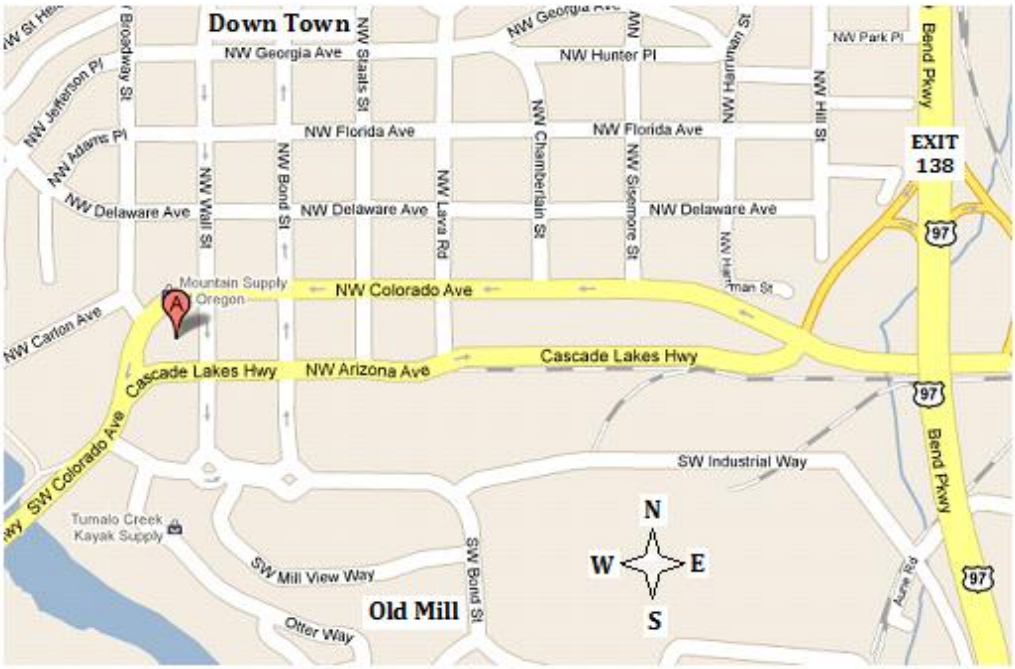
FALLING WATERS

INJURY & HEALTH MANAGEMENT CENTER

APPOINTMENT CHECKLIST

- ❒ **ARRIVAL TIME:**
  Please ensure that you come to your appointment at your scheduled arrival time. If needing to reschedule, please contact the office no less than 24 hours prior to your scheduled appointment.
- ❒ **PAPERWORK:**
  Please have this packet completed prior to arriving for your appointment. If not completed, please arrive 25 minutes prior to your scheduled arrival time.
- ❒ **UNDER 18 YEARS OF AGE:**
  If patient is under 18 years old, parental signatures are required on all paperwork.
- ❒ **REFERRAL / PRESCRIPTION:**
  If you are being referred to our office by another doctor or practitioner, please bring the referral or prescription with you to your appointment.
- ❒ **INSURANCE CARD AND DRIVER'S LICENSE:**
  Please ensure you bring these cards with you to your appointment as we will need copies for our records.

AREA MAP



Please print the "**DIRECTIONS TO FALLING WATERS**" page from our website for more specific directions on how to locate our clinic, or if using a GPS, enter the address below.

55 NW Wall St., Ste #100, Bend, OR 97703-3200 Phone: 541.389.4321 Fax: 541.389.4420

PERSONAL INJURY INTAKE

Remember to bring Completed Paperwork. (If paperwork is not completed, arrive 25 min prior to appt.)

First Name: _____ MI: _____ Last Name: _____ SS#: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Preferred Communication Type: ☐ Phone ☐ Text ☐ Email Preferred Language: _____

Sex: ☐M ☐F DOB: ___/___/_____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Do you have children: ☐ No ☐ Yes, if yes, how many children: _____ What are their ages: _____

Occupation: _____ Employer: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Do you give permission for our office to update your general medical practitioner with the progress of your condition? Yes No

Name of Medical Doctor: _____ Who may we thank for referring you to us? _____

In compliance with the governmental EHR incentive program and CMS requirements, we ask the following:

Race (select one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White (Caucasian) ☐ Other ☐ I Decline to Answer

Ethnicity (select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Decline to Answer

