

Adult Wellness History

Dr. J Chris Chlebowski, Chiropractic Physician
923 NE Couch Street
Portland, OR 97232

Patient Information

Today's Date: _____ Birth Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: M F Phone Number: _____

Previous Chiropractic Care Y N

Referred By: _____

Patient under the care of another physician? Y N

If yes, who? _____

Phone Number: _____

Social Security Number: _____

Email Address: _____

Insurance Information

Insured's Name: _____

Relationship to Patient: _____

Insurance Carrier: _____

Responsible Party Information

Name: _____

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Other Information

Occupation: _____

Employer: _____

Emergency Contact: _____

Emergency Phone #: _____

Authorization for Care

I have read the above information and certify it to be true and correct to the best of my knowledge. I hereby authorize this office to provide me with chiropractic care, in accordance with this states' statutes.

Patient or Guardian Signature: _____

Signature Date: _____

To help us serve you better, please complete all of the following information. We look forward to working with you to build better health for you and your family.

Your Health History

Patient Name: _____

What are your reasons for coming into the office today?

Are you under the care of another physician for another reason? Y N

If yes, for what condition? _____

Have you been hospitalized in the last 10 years? Y N

If yes, for what condition? _____

Do you have any mental or emotional disorders? Y N

If yes, please explain. _____

Have you been traveling recently? Y N

If yes, where? _____

Please list all supplements/herbs/homeopathics/vitamins you are currently or have taken in the past year:

Please list all medications you are currently taking:

Do you have any drug allergies? Y N If yes, which ones? _____

Do you have any food allergies? Y N If yes, which ones? _____

Habit	None	Light	Mod	Heavy
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<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"/>

Habit	None	Light	Mod	Heavy
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"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adult Past Health History

Patient Name: _____

Your doctors here at the clinic are interested in all aspects of your health. 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

O F C	O F C	O F C	O F C
Muscle / Joint	Genitourinary	Gastrointestinal	Respiratory
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed Wetting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or Gas	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest Pain
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bladder Infections	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloating Abdomen	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic Cough
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in Urine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult Breathing
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent Urination	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting Up Blood
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low Back Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney Infection	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting Up Phlegm
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumbago	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Urination	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck Pain/Stiffness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pus in Urine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult Digestion	Women Only
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain Betw Shoulders	Eye, Ear, Nose & Throat	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congested Breasts
General	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or Backache
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Circles Under Eyes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heavy Menstrual Flow
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anxiety	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot Flashes
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chills	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain Over Stomach	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Appetite	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps in Breast
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental Decay	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menopause
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting of Blood	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Menstruation
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear Discharge	Skin	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear Noise	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yeast Infections
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged Glands	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruises Easily	Are you pregnant?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged Thyroid	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Weight	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or Allergy	How many children do you have? _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing Vision	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neuralgia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Far-Sightedness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Psoriasis	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Night Terrors	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gum Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin Eruptions/Rash	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay Fever	Pain or Numbness in:	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweats	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulders	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arms	
Cardiovascular	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Near-Sightedness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbows	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nosebleeds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hands	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus Infection	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hips	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain Over Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore Throat	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legs	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Circulation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsillitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knees	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid Heartbeat		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feet	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow Heartbeat		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Tailbone	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart Murmur		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Posture	
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sciatica	
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal Curvature	
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen Joints	

Adult Past Health History

Patient Name: _____

Please check any of the conditions you currently has or has had.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Edema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cholera | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaccination Reaction |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Influenza | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Excema | | | |

Notice of Patient Privacy

Dr. J Chris Chlebowski, Chiropractic Physician
923 NE Couch Street
Portland, OR 97232

Notice of Patient Privacy (Short Form)

Health Insurance Portability and Accountability Act (HIPAA)

J. Chris Chlebowski, D.C., is dedicated to preserving your "Protected Health Information" (PHI). We are required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This Notice of Privacy Practices describes your rights and Dr. J. Chris Chlebowski's duties with respect to your protected health information.

We may use or disclose your PHI for the purpose of diagnosing or providing treatment, obtaining payment for health care bills or to conduct health care operations.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

Your PHI means health information, including your demographic information, collected by us, other health care providers, a health care clearinghouse, or an employer. This protected health information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing.

We have available a detailed NOTICE OF PRIVACY PRACTICES (long form) which fully explains your rights and our obligations under the law. You have the right to receive a copy of our most current NOTICE in effect, please ask at the front desk and we will provide you with a copy.

We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect. If you have any questions, concerns or complaints about the NOTICE or your medical information,

I acknowledge comprehension and receipt of Notice of Privacy Policy.

Patient Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____

Patient Informed Consent Form

Dr. J Chris Chlebowski, Chiropractic Physician
923 NE Couch Street
Portland, OR 97232

I, the undersigned, hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapies (e.g. massage, ultrasound, interferential current), physiological therapeutics (e.g. mineral/vitamin supplementation, botanicals, homeopathic remedies, flower essences, etc.) on me (or the patient named above for whom I am the guardian) by Dr. J Chris Chlebowski.

I understand and am informed that though chiropractic treatments are usually beneficial and rarely cause a problem, like every other form of healthcare, there are some risks. These can include, but are not limited to, sprains, strains, fractures, disc injuries, strokes, dislocations, nutrient-drug interactions and nutrient-nutrient interactions.

I understand that the doctor will perform an exam in order to minimize any risks. However, I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I therefore wish to rely on the doctor to exercise professional judgment during the course of the procedure which the doctor feels at the time, based upon the facts as then known, is in my best interests. Finally I understand that Dr. Chlebowski gives no guarantee or assurance as to the results of his procedures.

I have read, or had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the procedures. I intend this consent form to cover the entire course of present condition and for any further condition(s) for which I seek treatment.

Patient Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____