1296 S Shasta Ave
Eagle Point, OR 97524
761 Golf View
Medford, OR 97504

(Ph) 541.830.4325
(Fx) 541.826.2620
www.CompleteCare.net

(Please Print) (Maiden Name if different)

Name: _____ Date of Birth: _____ Age: _____

Maritial Status: _____ Biological Gender: _____ Preferred Pronoun: _____

Address: _____ City, State, Zip: _____

Parent/Guardian: _____ Parent/Guardian Phone: _____

Cell/Home: _____ Work Phone: _____ Email: _____

Referral: GP / Ortho / Self / Other _____ Due to: Work injury Y / N, Auto accident Y / N
Other _____

Previous PT: _____ Chiropractic: _____

Recent illness/accident: _____ Imaging: x-ray / MRI / Other _____

Recent surgeries: _____

Tobacco: Y / N ____ pack/day, ____ years Alcohol: ____ drinks/week Coffee: Y / N Soda/Energy: Y / N

Job: _____ Recreation: _____

% Time: ____ standing, ____ sitting, ____ moving Days per week: _____

SYMPTOM HISTORY

Symptoms at Onset: _____

_____

Present since (date): _____

Present symptoms: _____

_____

Are symptoms: Improving / Unchanging / Worsening

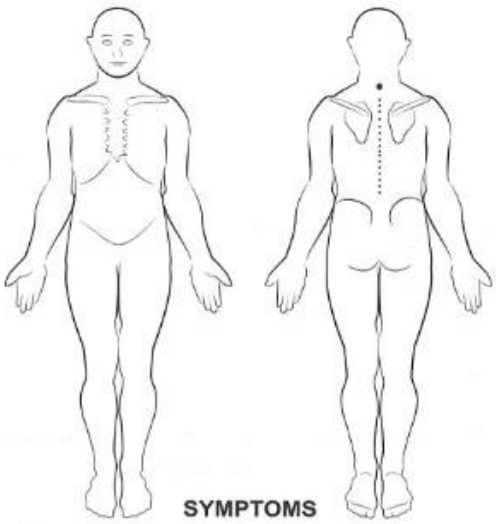
Are symptoms worse at any time of the day: Yes / No

If yes, when: _____

Previous episodes: 0 1-5 6-10 11+

Disturbed sleep: Yes / No Bed: firm / soft / sagging

Sleeping position: back / stomach / R side / L side



oooo Numb
. . . . . Tingling
- - - - Dull ache
xxxx Moderate pain
**** Severe pain

Aggravates your symptoms: ___ at rest ___ sitting ___ standing ___ twisting ___ walking
___ sneezing/coughing ___ working ___ lifting ___when moving ___ when still ___ intercourse

other: _____

Relieves your symptoms: ___ at rest ___ sitting ___ standing ___ lying down ___ walking
___ massage ___ traction ___ heat / ice ___ am / pm ___when moving ___ when still ___ medications

other: _____

Women Only: ___ Pregnant ___ Breast implants ___ Hysterectomy ___ Birth Control ___ Hormone Therapy

_____
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QUADRUPLE VISUAL ANALOGUE SCALE & TIME %

Instructions: (please circle the appropriate number) 0 = no pain/symptoms, 10 = worst possible pain/symptoms

Your level of discomfort RIGHT NOW?	0	1	2	3	4	5	6	7	8	9	10
Your TYPICAL or AVERAGE level of discomfort?	0	1	2	3	4	5	6	7	8	9	10
Your level of discomfort AT ITS BEST?	0	1	2	3	4	5	6	7	8	9	10
Your level of discomfort AT ITS WORST?	0	1	2	3	4	5	6	7	8	9	10
What percentage of the time are you in pain?	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

FAMILY MEDICAL HISTORY

	Age at Death	Age if Alive	General Health; Major Health Issues;
Mother:	_____	_____	_____
Father:	_____	_____	_____
Sibling:	_____	_____	_____
Sibling:	_____	_____	_____

Family History of Any of the Below Conditions (check all that apply)

___ Osteoporosis	___ Diabetes	___ Alcoholism	___ Blood Clots
___ Heart Attack	___ Stroke	___ Cancer	___ TB
___ Thyroid Disease	___ Ulcers	___ Mental Illness	___ High Blood Pressure

PERSONAL MEDICAL HISTORY

("P" = previous, "C" = current)

CONSTITUTIONAL
- P C Fatigue
- P C Weight Gain / Loss
- P C Fever

CARDIOVASCULAR
- P C High or low blood pressure
- P C Shortness of breath
- P C Heart disease
- P C Chest pain or angina pectoris
- P C Palpitations
- P C Feet or ankle swelling

GENITOURNIRAY
- P C Burning or painful urination
- P C Kidney stones
- P C Male: Erectile Dysfunction
- P C Male: Prostate problems

