

Chiropractic Intake



Kwan-Yin Healing Arts Center
2330 NW Flanders, Suite 101
Portland, OR 97210
(503) 701-8766

Thank you for scheduling with us, we strive to provide the best possible integrative care for our clients. Here at the clinic we have a team of Naturopathic Doctors, Oriental Medical Practitioners, Licensed Acupuncturists, Body Workers, Psychologists, Medical Doctors, Physical Therapists and Chiropractic Physicians. During your initial evaluation your practitioner will do their best to do a thorough evaluation and give you a treatment plan. You can assist us in that by making sure you have fully completed the intake paperwork enclosed. The advantage of the integrative office is that there are many modalities that can provide input should any of us find the need for assistance.

We are located just west of the intersection of NW 23rd on NW Flanders (between 23rd & 24th Ave.). Parking is available in the main and lower lot; please do not park below the building in the covered area. Wheelchair access for the first floor is located through the main level parking lot. Please come a few minutes early and enjoy a cup of tea before your appointment.

Please be aware that we ask patients to give us 48 hour notice if they need to reschedule or cancel an appointment. Late cancellation or missed appointments incur a \$45.00 fee or greater, as we are unable to reschedule the appointment with another patient without sufficient notice.

It will be a pleasure to support you on your path towards wellness.

PATIENT NAME: _____

PATIENT DOB: _____

Chiropractic Intake

Informed Consent for Chiropractic Treatment Dr. David Perham, DC

The State of Oregon requires that every patient be informed of the risks of, and the alternatives to, treatment prior to beginning said treatment. The following is the above named chiropractor's informed consent. We intend this consent form to cover the entire course of treatment for your present condition, and for any future conditions for which you seek treatment at this office.

The nature of Chiropractic treatment: The doctor will use his hands or a mechanical device in order to adjust the position of your joints. You may hear a "click" or "pop", similar to when a joint is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, massage, or traction, as well as exercise/nutritional instruction may be employed.

Possible risks and probability: There are inherent risks in any and all treatment delivered by any health care provider, ranging from administering a single aspirin to complicated brain surgery. Chiropractic is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic treatment. The risk is very minor to almost nonexistent in any treatment of extremities. The risks involved in treatment of the spine (excluding the neck) increase. A list from the least to most serious would include: muscular strain (rare), ligamentous sprain (rare), and injury to intervertebral discs, nerves or spinal cord (very rare). The risks involved in the treatment of the neck would include any of the proceeding risks, but also include the remote possibility of cerebrovascular injury, or stroke (very, very rare – chances are from one in one million to one in ten million.) A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary physical therapy procedures could produce skin irritation, burns, or other minor complications (rare). Other treatment options that could be considered may include the following: Over the counter analgesics. The risks of these medications include irritation to stomach, liver, kidneys, and other side effects in a significant number of cases.

Medical Care: Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of the drugs include numerous undesirable side effects, usually more serious than those listed above, and the patient dependence increases in a significant number of cases. Surgery, in conjunction with medical care, adds the risks of adverse reaction to anesthesia (which includes death) as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Concerns or questions: We at Kwan Yin Healing Arts Center have gone to great lengths to make your health and safety our top priority. We will be glad to explain any concern about treatment.

I have read the above explanation of Chiropractic treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment, I have feely decided to undergo treatment, and hereby give my full consent to treatment.

Signature of patient or Guardian

Date

Print Patient Name

PATIENT NAME: _____

PATIENT DOB: _____

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Comprehensive Health Profile

Kwan-Yin Healing Arts Center
Dr. David Perham, DC
2330 NW Flanders Suite 101, Portland, OR 97210
www.kwanyinhealingarts.com (503) 701-8766

Basic Information

Name _____ Date _____

Address _____

City _____ State _____ Zip code _____

Telephone # (home) _____ (work) _____

(cell) _____ Email Address _____

Age _____ Date of Birth _____ Gender _____

Relationship Status: Single Married Partnership Separated Divorced Widowed

Live with: Spouse Partner Parents Children Friends Alone Roommates

Occupation _____ Hours per week _____ Retired _____

How did you hear about our clinic? _____

Emergency Contact: Name _____ Relationship _____ Phone _____

Are you currently under the care of a medical professional? Y N

If yes, whom and where from? _____

If no, when and where did you last receive medical or health care and for what reason? _____

PATIENT NAME: _____

PATIENT DOB: _____

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PERSONAL HEALTH HISTORY

Patient's Name _____ DOB _____ Date _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional	F = Frequent	C = Constant
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O F C

Muscle / Joint

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain, stiffness
- Pain between shoulders

General

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness, depression
- Neuralgia
- Numbness
- Sweats
- Tremors

Cardiovascular

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heartbeat
- Slow heartbeat
- Swelling of ankles

Genitourinary

- Bed-wetting
- Blood in urine
- Frequent urination
- Lack of kidney control

- Kidney infection
- Painful urination
- Prostate trouble
- Pus in urine

O F C

Eye, Ear, Nose and Throat

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental decay
- Earache
- Ear discharge
- Ear noise
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nose bleeds
- Sinus infection
- Sore throat
- Tonsillitis

