Linn City Chiropractic & Spinal Decompression

18750 Willamette Drive Suite F West Linn, OR 97068 (503) 908.0122 www.linncitychiro.com

WELCOME TO OUR PRACTICE

Dr. Michael LoGiudice and the staff of Linn City Chiropractic welcome you to our practice. The doctor may consult with you prior to your examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient, but instead will refer you to another provider, if appropriate. Please inform the doctor if your injuries were sustained in the workplace or if you were injured in an auto accident (additional paperwork required).

INSURANCE

As a courtesy, this office will process your insurance forms. We will do our utmost to provide sufficient information to your insurance carrier to obtain payment for your treatment. We have found that, in some instances, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you understand that you are responsible to make payment in full. Our fee schedule is available upon request.

PATIENT IDENTIFICATION

_____ First and Last Name

_____ Name I prefer

_____ Preferred Phone: (circle) Work Home Cell Text

_____/_____/_____ Date of birth (mm/dd/yyyy)

Email: _____

_____ Street Address

For appt reminders, correspondence and newsletters

_____ City, State, Zip

_____ Insurance Co. Name

Marital Status: (circle) S/M/D/W

_____ Insurance ID #

_____ Drivers License # and State

_____ Emergency contact

_____ Employer

_____ Emergency relationship

_____ Occupation Title

_____ Emergency phone #

_____ Parent of Minor Patient (if applicable)

Whom should we thank for your referral? _____

ACCEPTANCE AS PATIENT

I understand and agree that **Dr. LoGiudice** and the staff of **Linn City Chiropractic** have the right to refuse to accept me as a patient at any time before treatment begins. I understand that the history and physical examination are not considered treatment, but are part of the process of gathering information to determine whether the doctor can accept me as a patient.

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CONSENT FORM

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal: to keep you healthy and out of pain. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column, and joints of the arms or legs, which can cause altered nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

Chiropractors **diagnose**, **treat** and **rehabilitate** soft tissue injuries and many musculoskeletal conditions. Doctors of Chiropractic specialty is the treatment of vertebral subluxation and musculoskeletal conditions. If you have an existing disease other than the vertebral subluxation or musculoskeletal conditions that we treat, we may refer you back to your Primary Care Physician (PCP) for treatment. Details about your current health and past medical history are imperative for an accurate diagnosis. If during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will refer you back to your primary care provider or another specialist.

Regardless of what other disease you have, we do not offer to treat it. However, from time to time alternative treatment(s) may be recommended. Nor do we offer advice regarding treatment prescribed by others. Our practice objective is to eliminate major interference to the expression of the body's innate wisdom. One method is the chiropractic adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold the adjustments.

I therefore accept chiropractic care on this basis.

I have read & fully understand the above statements.

Consent to evaluate and adjust a minor child or any person under 18 years old:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

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FINANCIAL ARRANGEMENTS

In order to keep our cost lower then the average in this area we expect payment at the time of service, anything other than this should be discussed with the staff before examination & treatment. Pre-paying for care may entitle you to a discount. We have a number of payment options available such as: Medical Insurance, Cash, Checks, Flex Savings, Health Savings, Debit Card, Credit Cards (**Visa and MasterCard**), and Chase Health Financing are accepted. Returned check will be subject to a $35.00 service charge. For best treatment outcomes, we ask that you do your best to keep all scheduled appointments. **A 24-hour notice is required for all cancellations, without exception. Appointments cancelled with less then 24-hour notice are subject to a $50.00 cancellation fee.** There will be a one-time forgiveness as a courtesy.

INSURANCE

As a courtesy to our patients, we are happy to assist you in obtaining maximum insurance benefits. Our office staff will assist you in verifying the coverage that your particular insurance company provides. We accept payment from your insurance carrier for the portion covered. **On the date of your visit, you are responsible for your deductible and the portion we estimate the insurance payer will not cover.** We ask that you assign your insurance benefits to this office. Should a problem arise with your insurance payments, we will do the best we can to resolve the matter with your insurance company, and if necessary we may request that you contact your insurance company to assist with the resolution of any problems.

PAYMENT RESPONSIBILITY

In the event my insurance company obligated to make payments to me upon the charges made by this office for their services refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute this cause of action either in my name or in the office's name and further I authorize this office to compromise, settle, or otherwise resolve such claim or cause of action as they see fit.

RIGHT TO PAYMENT

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to Linn City Chiropractic and/or Michael LoGiudice, D.C. such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no fault benefits, health and accident benefits, Worker's Compensation benefits or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect this office. I hereby further give a lien to this office against any and all insurance benefits names herein, and any and all proceeds of any settlements, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by this office. This is to act as an assignment of my rights and benefits to the extent of the office's service provided.

I have read and fully understand the above statements. Please print name legibly.

Patient Name:_____ Date:_____

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CONSENT TO TREAT

Medical Doctors, Chiropractors, Osteopaths, Naturopaths and Physical therapists who perform spinal and extremity joint manipulation are required by law to obtain your informed consent before starting treatment.