GASTROINTESTINAL
- P C IBS
- P C Abdominal Pain
- P C Nausea or vomiting
- P C Heartburn
- P C Stomach pain
- P C Constipation
- P C Diarrhea

RESPIRATORY
- P C Chronic or frequent cough
- P C Shortness of breath
- P C Asthma
- P C COPD

OTHER
- P C Diabetes
- P C Acne

MUSCULOSKELETAL
- P C Carpal Tunnel Syndrome
- P C Sciatica
- P C Fibromyalgia
- P C Difficulty walking
- P C Muscle pain or cramps
- P C Chronic Fatigue Syndrome

NEUROLOGICAL
- P C Peripheral neuropathy
- P C Freq./recurring headaches
- P C Convulsions or seizures
- P C Tremors
- P C Neurological Disorders
- P C Vertigo/dizziness
- P C Head injury/concussions
- P C Stroke
- P C Poor balance
- P C TIA's – Mini-strokes

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CURRENT MEDICATIONS & SUPPLEMENTS

Allergies: _____

Statins (Yes / No): _____

Any antibiotics within the last 2 months?: Yes / No

Levaquin or Cipro?: Yes / No

Medication	Drug Dose	How Often

ADDITIONAL HOSPITALIZATIONS FOR SURGERY OR MAJOR ILLNESS

(not listed on front page)

Date	Operation/Hospitalization	Complications

ADDITIONAL SEVERE ACCIDENTS

(not listed on front page)

Date	Details

_____

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Patient Information (Please Complete ALL Sections):

Patient Name	Date of Birth

Insurance Information (Please Complete ALL Sections):

Primary Health Insurance Name	Policy #	Group #	
Insured Name	Date of Birth	Sex	Relationship to Patient

Secondary Health Insurance Name	Policy #	Group #	
Insured Name	Date of Birth	Sex	Relationship to Patient

I am receiving treatment as a result of an accident: Yes _____ No _____
If Yes, was it a: Motor Vehicle Accident _____ Work Related Accident _____ Other _____

Please review and *initial next to each* policy listed below.

_____ **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.

_____ **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:**
I acknowledge, that at my request, Complete Care will provide me with a Copy of Complete Care's 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.

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_____ **ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT** I hereby give lifetime authorization for payment of insurance benefits to Complete Care for any services rendered. I will provide a copy of my current insurance card and 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 Complete Care to release all information necessary to secure payment of benefits. 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. I understand that my insurance company may have additional stipulations that may affect my coverage and that I am responsible for any amounts not covered. Services rendered may be considered non-covered by my 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 they are non-covered services or not payable by my insurance.

_____ **COPAYMENTS:** I understand that all copays are due at check-in, prior to seeing my provider.

_____ **PRIVATE PAY (SELF PAY):** I understand that if I will be responsible for all charges related to services provided to me by Complete Care. I agree to pay all balances will be due in full at check-in, prior to my appointment.

_____ **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. I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter is mailed.

_____ **MANAGED CARE (MEDICAID):** I understand that my insurance coverage is based on funding levels. There are some diagnoses and/or services that are considered non-covered and my insurance will not pay for any additional visits for these conditions or services.

_____ **MEDICARE:** 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. 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 and I will let my providers medical staff know so that they may schedule these services accordingly. If my provider orders any tests, imaging or services not processed here at Complete Care, they will be sent to an outside provider. 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. If you have questions regarding charges from one of these services, you will need to contact the outside entity directly.

_____ **CANCELLATION AND NO SHOW POLICY:** I understand that if I fail to notify Complete Care of a cancelation or reschedule at least 1 business day before my scheduled appointment, for any reason, it will be recorded as a "same day" cancellation. If I have more than 3 same-day cancellations per 12-month period I understand that I may be dismissed from care. To reschedule with a massage therapist after dismissal, a $150 non-refundable fee will be required prior to re-establishing care.

_____ **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.

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

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Authorization to Verbally Discuss Protected Health Information

Patient Name	Date of Birth

Complete Care has my permission to discuss the information I have marked below with the following people:

1. Name: _____
   Phone: _____
   Relationship to Patient: _____

2. Name: _____
   Phone: _____
   Relationship to Patient: _____

3. Name: _____
   Phone: _____
   Relationship to Patient: _____

The following information may be verbally shared with the people listed above:
(This form does not authorize releasing copies of my records.)

- ☐ Scheduling/Appointment Times and Dates
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plans
- ☐ Lab/Imaging/other test results
- ☐ Billing and Payment Information
- ☐ Other: _____

I understand that I have the right to revoke my permission at any time, and that these permissions remain in effect until the time I revoke in writing.

_____
Printed Name of Patient of Authorized Representative

_____ _____
Signature of Patient of Authorized Representative Date