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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** 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)

Auto Accident History Form

Patient's Name________________________________Today's Date_________DOB ___________Date of Injury______________
Patient Address____
Phone (H)____Email: ____
Insurance Company________________________________Insurance Company Contact Name______________________________
Claim #________________________________ Ins. Ph. #_______________________ Fax #_________________________________

General information

Marital status: ☐married ☐single ☐divorced ☐widowed ☐separated ☐partnered

Smoke: ☐none pack/day_____years_______

Alcohol: ☐none # drinks______per day/week/month

Employment status

At time of accident, where did you work?____________________________________☐Unemployed

Where do you currently work?_________________________________☐Unemployed

If unemployed, is it due to injuries from the accident? ☐yes ☐no

What activities does your work require?____

Accident details

You were:
☐driver ☐front passenger ☐rear passenger ☐pedestrian ☐bicyclist

Your vehicle (yr./make/model):

At time of accident, you were:
☐stopped ☐slowing ☐accelerating

Location/street:

Direction of travel: ☐N ☐S ☐E ☐W

Impact came from: ☐front ☐rear ☐L ☐R other:

Other vehicle(yr./make/model):

Time of day:

Road conditions: ☐dry ☐damp ☐wet ☐icy ☐snow

Body position at impact:
Head: ☐forward ☐R ☐L ☐up ☐down
Body: ☐forward ☐R ☐L ☐up ☐down

Head rest position: ☐up ☐down ☐don't know

Lap belt: ☐on ☐off Shoulder harness: ☐on ☐off

Aware of impending crash? ☐Y ☐N

Was seat broken by impact? ☐yes ☐no ☐don't know

Was your vehicle equipped with an airbag? ☐Y ☐N
If yes, did it inflate? ☐Y ☐N
Were you struck by the airbag? ☐Y ☐N
If yes, where were you struck?

Accident diagram:

General Description of Accident:

During the accident

Did you strike any parts of the vehicle? Y N If yes, describe:

Did your vehicle strike any objects after initial impact? Y N If yes, describe:

Was your vehicle pushed in any direction by the impact? Y N If yes, describe:

Were you wearing a hat or glasses before impact? Y N If yes, were they still on after the impact? Y N

Did the accident render you unconscious? Y N If yes, how long?

Were the police on the scene? Y N Was an accident report filed? Y N

Estimated property damage to your vehicle: $

Estimated property damage to other vehicle: None Mild Moderate Major

After the accident

Please describe how you felt immediately after the accident:____
____
____

Were you seen by a doctor or did you go to a hospital after the accident? Y N When did you go? Just after the accident The next day _____days later How did you get there? Ambulance Private transportation

After the accident---continued

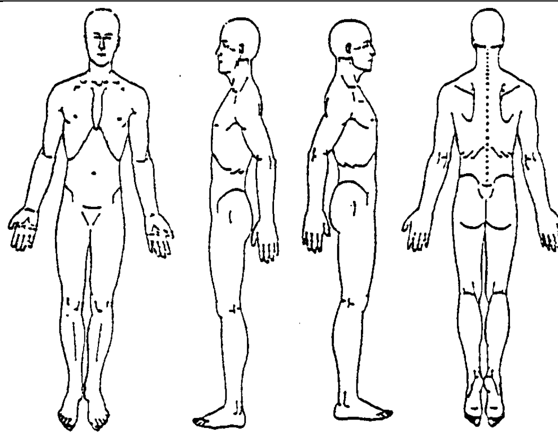
Name of hospital and/or attending doctor:
Were X-rays taken? Y N ______________________________ Was medication prescribed? Y N __________________
Have you been able to work since the injury? Y N Are your work activities restricted as a result of your injuries? Y N

Please indicate with a check mark, all of the symptoms which you feel are a result of this accident. In the columns to the right, fill in the appropriate information for each of the symptoms you checked.