I do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulation/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

- **Soreness:** I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
- **Dizziness:** Temporary symptoms like dizziness and nausea can occur, but are relatively rare.
- **Fractures/Joint Injury:** I further understand that in isolated cases physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative joint/disc disease, or other abnormality is detected, this office will proceed with extra caution.
- **Burns:** Some of the therapies used in this office generate heat or cold and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor or staff immediately.
- **Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are extremely rare. I am aware that nerve or brain damage including stroke is reported to occur in one million to one in ten million cervical adjustments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Tests are performed to minimize the risk of any complications from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

- **Medications:** Medication can be used to reduce pain or inflammation. These medications should

Patient Name:_____ Date:_____

be used for short periods of time. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology (disease), produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, interfere with the natural healing ability of the body, and may have to be continued indefinitely. Some medications are addictive and may involve serious risks.

- **Surgery:** Surgery may be necessary for joint stability or serious intravertebral disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, prolonged recovery and even death.
- **Rest/Exercise:** It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness and is rarely recommended. Exercises are of limited value but are not corrective of injured nerve and joint tissues.
- **Non-treatment:** I understand the potential risks of refusing or neglecting care may include increase in pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making a future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

FOR DOCTOR ONLY: DO NOT WRITE IN BOX!

PATIENT STATUS AT TIME OF INFORMED CONSENT

Based on my personal observations, medical history and direct conversation with the patient, I conclude that throughout the consent process the patient was:

[ ] Of Legal Age
[ ] Oriented X 3
[ ] Coherent and Lucid
[ ] On prescription/OTC medication, but unimpaired
[ ] Proficient in understanding the English language
[ ] Assisted in understanding by an interpreter: _____
[ ] Resolute in denying the use of alcohol and or recreational drug use prior to consent
[ ] Unable to give legal consent
[ ] Consent given through legal guardian Name: _____
Relationship: _____

Patient's questions or concerns (if any): _____
_____

I certify that the above accurately describes the above named patient's status during the informed consent process. ____ initials of Dr. LoGiudice

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment. Please sign below

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PAST AND PRESENT MEDICAL HISTORY

Do you have vertigo (dizziness)?	Yes( )	No( )
Do you pass out easily (faint or loss of consciousness)?	Yes( )	No( )
Do you have double vision or have you lost sight in one eye?	Yes( )	No( )
Do you have any slurred speech or difficulty with speech?	Yes( )	No( )
Do you have indigestion or difficulty swallowing?	Yes( )	No( )
Do you fall often, have difficulty with walking or coordination?	Yes( )	No( )
Do you have nausea or vomiting?	Yes( )	No( )
Do you have numbness on one side of your face or body?	Yes( )	No( )
Do you have any visual disturbances or rapid eye movement?	Yes( )	No( )
Do you have difficulty in arranging words properly?	Yes( )	No( )
Do you have a head pain unlike any you have had before?	Yes( )	No( )
Do you have headaches for hours or days?	Yes( )	No( )
Do you have a history of stroke in your family?	Yes( )	No( )
Do you have chest pain?	Yes( )	No( )
Do you have any change in bowel or bladder habits?	Yes( )	No( )
Do you have a sore that does not heal?	Yes( )	No( )
Do you have any unusual bleeding or discharge?	Yes( )	No( )
Do you have any thickening in your breasts or elsewhere?	Yes( )	No( )
Do you have a change in any wart or mole?	Yes( )	No( )
Do you have a nagging cough or hoarseness?	Yes( )	No( )
Do you have pain in neck, jaw or face? (Circle all that apply)	Yes( )	No( )
Do you have a drooping eyelid or change in your pupils?	Yes( )	No( )
Do you have any ringing in your ears (tinnitus)?	Yes( )	No( )
Have you ever had cancer?	Yes( )	No( )

Type:_____ Location:_____ Status:_____

Do you have night sweats?	Yes( )	No( )
Does your pain ever wake you from a sound sleep?	Yes( )	No( )
Are you losing weight now without trying?	Yes( )	No( )
Are you coughing up blood, have blood in your stool or urine?	Yes( )	No( )
Have you had any loss of bladder or bowel control?	Yes( )	No( )
Have you lost consciousness or had double vision recently?	Yes( )	No( )
Are you seeing another doctor for any reason?	Yes( )	No( )
Are you under the influence of pain medication right now?	Yes( )	No( )
Are you taking vitamins, herbs or botanicals?	Yes( )	No( )

Please list: _____

Women Only: Date of your last monthly period? _____

Please advise us if you think that you may be pregnant

Primary Care Physician (PCP):_____

Alternative Care Physician(s): _____

Other healer(s):_____

Can we share your progress notes with your doctors? Yes( ) No( )

Please list all prescription and Over-The-Counter (OTC) medication are you taking, if any?