PAYMENT INFORMATION

Do you or someone else have insurance coverage for the vehicle you were in?	☐ I have ☐ Someone else has coverage, Name: _____
How is this person related to you	☐ Self, ☐ Parent, ☐ Friend, ☐ Other: _____
Name of **your Auto Insurance Carrier**:	**Claim Number**:
Claim **Adjusters Name**:	Claim **Adjuster's Telephone Number:**
Do you know your **Policy Limits** for medical bills?	☐ No ☐ Yes, Limit is: $
Do you have an Insurance **Deductible**?	☐ No ☐ Yes, Deductible is: $

ATTORNEY INFORMATION

Do you have an **attorney** representing you? ☐ Yes ☐ No Attorney Name: _____

if **Yes**, please provide their information: Firm: _____

ASSIGNMENT AND RELEASE

Scheduling an appointment reserves this time especially for you and no one else. Therefore, our office requires **24 hours notice to cancel an appointment**. **If 24 hours is not given, a charge of $20** will be billed to your account.

I _____ clearly **understand and agree that all services provided will be charged directly to me and that I am personally responsible for payment**. I agree to allow Falling Waters, LLC and/or provider to bill my insurance company as a courtesy and permit the release of medical records necessary to process my claims. I authorize Falling Waters, LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I authorize payments to be made directly to Falling Waters, LLC and/or provider for treatment rendered. **I understand that co-payments and time of service fees are due at the time of service, I may receive an additional bill for services not covered by my insurance and any fees incurred by sending to collections will be added.**

Patient's Signature: _____ **Date:** _____
Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*

INJURY HISTORY INFORMATION

Patient Name: _____ Today's Date: _____

GENERAL INFORMATION

Date of injury: _____

Time of accident: _____ ☐ a.m. ☐ p.m.

Direction of impact? ☐ Front ☐ Rear ☐ Right ☐ Left

You were the:

☐ Driver ☐ Front passenger ☐ Rear passenger

☐ Other: _____

How many people were in your vehicle? _____

How many cars were involved in the accident? _____

YOUR VEHICLE

Year: _____ Make: _____ Model: _____

Was **your car**: ☐ Stopped ☐ Rolling
☐ Speeding up ☐ Slowing down

Estimated **speed** you were traveling? _____ mph

What **direction** where you traveling? _____

Estimated cost of **damage** to your car? $ _____

Who gave the estimate? _____

OTHER VEHICLE

Year: _____ Make: _____ Model: _____

Other car was: ☐ Stopped ☐ Rolling
☐ Speeding up ☐ Slowing down

Estimated **speed** they were traveling? _____ mph

What **direction** where they traveling? _____

Estimated cost of **damage** to their car? $ _____

Who gave the estimate? _____

IMPACT

During / **after the initial** crash did your car:

☐ Hit another car / object? ☐ Roll over

☐ other: _____

Road conditions: ☐ Dry ☐ Wet ☐ Icy

☐ Other _____

Visibility: ☐ Good ☐ Poor due to _____

Were you wearing your **seatbelt**? ☐ Yes ☐ No

If **Yes**, type? ☐ Lap ☐ Shoulder ☐ Lap & Shoulder

Did your seat have a headrest? ☐ Yes ☐ No

If **Yes**, what was the position of the headrest?

☐ Low ☐ Mid-position ☐ High

Impact Cont'd…

At the time of the impact which way were you **looking**?

☐ Straight ahead ☐ Up ☐ Down

☐ To the right ☐ To the left ☐ Behind you

Was your body back **against the seat**? ☐ Yes ☐ No

If **No**, why not? _____

Were both hands on the steering wheel? ☐ Yes ☐ No

If **No**, which was on the steering wheel: ☐ L ☐ R

Was your foot on the **brake?** ☐ Yes ☐ No

Did any part of your **body strike** anything inside the vehicle? ☐ Yes ☐ No

If **Yes**, explain: _____

Did your car have airbags? ☐ Yes ☐ No

If **Yes**, did they inflate? ☐ Yes ☐ No

Was your **seat broken** in the collision? ☐ Yes ☐ No

Were you: ☐ **Surprised** by impact ☐ **Braced** for impact

Were you wearing a **hat** or **glasses**? ☐ Yes ☐ No

If **Yes**, were they **still on** after the crash? ☐ Yes ☐ No

ACCIDENT SITE

City: _____

Road/Street name: _____

Please **describe the accident** in your own words:

_____

_____

_____

_____

_____

_____

_____

CRASH DIAGRAM:

Please sketch here:

AFTER THE ACCIDENT

Symptoms **immediately** after the accident: ☐ None

☐ Headache ☐ Leg pain
☐ Head pain ☐ Numbness/tingling
☐ Neck pain ☐ Confusion/disorientation
☐ Arm pain ☐ Dizziness
☐ Mid back pain ☐ Nausea
☐ Low back pain ☐ Other _____

Were you knocked unconscious? ☐ Yes ☐ No
If **Yes**, for how long? _____

Did the drivers exchange information? ☐ Yes ☐ No

Did the police come to the scene? ☐ Yes ☐ No
If **Yes**, was a report made? ☐ Yes ☐ No
If **No**, why not? _____

Vehicles **towed after crash**? ☐ No ☐ Mine ☐ Other

Where did you **go after** the crash?
☐ Home ☐ Work ☐ Hospital ☐ Other: _____
Mode of transportation? _____

Please describe your symptoms:
a) **1-3 hrs** later? _____
_____
b) Later in the **day / night**? _____
_____
c) **Days / weeks / months** later? _____
_____

EMERGENCY DEPARTMENT

Did you go to the **ER**? ☐ Yes ☐ No: Date _____
If **No**, why not? _____

X-rays taken? ☐ Yes ☐ No
If **Yes**, a) body parts imaged: _____
b) Results: _____

CT scan done? ☐ Yes ☐ No
If **Yes**, a) body parts imaged: _____
b) Results: _____

MRI done? ☐ Yes ☐ No
If **Yes**, a) body parts imaged: _____
b) Results: _____

Lab work: ☐ Yes ☐ No: _____

Diagnosis given? _____

Medications: _____

Were you given a cervical collar? ☐ Yes ☐ No

Follow-up instructions: _____

TREATMENT HISTORY

Have you received any evaluation and/or treatment for your current injuries? ☐ Yes ☐ No
If **No**, please briefly explain why not:
_____
_____

If **Yes**, fill out below from **first** to **last** provider seen:

1st Provider: _____
Specialty: _____ Date first seen: _____
Referred by: _____
Testing done? ☐ Yes ☐ No
If **Yes**, a) test(s) done: _____
b) results: _____
Diagnosis? _____
Treatment/recommendations: _____
_____
Effects of treatment: _____
Notes: _____

2nd Provider: _____
Specialty: _____ Date first seen: _____
Referred by: _____
Testing done? ☐ Yes ☐ No
If **Yes**, a) test(s) done: _____
b) results: _____
Diagnosis? _____
Treatment/recommendations: _____
_____
Effects of treatment: _____
Notes: _____

3rd Provider: _____
Specialty: _____ Date first seen: _____
Referred by: _____
Testing done? ☐ Yes ☐ No
If **Yes**, a) test(s) done: _____
b) results: _____
Diagnosis? _____
Treatment/recommendations: _____
_____
Effects of treatment: _____
Notes: _____

Treatment History Cont'd…

4th Provider: _____

Specialty: _____ Date first seen: _____

Referred by: _____

Testing done? ☐ Yes ☐ No

If **Yes**, a) test(s) done: _____

b) results: _____

Diagnosis? _____

Treatment/recommendations: _____

_____

Effects of treatment: _____

Notes: _____

5th Provider: _____

Specialty: _____ Date first seen: _____

Referred by: _____

Testing done? ☐ Yes ☐ No

If **Yes**, a) test(s) done: _____

b) results: _____

Diagnosis? _____

Treatment/recommendations: _____

_____

Effects of treatment: _____

Notes: _____

6th Provider: _____

Specialty: _____ Date first seen: _____

Referred by: _____

Testing done? ☐ Yes ☐ No

If **Yes**, a) test(s) done: _____

b) results: _____

Diagnosis? _____

Treatment/recommendations: _____

_____

Effects of treatment: _____

Notes: _____

PRIOR AUTOMOBILE ACCIDENTS

Have you been involved (driver or passenger) in a motor vehicle accident before? ☐ Yes ☐ No

If **Yes**, please fill out below:

Year: _____ Injuries: _____

Treatment: _____

Residual symptoms? ☐ Yes ☐ No

If **Yes**, List: _____

Year: _____ Injuries: _____

Treatment: _____

Residual symptoms? ☐ Yes ☐ No

If **Yes**, List: _____

Year: _____ Injuries: _____

Treatment: _____

Residual symptoms? ☐ Yes ☐ No

If **Yes**, List: _____

PRIOR INJURIES OR SYMPTOMS TO THE SAME AREAS

Have you ever had any injuries or symptoms in the **same areas** you have now, prior to this collision? ☐ Yes ☐ No

If **Yes**, please fill out below:

Year: _____ Injuries: _____

Treatment: _____

Residual symptoms? ☐ Yes ☐ No

If **Yes**, List: _____

Year: _____ Injuries: _____

Treatment: _____

Residual symptoms? ☐ Yes ☐ No

If **Yes**, List: _____

Year: _____ Injuries: _____

Treatment: _____

Residual symptoms? ☐ Yes ☐ No

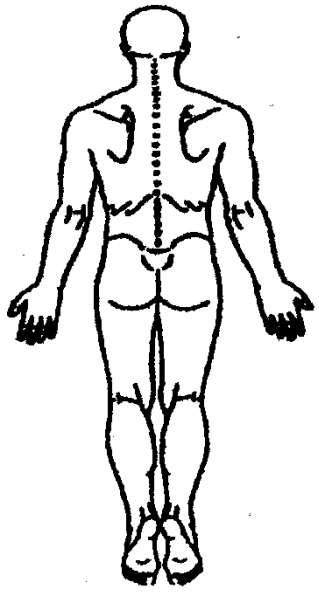
If **Yes**, List: _____

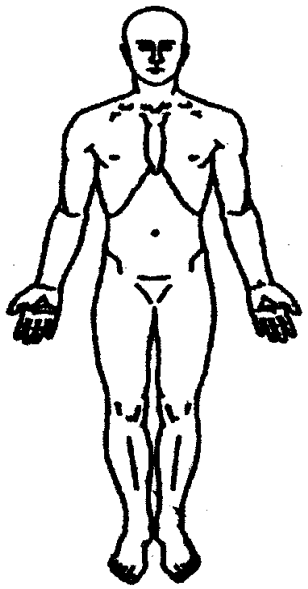
POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

***PATIENT INSTRUCTIONS**: It is **important** for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark, or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when any of the following symptoms began, noting if you experienced similar symptoms before this accident. Leave the row blank if the symptom listed below does not apply to you.*

Using the following abbreviations to indicate on the figures below where you are experiencing symptoms**:**

P = Pain **S** = Stiffness **A** = Aching
B = Burning **NT** = Numbness/Tingling





SYMPTOM LIST *(Check all that apply to you)*	FELT RIGHT AFTER INJURY	BEGAN 1 – 14 DAYS AFTER INJURY	YOU HAVE SYMPTOMS NOW	HAD SIMILAR SYMPTOMS 1-3 MONTHS BEFORE THIS INJURY
PAIN / STIFFESS:				
❒ Head				
❒ Jaw				
❒ Neck				
❒ Shoulder				
❒ Arm				
❒ Wrist / hand / fingers				
❒ Upper / middle back				
❒ Chest / Breast				
❒ Rib cage				
❒ Low back				
❒ Hip				
❒ Leg / thigh				
❒ Knee				
❒ Ankle / foot				
❒ Other _____				
NUMBNESS/TINGLING:				
❒ Arms				
❒ Wrist / hand / fingers				
❒ Leg / thigh				
❒ Foot / toes				
OTHER:				
❒ Weakness in arms/legs				
❒ Fatigue				
❒ Anxiety				
❒ Sleep Disturbance				
❒ Sensitivity to noise				
❒ Impaired concentration				
❒ Vision changes				
❒ Irritable/mood changes				
❒ Difficulty swallowing				
❒ Dizziness				
❒ Forgetfulness				
❒ Ringing in ears				
❒ Loss of coordination				
❒ Poor balance				
❒ Sensitivity to light				
❒ Other: _____				

REVIEW OF SYMPTOMS

1. CONSTITUTIONAL Please rate your overall level of health (compared to others in your age group)

1. Excellent
2. Very Good
3. Good
4. Fair
5. Poor
6. Other:_____

Please **circle YES** or **NO** for each of the symptom categories below, based on symptoms you've had in the **PAST 30 DAYS**.
If yes, please provide a **score** next to the individual symptom using the following point system:

