Welcome to Cedar Chiropractic!

Cedar Chiropractic Physicians LLC
Dawn Seater DC
Fred Seater DC
4141 SE Harrison St. Milwaukie, OR 97222
P: 503-653-2232 F: 503-305-8815

Date: ______________________

Patient Information

Name: _________________________________ SSN: ___________________________

Address: ________________________________ City:________________
State: ________ Zip: _________ Home/Cell Phone: _________________________
Employer: ____________________________________Work Phone: _____________________
Employer's address: ____
Email Address: ___________________________
Date of Birth:___________ Height: _____________ Weight:___________________
How did you hear about us? __________________
Do you want to receive text/email appointment reminders? YES________NO________
If yes, please provide your cell phone carrier (AT&T, Verizon, etc)_______________________________

Incase of Emergency: Contact ______________________________ Phone # __________________

Present Health Condition

****In order of importance, list the health problems You are most interested in getting corrected:***

1.___________________________
2.___________________________
3.___________________________
4.___________________________
5.___________________________

**** List approximately how long you have noticed these problems:***

1.___________________________
2.___________________________
3.___________________________
4.___________________________
5.___________________________

1) Is there a certain time of day any of these problems are better or worse?____
2) List the treatments you have used for these problems:
__Ice __Heat __Exercise __Massage __Chiropractic __Rest
__Medication(s):____
__Other
3) Describe any sudden movements, injuries, falls, accidents, etc. that have caused your problem(s):____
____
4) Have you ever had similar health problems or injuries before? __Yes __No If yes, please explain:____

5) Have your health problems: __Improved __Worsened __Stayed the same

6) List anything that makes your condition
*worse:*____
*better :*____

7) Please check off and describe how this problem interferes with your work and/or personal life:
*Have you missed and days of work? __Yes __No If yes, dates missed?*__________________
*__Home activities affected:*____
*__Recreational activities affected:*____
__Work activities affected: ____

Previous Health History

1) Who is your primary care physician/family doctor? ___________________________________
*2) When were you last seen there?*____
*3) May we send them updates on your treatment/condition?*_____________________________
4) During the last year, has your doctor treated you for any health problem(s)?__Yes __No
*If yes, please explain:*____
*5) Have you ever received Chiropractic care? __Yes __No If yes, please list the doctors name and reason for seeing them:*____
6) Please check any prescription drugs you are taking: __Anti-depressants __Anti-inflammatory __Birth Control __Blood pressure medication __Diet pills __Blood sugar medication __Muscle relaxants __Insulin __Pain pills __Sleeping pills __Other
*(please list):*____
*7) Please check any over the counter medication you are taking and how much: __Advil_______, __Aleve_________, __Aspirin_______________, __Motrin_______________, __Tylenol____________, __Other*____
8) Please list any allergies:
____
9) Please list any prior surgeries, injuries, or illnesses with dates.

____________________________________ ______________________________

*10) Please list any vitamins or nutritional supplements you are currently taking or have taken recently:*____

Social History

*1) Do you smoke? __Yes __No If yes, how many packs/daily:*__________

*2) Do you drink? __Yes __No If yes, how many drinks/week:*__________

*3) Do you exercise regularly? __Yes __No If yes, describe what type and how often:*____

4) Do you consider your diet to be healthy? __Yes __No

5) Do you consider yourself to have a good social support system (friends/family)? __Yes __No

Family Health History

1) Marital Status: __Married __Single __Divorced __Widowed __Separated
2) Name of spouse: _________________
3) Spouses Phone number (if different from yours):_____________________
4) Names and ages of children:____
____

To help your doctor determine if your health problem is hereditary please fill out the following table on the health of your immediate family members.

	Age (If living)	***Age (If deceased)***	***Chronic Health Problems***
Mother			
Father			
Brother/sister			
Brother/sister			
Brother/sister			

Review of Systems

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask one of the staff, or your doctor.

Const. (Health in General) *❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other:____*

Ears, Nose, Mouth & Throat *❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other____*

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: ______________________________

Resp. (Lungs & Breathing) *❑ No Problems | Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: ____*

GI (Stomach & Intestines) *❑ No Problems | Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____________________________*

GU (Kidney & Bladder) *❑ No Problems | Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: ______________________________*

MS (Muscles, Bones, Joints) *❑ No Problems | Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: ___________________________________*

Integ. (Skin, Hair & Breast) *❑ No Problems | Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: ________________________*

Neurologic (Brain & Nerves) *❑ No Problems | Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: ____________________________________*

Psychiatric (Mood & Thinking) *❑ No Problems | Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: __________________*

Endocrinologic (Glands) *❑ No Problems | Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____________________________*

Hematologic (Blood/Lymph) *❑ No Problems | Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _________________________________*

Allergic/Immunologic *❑ No Problems | Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other____*

Financial Responsibility

1) Who is responsible for your bill? __ Insurance __ My employer __Spouse __Me __Other

2) Type of insurance: __ Automobile __Health __ Worker's Comp

3)Insurance company's name, address and phone number:____

____

As a courtesy to you, we will bill your insurance carrier for you. All co-payments, deductibles, and payments for supplements, supports and other "non-covered" services are due at the time of service unless prior arrangements have been made. Payments may be made in cash, check, VISA, or MasterCard. Any unpaid balances 90 days and over will be charged interest of 2% per month. If you are unable to pay in full, it is your responsibility to contact our billing department to set up an agreeable payment plan. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. Your fees are due and payable at time examinations and treatments are received, unless arrangements have been made in advance.

Our practice is committed to providing the best treatment possible for our patient and we charge what is usual and customary for our area. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary rates.

I hereby assign to Cedar Chiropractic Physicians, LLC, those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with treatment rendered. I request that payment of authorized benefits be made directly to the medical provider named above on my behalf. I am responsible for any uncovered or unpaid balance owing regardless of assignment. These charges could include amounts applied to my annual deductible or co-payment amounts.

Missed Appointments:
We require 24 hours notice for cancellation of all appointments. There will be a $15.00 charge to the patient for all appointments that are missed and not cancelled.

Patient's Statement: I understand that I am ultimately responsible for the payment of any services or products that I receive from this office. I also understand that I will be responsible for any fees related to the collection of unpaid balances, including reasonable attorney's fees. Also by signing this form I am consenting for an examination and treatment by the Provider.

Patient's Signature:______________________________ Social Security #:____________________

Date: ______________

Parent or Guardian Signature (if patient is minor):_______________________________________

Social Security #:_________________________________ Date:__________________________