WELCOME TO
ACTIVE CHIROPRACTIC & REHABILITATION, LLC

233 SE Washington Street Hillsboro, OR 97123 (503) 648-1088 (503) 648-0748 fax

Dr. Patrick D. Bourlon
Chiropractic Physician

CONFIDENTIAL PATIENT INFORMATION

Name_____ Date_____
First MI Last .

Address_____ Sex M F
City State Zip

Home Phone (_____)_____ Cell (_____)_____ Birth Date_____ Age_____

For appointment reminder calls, which number would you prefer? (please circle) Home Cell Work

Email_____ Marital Status: S M Domestic Partner D Sep W

SS#_____ Driver's License # _____ State_____

Employer_____ Occupation_____

Work Phone (_____)_____ Extension_____ How long employed?_____

Whom may we thank for referring you?_____

If no referral, how did you find our office? Internet Search Insurance Provider Manual/Website

Our Website Yellow Pages Street Sign Other_____

Primary Care Physician_____ City/State_____ Phone (_____)_____

May we communicate with your Primary Care Physician regarding your care in this office? Yes No

IN CASE OF EMERGENCY, CONTACT:_____

Relationship_____ Phone (_____)_____ Work Phone (_____)_____ Extension_____

Patient Name_____ Date_____

HEALTH INSURANCE

Insured/Patient_____ Birth Date_____

Subscriber/Responsible Party (if not patient) _____

Subscriber Relationship to Patient_____ Subscriber Birth Date_____

Subscriber/Responsible Party Employer_____Work Phone (_____) _____ Extension_____

Insurance Company_____ Phone (_____) _____

ID#_____ Group#_____

Is patient covered by secondary/additional insurance? Yes No Other_____

Subscriber/Responsible Party_____

Subscriber Relationship to Patient_____ Subscriber Birth Date_____

Subscriber/Responsible Party Employer_____Work Phone (_____) _____ Extension_____

Insurance Company_____ Phone (_____) _____

ID#_____ Group#_____

AUTO ACCIDENT / WORKERS' COMPENSATION

Is this condition due to an accident? Yes No Date_____ Type of Accident? Auto Work
If yes, **please inform the receptionist immediately.**

PLEASE READ AND SIGN

ASSIGNMENT AND RELEASE: I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Active Chiropractic & Rehabilitation, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Active Chiropractic & Rehabilitation, LLC to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Date_____
Patient/Responsible Party/Parent/Guardian Signature

Patient Name_____ Date_____

GENERAL HEALTH INFORMATION

Primary Care Physician's Specialty_____ Date last seen_____

Date of most recent: Physical examination_____ Blood pressure test_____ Cholesterol test_____

Date of most recent: Mammogram/women's health tests _____

Current medical conditions and related medications:

_____

_____

_____

Please list all allergies_____

_____

Please check if you ever have had the following:

Headaches	___	Frequent colds	___	Upper back pain	___
Fainting	___	Chest pain	___	Pain between the shoulders	___
Dizziness	___	Hernia	___	Lower back pain	___
Loss of sleep	___	Diarrhea	___	Painful tail bone	___
Fatigue	___	Colon problems	___	Numbness in arms	___
Nervousness	___	Difficulty breathing	___	Pins and needles in arms	___
Constipation	___	High blood pressure	___	Numbness in legs	___
Eye pain	___	Stiff neck	___	Pins and needles in legs	___
Ear noises/pain	___	Swollen joints	___	Painful menstrual cycle	___
Ear discharge	___	Faulty posture	___		
Diabetes	___	Spinal curvature	___	Are you pregnant? Yes	No

Do you have metal implants (plates, pins, etc.), metal hip/shoulder/knee replacements, spinal metal implants or a pacemaker? Yes No

If yes, please describe_____

Please check if you or a blood relative have or have had the following:

Anemia	___You	___Mother	___Father	Epilepsy	___You	___Mother	___Father
Asthma	___You	___Mother	___Father	Glaucoma	___You	___Mother	___Father
Bleeding tendencies	___You	___Mother	___Father	Gout	___You	___Mother	___Father
Cancer or tumor	___You	___Mother	___Father	Heart trouble	___You	___Mother	___Father
Diabetes	___You	___Mother	___Father	High blood pressure	___You	___Mother	___Father
Kidney disease	___You	___Mother	___Father	Tuberculosis	___You	___Mother	___Father
Scoliosis	___You	___Mother	__ Father	Ulcer/stomach trouble	___You	___Mother	___Father
Mental disorder	___You	___Mother	___Father	Numbness	___You	___Mother	___Father
Rheumatism/arthritis	___You	___Mother	___Father	Sciatica	___You	___Mother	___Father
Stroke	___You	___Mother	___Father				

Patient Name_____ Date_____

Please list hospitalizations and surgeries:

_____ _____ Year

_____ _____ Year

_____ _____ Year

Have you had spinal x-rays, MRIs or CT scans? Yes No

Name and address of facility: Approximate date taken:

_____ _____

_____ _____

_____ _____

_____ _____

Have you previously received chiropractic care? Yes No Date last seen_____

Name and address of Chiropractor _____

PRESENT COMPLAINT

What is your present complaint?_____

When did it start?_____How did it start?_____

Is the pain worse in your: head_____ neck_____ back_____ arms_____ hips_____ down the legs_____ all of these__

Your pain is: (B= Better W= Worse N= No difference)

___ Coughing/Sneezing ___Sitting ___Bending forward ___Bending backward ___Lying on back

___Lying on stomach ___Lying on side ___Morning ___Midday ___Evening ___Late Night

How long have you been unable to work or do normal activities? _____ Does it awaken you at night? Yes No

Do you have to rest during the day due to pain? Yes No How often? _____

What treatments make your pain better?_____

What treatments make your pain worse?_____

Are you having any symptoms other than those that caused you to seek care? Yes No

Please describe: _____

_____

Patient Name_____ Date_____

PAIN SCALE: Please circle the number that best describes your pain.

0	1	2	3	4	5	6	7	8	9	10
None			Mild			Moderate			Severe	

PAIN DIAGRAM

Use the letters below to indicate the type and location of your sensations right now.

A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing O=Other