1 = Occasionally have it, effect is NOT severe
2 = Occasionally have it, effect IS severe
3 = Frequently have it, effect is NOT severe
4 = Frequently have it, effect IS severe

2. GENERAL YES NO

Fever/sweats	1 2 3 4	Chills	1 2 3 4	Weight loss	1 2 3 4	Other: _____
Fatigue	1 2 3 4	Recent infections	1 2 3 4	Multiple joint pain	1 2 3 4	
Fainting	1 2 3 4	Recurrent infections	1 2 3 4	Swollen joints	1 2 3 4	**Provider Score: _____**

3. HEAD / JAW YES NO

Headaches	1 2 3 4	Faintness	1 2 3 4	Grind teeth at night	1 2 3 4	Other: _____
Migraines	1 2 3 4	Dizziness	1 2 3 4	Insomnia/sleep change	1 2 3 4	
Jaw pain	1 2 3 4	Unexplained hair loss	1 2 3 4			**Provider Score: _____**

4. EYES YES NO

Loss/change in vision	1 2 3 4	Glasses/contacts	1 2 3 4	Swollen, red or sticky	1 2 3 4	Excessive watering 1 2 3 4
Double vision	1 2 3 4	Flashing lights/halos	1 2 3 4	eyelids		Other: _____
Blurry/tunnel vision	1 2 3 4	Pain/sensitivity to light	1 2 3 4	Bags or dark circles	1 2 3 4	
Floaters	1 2 3 4	Watery/itchy eyes	1 2 3 4	under the eyes		**Provider Score: _____**

5. EARS – HEARING YES NO

Hearing loss/change	1 2 3 4	Itchy ears	1 2 3 4	Balance problems	1 2 3 4	Other: _____
Ringing/buzz in ears	1 2 3 4	Drainage from the ear	1 2 3 4			
Ear pain	1 2 3 4	Earaches/infections	1 2 3 4			**Provider Score: _____**

6. NOSE-MOUTH-THROAT YES NO

Changes in smell	1 2 3 4	Post-nasal drip	1 2 3 4	Excessive mucus	1 2 3 4	Sore throat/infection 1 2 3 4
Nose bleeds	1 2 3 4	Sinus problems	1 2 3 4	formation		Gagging, need to clear 1 2 3 4
Nose pain	1 2 3 4	Sinus infections	1 2 3 4	Voice changes	1 2 3 4	throat
Hay fever	1 2 3 4	Changes in taste	1 2 3 4	Sore throat, hoarseness,	1 2 3 4	Other: _____
Sneezing attacks	1 2 3 4	Canker sores	1 2 3 4	loss of voice		
Colds	1 2 3 4	Swollen or discolored	1 2 3 4	Trouble swallowing	1 2 3 4	
Stuffy nose	1 2 3 4	tongue, gums or lips		Chronic coughing	1 2 3 4	**Provider Score: _____**

7. SKIN YES NO

Dry skin	1 2 3 4	Flushing	1 2 3 4	Excessive sweating	1 2 3 4	Other: _____
Skin lesions/rash	1 2 3 4	Dermatitis	1 2 3 4	Hives	1 2 3 4	
Pimples/acne	1 2 3 4	Infections	1 2 3 4	Hair loss	1 2 3 4	
Bruise easily	1 2 3 4	Warts	1 2 3 4			**Provider Score: _____**

8. CARDIOVASCULAR YES NO

Chest pain/angina	1 2 3 4	Irregular or skipped	1 2 3 4	Leg cramps while	1 2 3 4	Other: _____
Rapid or pounding	1 2 3 4	heart beat		walking		
heart rate		Leg or ankle swelling	1 2 3 4			
Cold fingers/toes	1 2 3 4	Leg cramps at night	1 2 3 4			**Provider Score: _____**

9. RESPIRATORY YES NO

Difficulty breathing	1 2 3 4	Chest congestion	1 2 3 4	Allergies	1 2 3 4	Other: _____
Shortness of breath	1 2 3 4	Cough/sputum	1 2 3 4	Asthma attacks	1 2 3 4	
Pain with breathing	1 2 3 4	Wheezing	1 2 3 4			**Provider Score: _____**

