16144 SE Happy Valley Town Center Dr., Suite 214, Happy Valley, OR. 07086
Phone: (503) 658-7715 Fax: (503) 658-7181

Confidential Health History Information

Today's Date:_____

Patient Information

Name(first) _____(last)_____

Date of Birth: ____/____/_____ Sex (Circle One) M | F | M to F | F to M

Address:_____ Zip Code:_____

City:_____ State:_____

Email:_____

Phone Number: _____ Home / Cell / work (circle one)

Primary Emergency Contact

Name:_____ Relationship to patient: _____

Phone Number:_____

Please list all authorized persons you give permission to inquire about and make changes to scheduling, rescheduling, and canceling appointments.

Name: _____ Phone# _____ Relationship: _____

Name: _____ Phone# _____ Relationship: _____

Current Health Care

Are you currently receiving health care? Y / N

If yes, Where and from Whom?_____

If no, where did you last receive health care? _____

Primary Pharmacy Name:_____ Phone#:_____

Pharmacy Address:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Sunnyside Collaborative Care

(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

PATIENT CONSENT TO TREATMENT

Patient's Name _____Date of Birth _____/_____/_____

A patient coming to Sunnyside Collaborative Care to see a provider gives his/her permission and authority for care by them in accordance with appropriate test, diagnosis, and analysis. The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I hereby consent to the provision of diagnosis, care, and/or treatment by **Sunnyside Collaborative Care Providers**.

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers.

I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Sunnyside Collaborative Care providers reserve the right to terminate the doctor-patient relationship if patient is continually unable to comply with reasonable treatment plans, schedules, or behaves in a manner deemed inappropriate by the doctor or staff.

_____ _____

Signature of Patient or Responsible Party Date

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FINANCIAL RESPONSIBILITY

PLEASE READ THIS DOCUMENT CAREFULLY. BY EXECUTING THIS CONTRACT, YOU AGREE TO ALL RIGHTS, DUTIES, AND RESPONSIBILITIES STATED HEREIN.

1. **If you do not have insurance, or do not provide insurance at time of service.** All payments are to be paid in full at the time of service.

2. **If You Have Insurance.** All owed deductibles and co-payments are to be paid within 90 days of service provided.

3. **Self Pay Patient.** All payments are to be paid at the time of services. You are a self pay patient until you submit insurance cards, and SCC qualifies and accepts your insurance coverage.

4. **Reasonable Fees.** SCC fees are usual, customary, and reasonable according to professional industry standard, and, therefore, are covered up to the maximum allowance determined by each carrier.

5**. Patient Financial Responsibilities:**

- I understand is it my responsibility to contact my insurance company should I have a dispute with coverage.
- I hereby authorize the release of all information necessary to secure payment for services rendered.
- I understand I am financially responsible for all charges, whether or not they are covered by insurance.
- I understand if I disagree with any charges, I will contact the office in writing within 30 days of billing date.
- Should legal action be taken by this office to collect an unpaid balance due for services provided, I agree to pay reasonable attorney's fees or other such costs as the court determines proper.
- I understand it is my responsibility to provide accurate and up to date insurance information at or before my scheduled appointment.

I have read, understood and agree to the policies described above.

_____ _____

Patient Signature Date

_____ _____

Signature of Responsible Party or Guardian Date

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Cancellation Policy/No Show Policy for Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "Full" appointment book.

If any appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company

Print Name_____ **Date** _____

X_____

PATIENT SIGNATURE (*Or Patient Representative*)

Chiropractic Consent Form

Chiropractic examination and therapeutic procedures (including spinal adjustment, cold laser, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help have complications. While the chances of experiencing complications are small, it is the practice of his clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, temporary worsening of symptoms. More serious complications are rare and their association with spinal adjustments (manipulation) is debated. Serious complications are estimated to be in the range of .5-2 incidents per million adjustments of the neck and 1 per million for adjustments of the low back. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurological impairment, injuries to spinal discs, and spinal fractures. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

Please read the following carefully:

I understand that I have any prosthetics or surgical implants (Including breast implants, and artificial joint, etc.) I should discuss this with my practitioner as it may affect care.

Print Name_____ **Date** _____

X_____

PATIENT SIGNATURE (*Or Patient Representative*)

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Acupuncture Informed Consent To Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by an acupuncturist at Sunnyside Collaborative Care.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). The clinic uses sterile disposable needles and maintains a clean and safe environment, but infection is another possible risk. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. I reserve the right to bring a companion with me to any of my appointments if I choose so.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Name_____ **Date** _____

X_____

PATIENT SIGNATURE (*Or Patient Representative*)

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Patient Informed Consent

Notice:

Before we proceed with your appointment, I want to inform you about an important aspect of how we document our consultations. We utilize a note taking tool called Heidi to accurately and efficiently capture the details of our discussions and the outcomes of our appointments. Heidi ensures that we can focus more on our conversation and less on manual note taking, enhancing the quality of care you receive.

Your consent is crucial for us to use this technology. Please understand that your information will be handled with the utmost care, and Heidi's use is aimed solely at improving your healthcare experience.

