Portland Family Health

4004 SE Woodstock Boulevard
Portland, Oregon 97202

Phone: (503)777-0444
Fax: (503)777-0445

info@portlandfamilyhealth.com
www.portlandfamilyhealth.com

Welcome to Portland Family Health!

We are honored that you have chosen us as part of your wellness team. Here we believe that the collaboration of minds for a client's health is greater than one perspective alone. We each present unique specialties, that when combined, create a holistic and superior health team to benefit your care.

Our practitioner family at Portland Family Health includes:

- **Acupuncture** with Cultivate Wellness
- **Chiropractic & Craniosacral** with Growing Care
- **Counseling** with Beth Bassett
- **Health Education** with Mary Makenna
- **Homeopathy & Nutritional Testing** with Judy Neall Epstein
- **Massage** with Growing Care
- **Midwifery** with Flourish
- **Naturopathy** with Nature's Path Family Wellness
- **Play Therapy** with Nicole Byers
- **Women's Wellness** with Flourish

I authorize the practitioners of Portland Family Health to use and disclose health information about me, which may include written records or spoken words regarding health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, and similar types of health-related information. This may be done to make decisions about, plan for care and treatment, and consult with other health care providers in my course of care. I may also request that some of my health information not be disclosed.

In summary, I would like to give specific permission for any of the Portland Family Health providers to communicate with each other regarding my care to best collaborate on my behalf.

Patient/Guardian signature _____Date_____

If the patient is a minor, I as the parent or guardian, authorize treatment to be provided to:

_____(minor)

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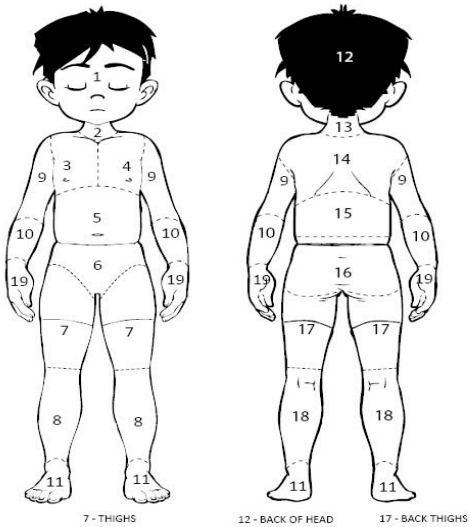
PEDIATRIC PATIENT REGISTRATION

Patient Name: _____ Date: _____
Age: _____ Birth date: _____ Parent Name (s): _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Email Address: _____
Birth interventions (pitocin, antibiotics, forceps, vacuum, cesarean, etc): _____
_____
Whom may we thank for referring you? _____
Been treated by a Chiropractor before? _____ Date of Last visit: _____
Please list practitioner names and specialties of other health care providers: _____
_____
Do I have your permission to contact them to coordinate care? ☐Yes ☐No
List any medications/vitamins/supplements (prescribed, or over-the counter) with the reason taken, dosage, and duration: _____
_____
Any diagnosed health conditions? _____
Emergency Contact: _____ Number: _____ Relationship: _____

MAIN COMPLAINT

If you are here for wellness, please check here ☐ and continue to "Past Health History"
Reason(s) for consulting this office: _____
Date problem began: _____
Does it seem to be getting: ☐ Worse ☐ Better ☐ Staying the same
It interferes with: Sitting ☐ Playing ☐ Sleep ☐ Walking ☐ Hobbies ☐ Leisure ☐ Other ☐
Mark current problem areas on these pictures (if applicable):

Imagine this picture is your body. Can you color the area that is hurting you right now?



Notes: _____

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LIFESTYLE

	YES	Notes, if YES
Does child consume caffeine?	☐	
Does child consume much sugar?	☐	
Does child eat a lot of vegetables?	☐	
Does child eat fast/processed foods?	☐	
Does child exercise?	☐	
Does child drink a lot of water?	☐	
Doe child seem to hold much stress?	☐	
Has child needed antibiotics?	☐	
Does child watch TV, play video/computer games	☐	

Please rate how willing you are to make lifestyle changes with your child to help accomplish your goals

Unwilling to change at all 1 2 3 4 5 6 7 8 9 10 completely willing

During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic . Check if your child has hit these developmental milestones

- ❒ Respond to Sound
- ❒ Respond to Visual Stimuli
- ❒ Hold Head Up Alone
- ❒ Sit Up Alone
- ❒ Cross Crawl
- ❒ Stand Alone
- ❒ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie: a bed, changing table, down stairs, etc).
Was this the case with your child? Y N Please explain: _____

HEALTH HISTORY

Please check all symptoms your child has ever had, even if they do not seem related to current problem

	YES	Notes
Surgery/Hospitalization	☐	
Serious injuries or traumas	☐	
Car accident	☐	
Allergies	☐	
Headache	☐	
Difficulty with bowels	☐	
Abnormal weight gain/loss	☐	
Abnormal fatigue	☐	
Acid Reflux	☐	
Cold/flu often	☐	
Sinus infection	☐	
Birth trauma	☐	
Rash or hives	☐	
Nausea	☐	
Balance difficulty	☐	
Learning difficulties	☐	