10. GASTROINTESINAL YES NO

Appetite/diet change	1 2 3 4	Heartburn/reflux	1 2 3 4	Bowel habit changes	1 2 3 4	Ulcers 1 2 3 4
Bloated feeling	1 2 3 4	Stomach pain	1 2 3 4	Hemorrhoids	1 2 3 4	Other: _____
Constipation	1 2 3 4	Nausea/vomiting	1 2 3 4	Rectal bleeding	1 2 3 4	
Diarrhea	1 2 3 4	Belching or gas	1 2 3 4	Jaundice (yellowing)	1 2 3 4	**Provider Score: ____**

11. JOINTS / MUSCLES — YES NO

Pain/ache in joints	1 2 3 4	Popping or locking of joints	1 2 3 4	Joint swelling	1 2 3 4	Other: _____
Pain/ache in muscles	1 2 3 4			Feelings of weakness or tiredness	1 2 3 4	
Stiff/limited motion	1 2 3 4	Giving way of joints	1 2 3 4			**Provider Score: _____**

12. WEIGHT — YES NO

Excessive weight	1 2 3 4	Compulsive eating	1 2 3 4	Craving certain foods	1 2 3 4	Other: _____
Underweight	1 2 3 4	Binge eating/drinking	1 2 3 4	Water retention	1 2 3 4	***Provider Score: _____***

13. MIND — YES NO

Personality changes	1 2 3 4	Difficulty making decisions	1 2 3 4	Stuttering or stammering	1 2 3 4	Other: _____
ADD/ADHD	1 2 3 4					
Poor concentration	1 2 3 4	Impulsiveness	1 2 3 4	Slurred speech	1 2 3 4	
Confusion, poor comprehension	1 2 3 4	Poor memory	1 2 3 4	Poor physical coordination	1 2 3 4	
		Learning disabilities	1 2 3 4			***Provider Score: _____***

14. EMOTIONAL — YES NO

Mood swings	1 2 3 4	Exhaustion	1 2 3 4	Anxiety, fear or nervousness	1 2 3 4	Abusive behavior	1 2 3 4
Short attention span	1 2 3 4	Impulsiveness	1 2 3 4			Abuse drugs	1 2 3 4
Scattered thoughts	1 2 3 4	Feel blue	1 2 3 4	Nervous breakdown	1 2 3 4	Abuse alcohol	1 2 3 4
Prone to stress	1 2 3 4	Frequent crying	1 2 3 4	Anger, irritability, aggression	1 2 3 4	Other: _____	
Difficulty sleeping	1 2 3 4	Prone to depression	1 2 3 4				
Poor dream recall	1 2 3 4	Depression	1 2 3 4	Short tempered	1 2 3 4	***Provider Score: _____***	

15. NEUROLOGICAL — YES NO

Numbness/tingling	1 2 3 4	Poor balance	1 2 3 4	Other: _____		
Weakness	1 2 3 4	Bowel/bladder changes	1 2 3 4			***Provider Score: _____***

16. URINARY — YES NO

Pain with urination	1 2 3 4	Trouble starting or stopping	1 2 3 4	Urinary tract infections	1 2 3 4	Other: _____
Frequent or urgent urination	1 2 3 4			Smelly urine	1 2 3 4	
		Leakage	1 2 3 4	Blood in urine	1 2 3 4	
Nighttime urination	1 2 3 4	Urinary discharge	1 2 3 4	Pus in urine	1 2 3 4	***Provider Score: _____***

17. ENDOCRINE — YES NO

High/low blood sugar	1 2 3 4	Hard to lose weight	1 2 3 4	Headaches	1 2 3 4	Other: _____
		Dry skin, hair, nails	1 2 3 4	Fatigue	1 2 3 4	
Weight gain/loss	1 2 3 4	Heat/cold intolerance	1 2 3 4			***Provider Score: _____***

WOMEN ONLY

18. Do you have now or have had any of these symptoms in the last 3 months? — YES NO

Menstrual cramps or problems	1 2 3 4	Sore breasts	1 2 3 4	Genital discharge/odor	1 2 3 4	Low libido	1 2 3 4
		Abdominal/pelvic pain	1 2 3 4	Yeast infections or itchiness	1 2 3 4	Other: _____	
Irregular cycle	1 2 3 4	Pain with intercourse	1 2 3 4				
Irregular flow	1 2 3 4	Hot flashes	1 2 3 4	Breast lumps	1 2 3 4	***Provider Score: _____***	

MEN ONLY

19. Do you have now or have had any of these symptoms in the last 3 months? — YES NO

Erectile difficulties	1 2 3 4	Penile discharge	1 2 3 4	Low libido	1 2 3 4	Other: _____
Lumps in testicles	1 2 3 4	Sores on penis	1 2 3 4	Breast lumps	1 2 3 4	
Enlarged prostate	1 2 3 4	Itchy genitals	1 2 3 4	Reduced muscle mass	1 2 3 4	***Provider Score: _____***

GRAND TOTAL: _____

CERTIFICATE OF AUTHENTICITY

I hereby certify that the above information is true and correct within the best of my knowledge.