By signing this consent form, you agree to allow your clinician to use Heidi during your consultation.

Print Name_____ **Date** _____

X_____

PATIENT SIGNATURE (*Or Patient Representative*)

For more information about Heidi Health, scan this QR code:

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Insurance Information

Auto/Worker's Comp Insurance

Is condition due to accident? Auto / Work

Accident Date:___/___/___ Claim Filed? Y N

Insurance Company:_____ Claim #_____

Insurance company Billing address:_____

Adjuster:_____ Adjuster Phone#_____

Group Health Insurance (Primary Insurance)

Insurance Company:_____ Policy Holder:_____

Relationship to patient:_____ Policy #_____

Group Plan #_____

Group Health Insurance (Secondary Insurance)

Insurance Company:_____ Policy Holder:_____

Relationship to patient:_____ Policy #_____

Group Plan #_____

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PERSONAL HEALTH HISTORY

Name

What are your most important health concerns?

1	Date of Birth		
2	Sex	Male	[ ]
		Female	[ ]
		M to F	[ ]
		F to M	[ ]
	Gender		
3	Marital status	Single	[ ]
		Married	[ ]
		Divorced	[ ]
		Separated	[ ]
		Widowed	[ ]
4	Occupation:		
	How many hours do you work a week?		
5	Have you ever been hospitalized?	Yes	No
6	Please list illnesses, surgical operations and other treatments and give dates?		

7	Are you allergic to any drug or substances?	Yes	No
	If yes, specify		
8	What medications are you taking at present?		
9	How much alcohol do you drink**?** *Type of drinks* _____ *No. drinks / day* _____ *No. drinks / week* _____		Never Used
10	How much tobacco do you use? *# cigarettes / day* _____*; # years of use* _____		Never Used
11	What recreational drugs do you use? *Please specify***:** _____		Never Used
12	How much caffeine do you drink a day? *Source:* _____*; # per day* _____		Never Used

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Family History. *Please answer where applicable.*

	Father	Mother	Brother/s	Sister/s	Children	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
Age if living									
Health (G=good, P=poor)									
Cancer									
Diabetes									
Heart disease									
High blood pressure									
Stroke									
Mental Illness									
Asthma, hay fever, Hives									
Autoimmune disease									
Other, please describe									
Age at death									
Cause of death									

Did any of the following happen to you in the past year?			
13	Death of family member	Yes	No
14	Separation from spouse or long-time partner	Yes	No
15	Recent job change	Yes	No
16	Financial difficulties	Yes	No
17	Moving within the same city	Yes	No
18	Moving to another city	Yes	No
19	Legal problems	Yes	No
20	Beginning a new relationship	Yes	No

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Please answer the following questions			
21	Do you have a job?	Yes	No
	If you have a job:		
	22. Are you satisfied with your work?	Yes	No
	23. Do you feel under pressure from work?	Yes	No
	24. Do you have problems with your colleagues at work?	Yes	No
	If you do not have a job:		
	22. Are you retired or a student	Yes	No
	23. Do you feel under pressure during the day?	Yes	No
	24. Are you unable to find a job?	Yes	No
25	Do you have serious arguments with close relatives?	Yes	No
26	Do you have serious arguments with other people?	Yes	No
27	Has any close relative been seriously ill in the past year?	Yes	No
	If yes, please specify		
28	Do you feel tension at home?	Yes	No
29	Do you live by yourself?	Yes	No
30	Do you feel lonely?	Yes	No
31	Do you have anyone whom you can trust and confide in?	Yes	No
32	Do you get along well with people?	Yes	No
33	Do you often feel overwhelmed by demands of everyday life?	Yes	No
34	Do you often feel that you cannot make it?	Yes	No
35	Do you tend to be influenced by people with strong opinions?	Yes	No
36	Do you tend to worry about what other people think about you?	Yes	No

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Please describe any problems or difficulties you have had recently and indicate how much they have troubled you by marking the appropriate column

		Not at all	Only a little	Somewhat	A great deal
37	It takes a long time to fall asleep	[ ]	[ ]	[ ]	[ ]
38	Restless sleep	[ ]	[ ]	[ ]	[ ]
39	Waking too early and not being able to fall asleep again	[ ]	[ ]	[ ]	[ ]
40	Feeling tired on waking up	[ ]	[ ]	[ ]	[ ]
41	Stomach, bowel pains	[ ]	[ ]	[ ]	[ ]
42	Heart beating quickly or strongly without reason	[ ]	[ ]	[ ]	[ ]
43	Feeling dizzy or faint	[ ]	[ ]	[ ]	[ ]
44	Feelings of pressure or tightness in head or body	[ ]	[ ]	[ ]	[ ]
45	Breathing difficulties or feeling of not having enough air	[ ]	[ ]	[ ]	[ ]
46	Feeling tired or lack of energy	[ ]	[ ]	[ ]	[ ]
47	Irritable	[ ]	[ ]	[ ]	[ ]
48	Sad or depressed	[ ]	[ ]	[ ]	[ ]
49	Feeling tense or 'wound up'	[ ]	[ ]	[ ]	[ ]
50	Loss of interest in most things	[ ]	[ ]	[ ]	[ ]
51	Attacks of panic	[ ]	[ ]	[ ]	[ ]
52	Do you believe you have a physical disease but that doctors have not diagnosed it correctly?	[ ]	[ ]	[ ]	[ ]
53	When you read or hear about an illness, do you get similar symptoms?	[ ]	[ ]	[ ]	[ ]
54	When you notice a sensation in your body, do you find it difficult to think of something else?	[ ]	[ ]	[ ]	[ ]

