1842 NW 25th Ave.
Portland OR 97210
p503-750-2804
f503-296-5362

PATIENT INTAKE FORM

Please complete all sections completely and thoroughly. Thank you.

SECTION A
GENERAL INFORMATION

Name:____Date:______________

DOB:____________ODL#/State:_______________SSN:________________________

Current Address:____Apt.________

City:______________________________State:__________Zip:____________

Email:____

Home Phone:______________________Cell Phone:______________________

Work Phone:______________________Message Phone:____________________

Occupation:____________________________Title:______________________

Employer:____

SECTION B
LOCAL EMERGENCY CONTACT

In case of emergency, please contact:_______________________________________

Phone:____________________ Relation to self:______________________________

SECTION C
PRIMARY CARE PROVIDERS

Referring Physician:____

Clinic:_______________________________Phone:_________________________

Other Current Physician:____

Clinic:_______________________________Phone:_________________________

Other Current Physician:____

Clinic:_______________________________Phone:_________________________

Do we have permission to contact these physicians if medically necessary? Yes No

Do we have permission to send treatment related reports to these physicians? Yes No

SECTION D
INSURANCE INFORMATION

INSURANCE COMPANY

Company Name:_______________________Plan Name:_______________________

Adjuster Name:_______________________Phone:_______________________

Claims Office Address:____

City:_______________________State:__________Zip:_______________________

Claim #:_______________________Policy/Group #:_______________________

PRIMARY POLICY HOLDER

❑ PPH is patient, information is the same as above (continue to Section E)

Patient's Relation to PPH: ❑ Spouse ❑ Child ❑ Other:__________

Name (as stated on policy)____

SSN:_______________________DOB:__________Phone:_______________________

Current Address:_______________________________________Apt.__________

City:_______________________State:__________Zip:_______________________

Cell Phone:_______________________Message Phone:_______________________

GENERAL BILLING INFORMATION

Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Employment: ❑ Full-time ❑ Part-time ❑ Self ❑ Retired ❑ Unemployed

Student: ❑ Full-time ❑ Part-time

Do we have permission to bill your insurance on your behalf? ❑ Yes ❑ No

Do we have permission to release all appropriate case related documents to your insurance adjuster for billing related purposes? ❑ Yes ❑ No

ATTORNEY (in case of litigation)

Name:_______________________Firm:_______________________

Address:_______________________________________Ste.__________

City:_______________________State:__________Zip:_______________________

Phone:_______________________Message Phone:_______________________

SECTION E
CAUSE OF INJURY

Is your condition related to an accident? ❑ Yes (please complete) ❑ No (continue to Section F)

What type of accident? ❑ Auto ❑ Work ❑ Personal injury

Was a police report filed for this accident? ❑ Yes ❑ No

When did the accident occur?______________

What state did the accident occur?__________

SECTION F
GENERAL MEDICAL HISTORY

YES	NO	
❑	❑	Are you wearing any medical devices? If yes, what type? ____________________
❑	❑	Do you suffer from any of the following skin disorders? ❑ Rash ❑ Yeast ❑ Fungus ❑ Psoriasis ❑ Brittle skin ❑ Basel Cell Carcinoma ❑ Virus ❑ Bacteria ❑ Cancer ❑ Other:____________________
❑	❑	Do you suffer from any of the following allergies? ❑ Oils ❑ Nuts ❑ Detergents ❑ Perfumes ❑ Skin care ingredient(s) ❑ Other:____________________ If so, please list and describe symptoms of allergy:____________________
❑	❑	Are you currently under the care of a physician for any reason? If yes, please explain the condition and treatment:____________________
❑	❑	Are you currently taking any medications? If yes, what kind and when was your last dosage?____________________
❑	❑	Have you had any recent illnesses? If yes, what and when? ____________________
❑	❑	Are you sick now? If yes, with what and how do you feel?____________________
❑	❑	Have you ever been diagnosed with any of the following conditions? ❑ High blood pressure ❑ Low blood pressure ❑ Aneurism ❑ Embolism ❑ Heart disease ❑ HIV ❑ AIDS ❑ Diabetes type I ❑ Diabetes type II (adult onset) ❑ Cancer (type and location(s)):____________________ ❑ Scoliosis ❑ Osteoporosis ❑ Fractures ❑ Dislocations ❑ Other:____________________
YES	NO	
❑	❑	Have you ever had surgery? If yes, when and what type?____________________
❑	❑	Do you have any needs that require special attention?____________________
❑	❑	Do you have any concerns about your injury or this type of treatment?____________________

SECTION H
CURRENT CONDITION: DIAGRAMING

On the following diagram, please indicate the areas you are currently experiencing pain by circling and then rate and label these areas on a 1-10 analog scale (1 – least pain; 10 – most pain).

Please indicate and discuss any specific areas of concern related to this diagram:

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SECTION J
SUBJECTIVE EXPLANATION

To the best of your abiity, please descrive your most relevant and serious symptoms:

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____

SECTION K
CONSENTUAL AGREEMENT

AGREEMENT & CONSENT
By signature I consent that all information contained on this form is true and correct to the best of my knowledge. I promise to keep my health care providers updated as to any changes in my health and residence.

______________________________________ ________________
Patient Signature (guardian if minor) Date