Symptoms	How long after accident did symptoms begin?	Is this condition getting worse?	How frequent are the symptoms?	-Rate the Discomfort from 0-10 (0=no pain, 10=worst pain ever) -And describe the type of the pain
Neck pain		Y N	Constant Intermittent	
Headache		Y N	Constant Intermittent	
Fatigue		Y N	Constant Intermittent	
Memory loss		Y N	Constant Intermittent	
Blurred vision		Y N	Constant Intermittent	
Ears ringing		Y N	Constant Intermittent	
Neck stiff		Y N	Constant Intermittent	
Difficulty sleeping		Y N	Constant Intermittent	
Numb hands/fingers		Y N	Constant Intermittent	
Jaw problems		Y N	Constant Intermittent	
Mid-back pain		Y N	Constant Intermittent	
Low back pain		Y N	Constant Intermittent	
Leg pain		Y N	Constant Intermittent	
Numb feet/toes		Y N	Constant Intermittent	
Tingling in extremities		Y N	Constant Intermittent	
Nausea		Y N	Constant Intermittent	
Irritability		Y N	Constant Intermittent	
Dizziness		Y N	Constant Intermittent	
Chest pain		Y N	Constant Intermittent	
Shortness of breath		Y N	Constant Intermittent	
Confusion		Y N	Constant Intermittent	
Difficulty swallowing		Y N	Constant Intermittent	
Disorientation		Y N	Constant Intermittent	

Who have you seen *for this condition*	**Office use in this column**
Doctor's name/specialty:	Dx:
Address:	Tx:
City: State: Zip:	X-rays/Tests: Freq.: Dur.:
Currently treating? May we contact this Dr.?	Referred to/from:
Doctor's name/specialty:	Dx:
Address:	Tx:
City: State: Zip:	X-rays/Tests: Freq.: Dur.:
Currently treating? May we contact this Dr.?	Referred to/from:
Provide descriptions and dates of all past injuries or conditions:	these include: fractures, dislocations, concussions, surgeries, major injuries or illness, sprains, hospitalizations, accidents, chronic issues

Have you retained an attorney? Y N If so, whom?__________________________Phone_______________

Recovery	**Mark all areas of current pain with an "X"**
To evaluate the effect that continuing work will have on your recovery, please complete the following: **How many hours are in your normal work day?______** Please indicate your daily job duties and any activities which you are occasionally asked to perform: DAILY: / OCCASSIONAL: Standing / Standing Driving / Driving Operating equipment / Operating equipment Working with arms over head / Working with arms over head Walking / Walking Lifting / Lifting Other______________________________ What positions can you work in with minimal physical effort & for how long?__________________ N/A	

The area below is for office use only, please do not fill in!

1) Constant/Intermittent Dull/Achy/Sharp/Electrical/_______________ Body part system______________________ Onset___________Temporal________________ Severity: now______ avg_______ worst_______________ Provocative:______________________________ Palliative:_________________________________	5) Constant/Intermittent Dull/Achy/Sharp/Electrical/_______________ Body part system______________________ Onset________________ Temporal__________________ Severity: now______ avg_______ worst_______________ Provocative:______________________________ Palliative:_________________________________
2) Constant/Intermittent Dull/Achy/Sharp/Electrical/_______________ Body part system______________________ Onset___________Temporal________________ Severity: now______ avg_______ worst_______________ Provocative:______________________________ Palliative:_________________________________	6) Constant/Intermittent Dull/Achy/Sharp/Electrical/_______________ Body part system______________________ Onset___________Temporal________________ Severity: now______ avg_______ worst_______________ Provocative:______________________________ Palliative:_________________________________
3) Constant/Intermittent Dull/Achy/Sharp/Electrical/_______________ Body part system______________________ Onset___________Temporal________________ Severity: now______ avg_______ worst_______________ Provocative:______________________________ Palliative:_________________________________	7) Constant/Intermittent Dull/Achy/Sharp/Electrical/_______________ Body part system______________________ Onset___________Temporal________________ Severity: now______ avg_______ worst_______________ Provocative:______________________________ Palliative:_________________________________
4) Constant/Intermittent Dull/Achy/Sharp/Electrical/_______________ Body part system______________________ Onset___________Temporal________________ Severity: now______ avg_______ worst_______________ Provocative:______________________________ Palliative:_________________________________	8) Constant/Intermittent Dull/Achy/Sharp/Electrical/_______________ Body part system______________________ Onset___________Temporal________________ Severity: now______ avg_______ worst_______________ Provocative:______________________________ Palliative:_________________________________

NECK Index- the statements should be applied to how you feel from the shoulder blades and UP.

Patient Name____Date___________________________

This questionnaire will give your provider information on how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one that most closely describes your problem.