- Vomiting
- Vomiting of blood

Gastrointestinal

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Bloating abdomen
- Excessive hunger
- Gallbladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite

PATIENT NAME: _____

PATIENT DOB: _____

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O F C

Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

Pain or numbness in

- Shoulders
- Arms
- Elbows
- Hand
- Hips
- Legs
- Knees
- Feet
- Painful tailbone
- Poor posture
- Sciatica
- Spinal curvature
- Swollen joints

Respiratory

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

Women only

- Congested breasts
- Cramps or backache
- Excess menstrual flow
- Hot flashes
- Irregular cycle
- Lumps in breast
- Menopause
- Painful menstruation
- Vaginal discharge

Check any of the following conditions you currently have or have had:

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Cancer
- Chicken pox
- Cholera
- Cold sores
- Diabetes
- Diphtheria
- Eczema
- Edema
- Emphysema
- Epilepsy
- Fever blisters
- Goiter
- Gout
- Heart disease
- Herpes
- Influenza
- Lumbago
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Pacemaker
- Pleurisy
- Pneumonia
- Polio
- Rheumatic fever
- Scarlet fever
- Stroke
- Tuberculosis
- Typhoid fever
- Ulcers
- Venereal disease
- Whooping cough

Are you pregnant? Yes No
If yes, how many months? ____
How many children do you have?—

Describe chiropractic problem: _____

How long have you had this condition?	Is it getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does it bother your (check appropriate box): <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Other (please specify)	
What seemed to be the initial cause?	

PATIENT NAME: _____

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Have you seen a chiropractor before? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long ago? _____
For what reason?	
Are you under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, for what reason?	

Patient's Name _____ DOB _____ Date _____

Have you been hospitalized in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for major surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	for serious injury? <input type="checkbox"/>
Have you had any mental or emotional disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, when?		
Indicate the drugs do you now take? <input type="checkbox"/> birth control pills <input type="checkbox"/> tranquilizers <input type="checkbox"/> pain killers <input type="checkbox"/> other (specify)		
Do you wear: <input type="checkbox"/> heel lifts? <input type="checkbox"/> sole lifts? <input type="checkbox"/> inner soles? <input type="checkbox"/> area supports? <input type="checkbox"/> negative heels? <input type="checkbox"/> platform shoes?		
What is the age of your mattress? _____ Is it <input type="checkbox"/> comfortable? <input type="checkbox"/> uncomfortable? Do you use a bedboard? <input type="checkbox"/>		
How is most of your day spent? <input type="checkbox"/> standing <input type="checkbox"/> sitting <input type="checkbox"/> walking <input type="checkbox"/> other (specify)		

Have you ever:	Yes	No	If yes, briefly explain.
- had a broken bone?	<input type="checkbox"/>	<input type="checkbox"/>	
- been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	
- had strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	
- used a cane, crutch or other support?	<input type="checkbox"/>	<input type="checkbox"/>	
- been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	
- been hospitalized for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	

Do you:	Yes	No	If yes, briefly explain.
- take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	
- think you need minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	
- have any drug allergy?	<input type="checkbox"/>	<input type="checkbox"/>	

When did you last have:	Never	0-6 mos.	6 -18 mos.	longer
- spinal x-ray?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- spinal examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- physical examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS	None	Light	Mod	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

PATIENT NAME: _____

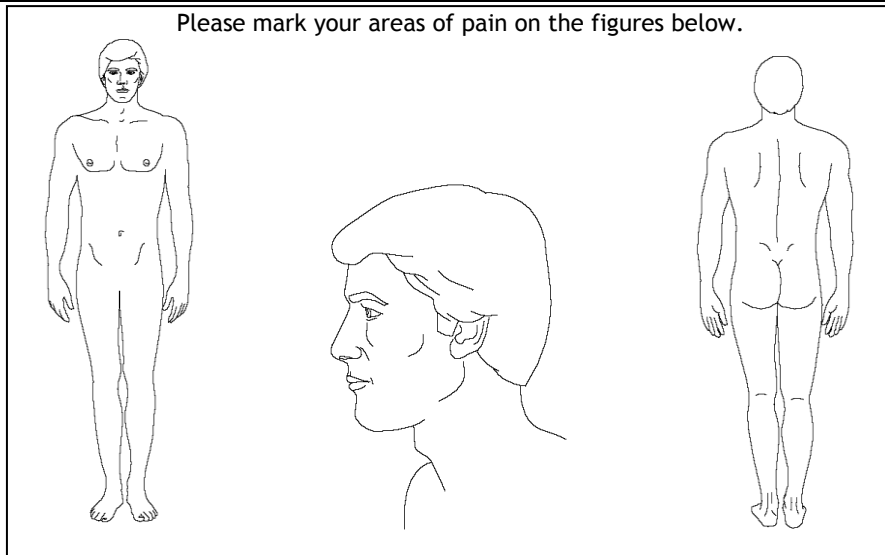
PATIENT DOB: _____

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FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Please mark your areas of pain on the figures below.



PATIENT NAME: _____

PATIENT DOB: _____