tests not processed here at Complete Care they will be sent to an outside reference laboratory. If you have labs processed at more than one facility, you could receive a statement from both Complete Care and the outside laboratory with any out-of-pocket expense as well as two EOB's (explanation of benefits) from your insurance company. Sarah Roberson, FNP is the Clinical Consultant for Complete Care, laboratory and her name will be noted on the EOB as referenced above. It is often necessary to send some laboratory specimens and pathology to outside laboratories. If you have questions regarding charges from one of these services, you will need to contact the outside entity directly.

_____ **Massage Times:** Your massage sessions may last anywhere from a half hour to 2 hours. **Your massage hour will consist of 53 minutes of hands on treatment.** If you are running late to your appointment, your massage appointment may be shortened to assure that our next scheduled massage can start on time. If Complete Care is running behind, you will still receive the full length of the scheduled massage.

_____ **Cancellation and No Show Policy:** I understand that I will be charged a **\$30 Cancellation Fee** if I fail to notify Complete Care of a cancellation at least 1 business day before my scheduled appointment. Your appointment time is reserved for you. In order to better serve our patients we ask that you call our office at least 1 business day prior to your appointment. Please help us to help others.

_____ **Returned Checks:** I understand that personal checks returned for non-sufficient funds may be charged a fee of \$25. Balances must be handled by cash, credit card, or money order.

_____ **Past Due Accounts:** I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter mailed. Please contact us before this if you would like to set up payment arrangements.

_____ **Authorization for Disclosure of Information for Purposes of Service Reimbursement:** I hereby authorize Complete Care to disclose all or part of the medical record of the above patient to any company that may be responsible for payment of all or part of that patient's medical charges. Disclosure of the medical record may be necessary to determine eligibility for benefits and to obtain reimbursement for health care services. I hereby release Complete Care from all legal responsibility or liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing except to the extent that Complete Care has already taken action on my claim.

_____ **On-Call Provider Services:** Please note that after hours call is available for all primary care urgent needs. Please be advised prescription refills will not be addressed after hours and that no opioids or benzodiazepines will be prescribed for urgent needs. Please also be advised that if you choose to utilize our after-hours call service and receive care via the phone by the medical provider, that there will be a \$50.00 fee billed to your account. Thank you for your understanding.



Assignment of Benefits: I give lifetime authorization for payment of insurance benefits to Complete Care for any services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for services rendered. I hereby authorize this health care provider to release all information necessary to secure payment of benefits.

Please understand that the services you elect to participate in denote a financial responsibility on your part and you are ultimately responsible for payment of your bill. If you have any financial questions about your visit, please contact our Billing Department as soon as possible. We accept cash, checks, Visa, MasterCard, Discover, American Express and Care Credit.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept the above policies.

Signature of Patient or Guardian

Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that Complete Care will use and disclose health information about me. I understand that my health information may include information both created and received by Complete Care, 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 Complete Care 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 acknowledge, that at my request, Complete Care will provide me with a Copy of Complete Care’s Notice of Privacy Practices.

Patient/Guardian/Guarantor Signature

Date

Please Print Name

DOB

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- Spouse _____
- Child(ren) _____
- Other _____

Information is not to be released to anyone.

This **Release of information** will remain in effect until terminated by me in writing.

If unable to reach me:

you may leave a detailed message please leave a message asking me to return your call Other: _____

Informed Consent

I understand that health care providers cannot guarantee results of treatment. I know that each person reacts in a different way to treatments and procedures. Therefore, the results cannot be certain. I acknowledge that no guarantee of the outcome of the care I have requested has been made. I have ample opportunity to ask questions, and my questions have been answered to my satisfaction.

Chiropractic Care, Physical Therapy, Osteopathy, Massage Therapy, Nutrition Therapy:

Though chiropractic, physical therapy, osteopathy, massage therapy and nutrition therapy treatments are usually beneficial and rarely cause any problems, I understand that, like many other forms of health care, there are some risks. These can include, but are not limited to; fractures, disc injuries, cerebral-vascular accidents, dislocations and sprain/strains. These complications are extremely rare occurrences.

Initial here to confirm that you have read and understand the Informed Consent.