Pain Intensity

- ❒ I have no pain at the moment
- ❒ The pain is very mild at the moment
- ❒ The pain comes and goes and is moderate
- ❒ The pain is fairly severe at the moment
- ❒ The pain is very severe at the moment
- ❒ The pain is the worst imaginable at the moment

Sleeping

- ❒ I have no trouble sleeping
- ❒ My sleep is slightly disturbed (less than 1 hr sleepless)
- ❒ My sleep is mildly disturbed (1-2 hours sleepless)
- ❒ My sleep is moderately disturbed (2-3 hrs sleepless)
- ❒ My sleep is greatly disturbed (3-5 hrs sleepless)
- ❒ My sleep is completely disturbed (5-7 hrs sleepless)

Reading

- ❒ I can read as much as I want with no neck pain
- ❒ I can read as much as I want with slight neck pain
- ❒ I can read as much as I want with moderate neck pain
- ❒ I cannot read as much as I want because of moderate neck pain
- ❒ I can hardly read at all because of severe neck pain
- ❒ I cannot read at all because of neck pain

Concentration

- ❒ I can concentrate fully when I want with no difficulty
- ❒ I can concentrate fully when I want with slight difficulty
- ❒ I have a fair degree of difficulty concentrating when I want
- ❒ I have a lot of difficulty concentrating when I want
- ❒ I have a great deal of difficulty concentrating when I want
- ❒ I cannot concentrate at all.

Work

- ❒ I can do as much work as I want
- ❒ can only do my usual work but no more
- ❒ I can only do most of my usual work, but no more
- ❒ I cannot do my usual work
- ❒ I can hardly do wany work at all
- ❒ I cannot do any work at all

Personal Care

- ❒ I can look after myself normally without causing extra pain
- ❒ I can look after myself normally, but it causes extra pain
- ❒ It is painful to look after myself and I am slow and careful
- ❒ I need some help but I manage most of my personal care
- ❒ I need help every day in most aspects of self care
- ❒ I do not get dressed, I was with difficulty and stay in bed

Lifting

- ❒ I can lift heavy weights without extra pain
- ❒ I can lift heavy weights but it causes extra pain
- ❒ Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned (e.g. on a table)
- ❒ Pain prevents me from lifting heavy weights off the floor, but I can manage light weights if they are conveniently positioned.
- ❒ I can only lift very light weights
- ❒ I cannot lift or carry anything at all.

Driving

- ❒ I can drive my care without any neck pain
- ❒ I can drive my car as long as I want with slight neck pain
- ❒ I can drive my care as long as I want with moderate neck pain
- ❒ I cannot drive my car as long as I want because of neck pain
- ❒ I can hardly drive at all because of severe neck pain
- ❒ I cannot drive my car at all because of neck pain

Recreation

- ❒ I am able to engage in all my recreation activities without neck pain
- ❒ I am able to do all my usual activities with some neck pain
- ❒ I am able to do most but not all of my usual activities because of pain
- ❒ I am only able to do a few of my usual activities because of pain
- ❒ I can hardly do any recreation activities because of neck pain
- ❒ I cannot do any recreation activities at all

Headaches

- ❒ I have no headaches at all
- ❒ I have slight headaches which come infrequently
- ❒ I have moderate headaches which come infrequently
- ❒ I have moderate headaches which come frequently
- ❒ I have severe headaches which come frequently
- ❒ I have headaches almost all the time

Index Score=
[sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

BACK Index- the statements should be applied to how you feel from the shoulder blades and DOWN.

Patient Name____Date__________________________

This questionnaire will give your provider information on how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one that most closely describes your problem.

Pain Intensity

- ❒ My back pain comes and goes and is very mild
- ❒ The pain is mild and does not vary much
- ❒ The pain comes and goes and is moderate
- ❒ The pain is moderate and does not vary much
- ❒ The pain comes and goes and is very severe
- ❒ The pain is very severe and does not vary much

Sleeping

- ❒ I get no back pain in bed
- ❒ I get pain in bed but it does not prevent me from sleeping well
- ❒ Because of pain, my normal sleep is reduced by less than 25%
- ❒ Because of pain, my normal sleep is reduced by less than 50%
- ❒ Because of pain, my normal sleep is reduced by less than 75%
- ❒ Pain prevents me from sleeping at all

