Network Chiropractic **2960 Adams St. Eugene, OR 97405**
Jordan L. Michels, DC **541-543-6321**

Name: _____ E-mail: _____Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Wk/Cell. 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 continuing or related unresolved problems

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

_____

_____

- Surgeries: dates, procedures and comments check if continuing 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 mild moderate severe

- Physical abuse: ☐ ☐ ☐ Divorce: ☐ ☐ ☐
- Emotional abuse: ☐ ☐ ☐ Death of a love one ☐ ☐ ☐
- Sexual abuse: ☐ ☐ ☐ Addiction: ☐ ☐ ☐
- Rate your childhood trauma on a scale of 1 - 10, ten being the worst _____
- Comments: _____

_____

CURRENT STRESS: mild moderate severe mild moderate severe

- Relationships: ☐ ☐ ☐ Work: ☐ ☐ ☐
- Financial: ☐ ☐ ☐ Loss: ☐ ☐ ☐
- Addiction: ☐ ☐ ☐ Lifestyle change: ☐ ☐ ☐
- Illness: ☐ ☐ ☐
- 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 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, 2022

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. Here are ways to pay:

- **Invoiced through SQUARE** (preferred) – The amount owed will be sent by email before your appointment time. Click on the link you received to pay online. A SQUARE account is *not* required. You may pay via SQUARE as a guest with a credit card.
- **Checks** – can be taken in the office of mailed to 2960 Adams St., Eugene, OR 97405
- **Phone credit card payment** – Call Janene at 541.687.9528.
- **Cash** can be given in the office. Try to have exact amount, change is limited.
- **Credit cards** taken in the office if needed. Pay by invoice as above if possible to save time and decrease time in waiting room.

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 strongly recommend that you contact your carrier for verification of your coverage and related information.. Co-payments are due at time of visit as above. 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 the time of your visit.

Appointments & Cancellation Policy

Appointments can be made in the office or call or text Janene at 541.687.9528.

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.

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. (If desired, please ask to see the full HIPPA Privacy Policy)

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

Signature _____ Date: _____ /_____ /_____

Print: _____