	YES	Notes
Hip dysplasia	☐	
ADD/ADHD	☐	
Cancer/tumor	☐	
Poor sleep	☐	
Colic	☐	
Teeth grinding	☐	
Scoliosis	☐	
Growing pains	☐	
Misshaped head	☐	
Bed wetting	☐	
Highly emotional	☐	
Vaccinated?	☐	
Slow healing	☐	
Asocial with others	☐	
Asthma	☐	
Ear infection	☐	

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Insurance Information

Patient Name: _____ Date of Birth: _____

ID #: _____ Group or Plan#: _____

Insurance Company: _____ Ins Phone #: _____

Primary Subscriber (if not Patient): _____ DOB of Insured: _____

Insured Relationship to Patient: _____ Insured is: ☐ Male ☐ Female

Please call your insurance company to obtain *all* of the following information

1. Does your plan have benefits for: Notes

Chiropractic? ☐ Yes ☐ No _____
Massage? ☐ Yes ☐ No _____
Acupuncture? ☐ Yes ☐ No _____
Naturopathy? ☐ Yes ☐ No _____
Counseling? ☐ Yes ☐ No _____

	In- Network Benefits	Out-of Network Benefits
Deductible Amount met so far		
Co-pay/ Co-insurance amount		
% Covered		
Maximum coverage $ amount $ met so far		
Maximum # visits per year # met so far		

If there is ANY coverage for massage: Notes

2. Can it be performed by an LMT? ☐ Yes ☐ No _____
3. Will these CPT codes be covered when billed up to 4 units?

97124 ☐ Yes ☐ No _____
97140 ☐ Yes ☐ No _____
97112 ☐ Yes ☐ No _____
97110 ☐ Yes ☐ No _____

4. Date of annual plan renewal: _____ *Thank You for taking the time to do this, it really helps us!*

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Consent Form, Business Agreement, Insurance Information

Growing Care includes chiropractic, craniosacral therapy and massage therapy. By signing this, you consent to all types of the care we provide, but certainly choose which of these to pursue.

❒ Initials: _____ 1. Consent to Treatment by Growing Care

The nature of chiropractic care is directed toward balancing the muscles, joints and nerves of your body. To achieve this, the doctor will use her hands or tools to adjust your joints and align your soft tissues. You may hear a "click or pop", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, massage, craniosacral therapy, traction, taping, massage therapy and exercise/nutritional instruction may also be employed.

Though we take every precaution, there are some risks associated with chiropractic and massage therapy. The most common is muscle soreness the first couple days after treatment. A list of rare possibilities with chiropractic includes muscular stain, ligamentous strain, and fractures. Injury to the intervertebral discs, nerves or spinal cord is possible, though are considered even less likely. The risks involved with treating the neck may include any of these, but also includes the remote possibility of cerebrovascular injury or stroke. Current literature states the chances of this occurring to be one in one million to one in ten million. The ancillary physical therapy procedures could produce skin irritations, burns or bruising. Other treatment options may include over the counter analgesics, which carry with them the risks of irritation to the stomach, liver, kidneys, and various other side effects.

This consent form is intended to cover the entire course of treatment for my present conditions, and any future conditions for which I may seek treatment at this office. I accept the risks and benefits, and hereby give my full consent to treatment.

❒ Initials: _____ 2. Privacy Policy

I understand that the treating providers may disclose health information about me for purposes of treatment, payment or health care procedures. I have the right to receive a written Notice of Privacy Practices should I request it.

❒ Initials: _____ 3. Internal Release of Information

As Growing Care is part of Portland Family Health (PFH), I would like to give specific permission for any of the PFH providers of whom I am a patient to communicate with each other regarding my care to best collaborate on my behalf.

❒ Initials: _____ 4. Cancellation and No Show Policy

I understand that without giving Growing Care 24 hours notice to cancel or change an appointment, **there is a $55 charge for the missed appointment**, which will be due prior to my next visit.

❒ Initials: _____ 5. Release of Records/Payment Policy

Full payment is expected at the time of service. In the case that you are using health or auto insurance to pay for a portion of your care in this office, arrangement may be made to omit payment to await reimbursement. We are often unable to predict these costs exactly, and may not know for 12 weeks up to six months after the date of service, once your company has processed the claim. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my company and I authorize the doctor to release my related medical records to claim for benefits submitted.

❒ Initials: _____ 6. Authorization to Communicate via E-mail

Communication via e-mail can be convenient for all parties; however, e-mails may not be encrypted and could be read by some outside party with the skills to access this information. By initialing here, I consent the providers of Growing Care to communicate via e-mail in spite of the above.

My signature re-iterates and confirms the initialed consent to each of the points made in this document

Signature of Patient, Parent or Guardian_____ Date:_____

Patient Name (please print):_____