55	How do you rate the quality of your life	Excellent	Good	Fair	Poor	Awful

Piolanti, Antonio, Emanuela Offidani, Jenny Guidi, Sara Gostoli, Giovanni A. Fava, and Nicoletta Sonino. 2016. "Use of the Psychosocial Index: A Sensitive Tool in Research and Practice." *Psychotherapy and Psychosomatics* 85 (6): 337–45.

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REVIEW OF SYSTEMS

Constitutional		
Fever	Yes	No
Night sweats	Yes	No
Weight gain	Yes___lbs	No
Weight loss	Yes___lbs	No
Exercise intolerance	Yes	No
Sedation	Yes	No
Lethargy	Yes	No
Chills	Yes	No
Malaise	Yes	No

Eyes		
Dry Eyes	Yes	No
Irritation	Yes	No
Vision Change	Yes	No
Eye disease / Injury	Yes	No

Ears, Nose, Mouth, Throat		
Difficulty Hearing	Yes	No
Ear Pain	Yes	No
Frequent Nose Bleeds	Yes	No
Nose Problems	Yes	No
Sinus Problems	Yes	No
Sore Throat	Yes	No
Bleeding Gums	Yes	No
Snoring	Yes	No
Dry Mouth	Yes	No
Oral Abnormalities	Yes	No
Mouth Ulcer	Yes	No
Teeth Abnormalities	Yes	No
Mouth Breathing	Yes	No
Ringing in the Ears	Yes	No
Sinusitis	Yes	No

Genitourinary		
Urinary loss of control	Yes	No
Difficulty urinating	Yes	No
Increased urinary frequency	Yes	No
Blood in urine	Yes	No
Incomplete urination	Yes	No

Cardiovascular		
Chest pain on exertion	Yes	No
Arm pain on exertion	Yes	No
Shortness of breath when walking	Yes	No
Shortness of breath when lying down	Yes	No
Palpitations	Yes	No
Known heart murmur	Yes	No
Light-headed on standing	Yes	No
Ankle Swelling	Yes	No

Respiratory		
Cough	Yes	no
Wheezing	Yes	No
Shortness of breath	Yes	No
Coughing up blood	Yes	No
Sleep Apnea	Yes	No

Gastrointestinal		
Abdominal Pain	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Change in Appetite	Yes	No
Black or Tarry Stools	Yes	No
Vomiting blood	Yes	No
Stomach Pain	Yes	No
Heart burn	Yes	No

Neurological		
Loss of Consciousness	Yes	No
Weakness	Yes	No
Numbness	Yes	No
Seizures	Ye	No
Dizziness	Yes	No
Frequent or severe headaches	Yes	No
Migraines	Yes	No
Restless Legs	Yes	No
Tremor	Yes	No
Gait Dysfunction	Yes	No
Paralysis	Yes	No

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Musculoskeletal		
Muscle Aches	Yes	No
Muscle Weakness	Yes	No
Back pain	Yes	No
Swelling in extremities	Yes	No
Neck pain	Yes	No
Difficulty walking	Yes	No
Cramps	Yes	No
Osteoporosis	Yes	No
Fractures	Yes	No

Integumentary		
Abnormal mole	Yes	No
Jaundice	Yes	No
Rash	Yes	No
Itching	Yes	No
Dry skin	Yes	No
Skin Growths	Yes	No
Lacerations	Yes	No
Non-healing areas	Yes	No
Changes in hair and nails	Yes	No
Psoriasis	Yes	No
Change in skin color	Yes	No
Breast lump	Yes	No

Hematologic / Lymphatic		
Swollen glands	Yes	No
Easy bruising	Yes	No
Excessive Bleeding	Yes	No
Anemia	Yes	No
phlebitis	Yes	No

Psychiatric		
Depression	Yes	No
Sleep Disturbances	Yes	No
Feeling unsafe in relationship	Yes	No
Restless sleep	Yes	No
Alcohol abuse	Yes	No
Anxiety	Yes	No
Hallucinations	Yes	No
Suicidal thoughts	Yes	No
Mood swings	Yes	No
Memory loss	Yes	No
Agitation	Yes	No
Dementia	Yes	No
Delirium	Yes	No

Endocrine		
Fatigue	Yes	No
Increased thirst	Yes	No
Hair loss	Yes	No
Increased hair growth	Yes	No
Cold intolerance	Yes	No

Allergic		
Runny nose	Yes	No
Sinus pressure	Yes	No
Itching	Yes	No
Hives	Yes	No
Frequent sneezing	Yes	No