_____

_____

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Please list all surgical procedures; include procedure and year: (ie. R. Bunionectomy 2005)

_____
_____
_____
_____

Any other medical concerns?_____
_____

SOCIAL HISTORY

Current Smoker Yes ( ) No( ), If Yes, how many packs/day? _____
Former Smoker Yes ( ) No( ) For how many years?_____ Quit smoking which year?_____
Consume Alcohol Yes ( ) No( ), If Yes, how much? _____

Recreational Drug Use: (circle all that apply)

Psychoactive: Cannabis, Caffeine, Opiates, Tobacco, Alcohol, and Cocaine
Inhalant: Gases, aerosols, and solvents.
Antihistamine: Allergy and cough medicine
Tranquilizer: Barbiturates, Benzodiazepines, Nonbenzodiazepines, and Ethanol
Painkiller: Morphine, codeine, heroin, hydro/oxycodone, and hydro/oxymorphone
Hallucinogen: Psychedelics, dissociatives, or deliriants.
Others: _____

FAMILY HISTORY

How many brothers? (____) list health problems: _____
How many sisters? (____) list health problems: _____
How many children? (____) boys / (_____) girls

List health problems within your immediate (blood relation) family:

_____

Do your Mother or Father have any of the following: **M** = **M**other **F** = **F**ather **B** = **B**oth

( ) High Blood Pressure
( ) Heart Attack
( ) Emphysema
( ) Seizure-Convulsions
( ) HIV Positive
( ) Asthma
( ) Diabetes
( ) Kidney Disease
( ) Ulcer or Stomach Problems
( ) Stroke (Please indicate age when stroke occurred, Mother _____ Father _____)
( ) Arthritis-Rheumatism
( ) Mental Illness
( ) Thyroid Disease
( ) Circulation Problems
( ) Cancer

QUESTIONS, COMMENTS OR CONCERNS:

_____
_____
_____

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VISUAL PAIN CHART

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations. Mark areas of radiation. Include all affected areas.

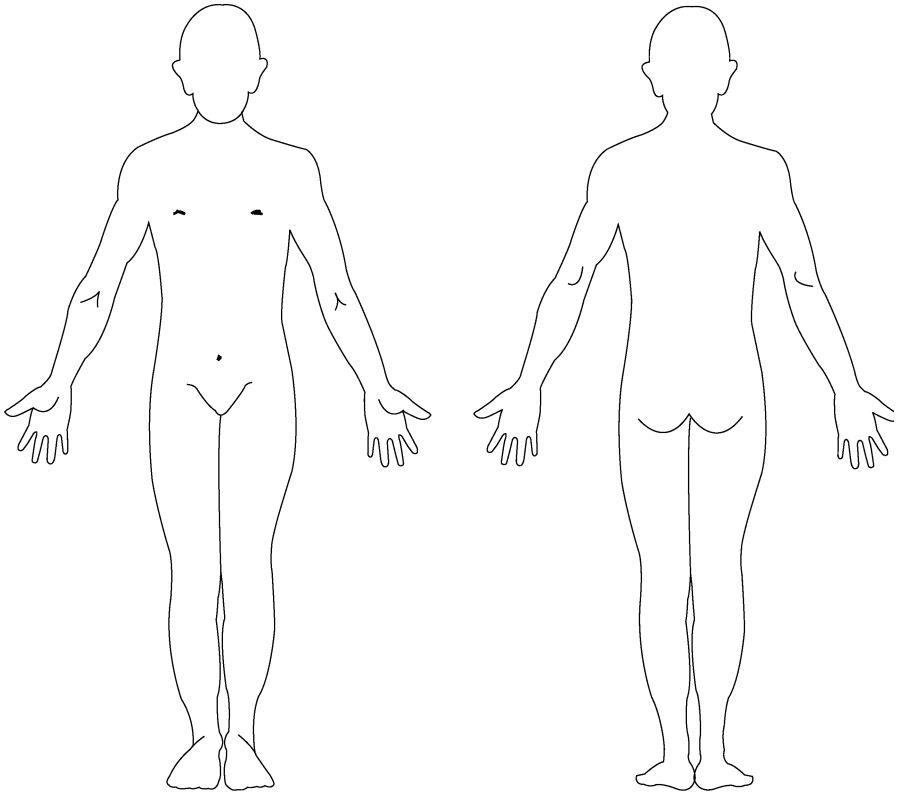
Use symbols to indicate your symptoms:

Numbness	Pins / Needles	Burning	Aching	Stabbing	Electric
- - - - - - -	**0000000000**	**XXXXX**	******	**/ / / / / /**	**∇∇∇∇**

Rate your pain on a scale from 0 to 10 the pain you feel with this condition.

0 - No pain	1 - Very mild	2 - Discomforting	3 - Tolerable	4 - Distressing	5 Very distressing
6 - Intense	7 - Very intense	8 - Utterly horrible	9 - Excruciating	10 - Unimaginable	11+ Hospital

Right **Front** **Left** **Left** **Back** **Right**



Neck-Shoulder-Arm-Pain
On a scale of 0 to 10, I rate my discomfort as follows:

_____
0 **10**
no pain **severe pain**

Mid Back Pain
On a scale of 0 to 10, I rate my discomfort as follows:

_____
0 **10**
no pain **severe pain**

Low Back & Leg Pain
On a scale of 0 to 10, I rate my discomfort as follows:

_____
0 **10**
no pain **severe pain**

Patient Name:_____ Date:_____