Traveling

- ❒ I get no pain while traveling
- ❒ I get some pain while traveling, but none of my usual forms of travel make it worse
- ❒ I get extra pain while traveling but it does not cause me to seek alternative forms of travel
- ❒ I get extra pain while traveling which causes me to seek alternative forms of travel
- ❒ Pain restricts all forms of travel except that done while lying down
- ❒ Pain restricts all forms of travel

Standing

- ❒ I can stand as long as I want without pain
- ❒ I have some pain while standing but it does not increase with time
- ❒ I cannot stand for more than 1 hour without increasing pain
- ❒ I cannot stand for more than 1/2 hour without increasing pain
- ❒ I cannot stand for more than 10 minutes without increasing pain
- ❒ I avoid standing because it increases pain immediately

Walking

- ❒ I have no pain while walking
- ❒ I have some pain while walking but it doesn't increase with distance
- ❒ I can not walk more than 1 mile without increasing pain
- ❒ I can not walk more than 1/2 mile without increasing pain
- ❒ I can not walk more than 1/4 mile without increasing pain
- ❒ I cannot walk at all without increasing pain

Personal Care

- ❒ I can look after myself normally without causing extra back pain
- ❒ I can look after myself normally, but it causes extra back pain
- ❒ It is painful to look after myself and I am slow and careful
- ❒ I need some help but I manage most of my personal care
- ❒ I need help every day in most aspects of self care
- ❒ I do not get dressed, I wash with difficulty and stay in bed

Lifting

- ❒ I can lift heavy weights without extra back pain
- ❒ I can lift heavy weights but it causes extra pain
- ❒ Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned (e.g. on a table)
- ❒ Pain prevents me from lifting heavy weights off the floor, but I can manage light weights if they are conveniently positioned.
- ❒ I can only lift very light weights
- ❒ I cannot lift or carry anything at all.

Sitting

- ❒ I can sit in any chair as long as I like
- ❒ I can only sit in my favorite chair as long as I like
- ❒ Pain prevents me from sitting more than 1 hour
- ❒ Pain prevents me from sitting more than ½ hour
- ❒ Pain prevents me from sitting more than 10 minutes
- ❒ I avoid sitting because it increases pain immediately

Social Life

- ❒ My social life is normal and gives me no extra back pain
- ❒ My social life is normal but increases my degree of back pain
- ❒ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing, etc)
- ❒ Pain has restricted my social life and I do not go out very often
- ❒ Pain has restricted my social life to my home
- ❒ I have hardly any social life because of my back pain

Changing Degree of Pain

- ❒ My pain is rapidly getting better
- ❒ My pain fluctuates but overall is definitely getting better
- ❒ My pain seems to be getting better but improvement is slow
- ❒ My pain is neither getting better nor worse
- ❒ My pain is gradually worsening
- ❒ My pain is rapidly worsening

Index Score=
[sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score ☐

Name______________________________________ Date___________________

Please check each of the symptoms that apply to you:

- ❒ Attention/concentration challenges (mind wanders, easily distracted, difficulty focusing)
- ❒ Short-term memory loss, forgetfulness or trouble learning new things
- ❒ Difficulty finding the right word when speaking
- ❒ Difficulty making decsions or solving problems
- ❒ Difficulty understanding what is said or read
- ❒ Difficulty planning or organizing
- ❒ Make more mistakes than usual or not catching your mistakes
- ❒ Getting lost or disoriented even in familiar places
- ❒ Difficulty alternating attention or "juggling" several things at once
- ❒ Disorganized or confused thinking

- ❒ Dizziness
- ❒ Periods of "blacking out" or seizures
- ❒ Problems coordinating hands, feet, legs or dropping things
- ❒ Lose balance easily
- ❒ Stuttering or slurring
- ❒ Change in sense of taste or smell
- ❒ Blurry or double vision
- ❒ Ringing in the ears
- ❒ Headaches
- ❒ Greater than normal fatigue
- ❒ More sensitive to light and/or loud noise
- ❒ Tingling or numbness in arms or legs

- ❒ Feelings of sadness or depression
- ❒ Crying spells or weepiness
- ❒ Suicidal thoughts or intentions
- ❒ Increased or decreased emotions (circle appropriate answer)
- ❒ Increased or decreased appetite (circle one)
- ❒ Decreased interest in "fun" activities
- ❒ Difficulty with sleeping- getting to or staying asleep
- ❒ Increased irritability or easily frustrated
- ❒ Feelings of fear or anxiety

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):____