Network Chiropractic
Jordan L. Michels, DC

2960 Adams St.
Eugene, OR 97405

Name: _____ E-mail_____ Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Wk. Phone: _____ Occupation: _____

Date of Birth: _____ Age: _____ M _____ F ____ Marital Status: _____ Children: _____

Social Security Number: -_____ Insurance: _____

How did you hear about our office and Network Chiropractic? _____

_____

HISTORY

- Have you ever had your spine or nervous system examined professionally? When and by whom?

  _____

- Have you ever seen a Dr. of Chiropractic? _____
- If yes when was your last visit? _____ How long did you go? _____
- How often did you go? _____ Why did you stop? _____
- Describe the methods or techniques performed: _____

  _____

- Were you pleased with his/her services? _____
- Does your immediate family receive chiropractic care? _____

GROWTH AND THERAPY METHODS USED:

	Currently	Past	Comments
Chiropractic:	☐	☐	_____
Network Chiropractic:	☐	☐	_____
Cranial work:	☐	☐	_____
Meditation:	☐	☐	_____
Psychotherapy:	☐	☐	_____
Movement or exercise:	☐	☐	_____
Yoga:	☐	☐	_____
Other:	☐	☐	_____

CURRENT HEALTH AND GOALS:

- If you consider yourself ill, why do you feel you are ill? (list current complaints)_____

  _____

  _____

- If you consider yourself well, why do you feel you are well? _____

  _____

  _____

- What do you wish to receive from Network Chiropractic? _____

  _____

BIRTH HISTORY

yes no

- Was your Mother ill or injured during her pregnancy with you? ☐ ☐
- Was your deliver traumatic? ☐ ☐
- Was your mother exposed to chemical substances during pregnancy? Drugs ☐ Alcohol ☐ Other ☐
- Was your delivery: Drug induced ☐ "C" Section ☐ Breech ☐
  Forceps ☐ Cord around neck ☐ Prolonged ☐
- Comments: _____

_____

PHYSICAL TRAUMA

PAST PHYSICAL TRAUMA: dates and comments check if contiuing or related unresolved problems

- Knocked unconscious: _____ ☐
- Broken Bones: _____ ☐
- Impacts, falls, jolts: _____ ☐
- Auto Injuries: _____ ☐
- Lifting injuries _____ ☐
- Extensive Dental work: _____ ☐
- Orthodontic work: _____ ☐
- Additional comments concerning injuies that you suspect may be causing any continuing problems:

_____

_____

- Surgeries: dates, procedures and comments check if contiuing or related unresolved problems

_____ ☐

_____ ☐

- Have you had: Corrective shoes ☐ Foot problems ☐ Heel lift ☐ Major burns ☐ Major scars ☐
  Spinal injections ☐ Traction ☐ Radiation treatment ☐ Casts or immobilization ☐

CURRENT PHYSICAL STRESSES:

Stress level: mild moderate severe comments

- Work ☐☐☐ _____
- Exercise ☐☐☐ _____
- Other ☐☐☐ _____
- Sleep position: back ☐ side ☐ stomach ☐ Bed type? _____
- Daily activities: Sitting ____ hrs. Standing ____ hrs. Walking ____ hrs. Bed ____ hrs.
- Rate your physical health on a scale from 1 - 10, ten being the best: _____ Improving ☐ worsening ☐
- Comments: _____

_____

EMOTIONAL TRAUMA

PAST STRESS: mild moderate severe

- Physical abuse: ☐ ☐ ☐
- Emotional abuse: ☐ ☐ ☐
- Sexual abuse: ☐ ☐ ☐

mild moderate severe

Divorce: ☐ ☐ ☐
Death of a love one ☐ ☐ ☐
Addiction: ☐ ☐ ☐

- Rate your childhood trauma on a scale of 1 - 10, ten being the worst _____
- Comments: _____

_____

CURRENT STRESS: mild moderate severe

- Relationships: ☐ ☐ ☐
- Financial: ☐ ☐ ☐
- Addiction: ☐ ☐ ☐
- Illness: ☐ ☐ ☐

mild moderate severe

Work: ☐ ☐ ☐
Loss: ☐ ☐ ☐
Lifestyle change: ☐ ☐ ☐

- Rate your current stress on a scale of 1 - 10. _____
- Rate your emotional health on a scale of 1 - 10 _____ Improving ☐ worsening ☐
- Comments: _____

_____

CHEMICAL TRAUMA

PAST CHEMICAL EXPOSURE:

- Previous regular use of medication including pain killers, antibiotics, tranquilizers, antidepressants, etc.:

_____

- Previous regular use of recreational drugs including tobacco, alcohol, coffee, marijuana, pills, etc.

  Check here if you prefer to discuss this topic orally so it does not appear in your record. ☐

_____

- Are you aware of any exposure to toxic chemicals, fumes, or radiation, etc.: _____

CURRENT CHEMICAL STRESS:

- Current medications, vitamins, herbs, etc.: _____
- Current use of recreational drugs (check here if you prefer to discuss this orally) ☐

_____

- Are you aware of any respiratory allergies? _____
- Are you aware of any food allergies? _____
- Foods you crave or over-consume: _____
- Do you suspect systemic candida or dysbiotic problems? _____
- Frequency of use: daily weekly

Alcohol	____ X	☐ ☐	Refined Sugar	____ X	☐ ☐
Coffee	____ X	☐ ☐	Fried Foods	____ X	☐ ☐
Tobacco	____ X	☐ ☐	Red Meat	____ X	☐ ☐

- The type of diet you usually follow is: _____

Office Policies & Privacy Notice

Effective January 1, 2016

Private Pay

Payment for services rendered is due at time of appointment. Accounts that maintain a 0 balance will be given a discounted fee. If you are experiencing financial difficulties, contact our office to discuss a payment plan.

Health and Auto Insurance

Financial arrangements are between patients and our office. Third-party billing is provided as a courtesy to our patients; however you remain responsible for any unpaid balance. We will contact your insurance carrier to verify benefits and submit claims in a timely manner. We strongly recommend that you contact your carrier for verification of your coverage and related information, since we have at times received conflicting information. Co-payments are due at time of visit. Auto insurance generally pays 100 percent; however, you are responsible for deductibles or other uncovered items.

Nutritional Supplements and Supplies

Nutritional supplements or other supplies may not be covered by insurance. These costs must be paid in full at time of service unless we are able to verify insurance coverage or other payment arrangements are made.

Cancellation Policy

We ask that you notify us as soon as possible if you need to modify your appointment time. If you give us less than four hours notice, there will be a $15 charge. If you do not notify us and fail to arrive for your appointment, you will be charged $42. These charges are your responsibility as they cannot be billed to your insurance. We believe that healing requires your personal commitment. Frequently missed appointments may indicate a lack of commitment and may result in termination of the doctor/patient relationship.

Payments

We accept cash, checks and credit cards, although we prefer checks.

Privacy Notice

We are committed to maintaining the privacy of your protected health information ("PHI"). We may use and/or disclose your PHI for purposes related to your care, payment for your care, and health care operations of the practice. (See full Privacy Policy for entire statement.)

I have read and understand the office policies.
I acknowledge that I have received a copy of the Practice's Privacy Notice.

Signature_____ Print:_____

Date:_____/_____/_____