Signature of Patient: _____ Date: _____

Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*

HEALTH HISTORY

PAST HEALTH

1. Do **you currently**, or **have you ever** suffered from any of the following? *(if yes please circle)* **YES** **NO**

Anemia	Depression	Hepatitis	Liver disease/Cirrhosis	Skin condition
Aneurysm	Diabetes	Herpes	Lyme's disease	Sleep apnea
Arthritis	Emphysema	High/low blood pressure	Mononucleosis	Stroke
Asthma	Enlarged prostate	High cholesterol	Osteoporosis	Tendonitis
Bleeding disorder	Eye condition	HIV/AIDS	Pneumonia	Thyroid condition
Bronchitis	Gallbladder disorder	Inherited bone disorder	Pancreatitis	Torn ligaments
Bursitis	Gout	Injured/pinched nerve	Recurrent sprains	Torn muscle/tendon
Cancer	Growth disorders	Irritable bowel disease	Rheumatoid arthritis	Tuberculosis
Colitis	Heart disease/attack	Kidney stones/problems	Rheumatic fever	Venereal disease
Colon cancer	Heart murmur	Leukemia	Seizure disorder	Other: _____

2. Have you ever been **HOSPITALIZED** or had **SURGERY?** **YES** **NO**

If yes, describe:

Year	Reason	Surgery	Outcome

3. Have you ever had any **MODERATE TRAUMA** or **ACCIDENTS?** *(e.g. Car accidents, Sports injuries, Fractures)* **YES** **NO**

If yes, describe:

Year	Trauma	Treatment	Outcome

4. Do you take any **MEDICATIONS** or **VITAMINS / HERBS?** **YES** **NO**

If yes, describe:

Med/Supp	Route (oral, etc.)	Dosage	x/day	Reason

5. Do you have any **ALLERGIES?** *(Medications, foods, environmental or other substances)* **YES** **NO**

If yes, describe:

Allergy	Allergic Response	Onset

6. Have you ever had any **SPECIAL TESTS** performed? **(X-RAY, MRI, CT, etc.)** **YES** **NO**

If yes, describe:

Test	When	Reason	Results

7. When was your **LAST PHYSICAL** by your general practitioner? **Date:** ____/____/_____

Were there any problems / concerns? **YES** **NO**

If yes, describe:

WOMEN ONLY

8. Date of last menstrual period? _____ Are you **pregnant**? _____ Due date? _____

Date of last pap smear? _____ How many children do you have? _____

Date of last mammogram? _____ Have you ever had a "C-section?" _____

FAMILY HISTORY

1. Has **anyone** in your **immediate family** suffered from any of the following? *(if yes, please circle)* **YES** **NO**

Aneurysm	Colon cancer	Gout	Irritable bowel disease	Skin condition
Arthritis	Depression	Heart disease/attack	Kidney stones/problems	Stroke
Bleeding disorder	Diabetes	High/low blood pressure	Osteoporosis	Thyroid condition
Cancer	Gallbladder disorder	High cholesterol	Seizure disorder	Other: _____

PERSONAL HISTORY

1. Describe your **WORK CONDITIONS**

	None	25%	50%	>75%
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Light labor	☐	☐	☐	☐
Heavy labor	☐	☐	☐	☐
Prolonged postures	☐	☐	☐	☐
Repetitive stresses/motions	☐	☐	☐	☐
Overhead activities	☐	☐	☐	☐
Mental stress	☐	☐	☐	☐

2. Do you have **STRESS** in your life? **YES** **NO**

If yes, is it: □ Mild □ Moderate □ Severe

a) What stresses do you have? _____

b) How do you manage your stress? _____

3. Please note the following **HABITS**

	Light	Moderate	Heavy	None
Coffee	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Recreational drugs	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐

Smoking Status: □ Never smoked □ Former Smoker □ Occasionally □ Smoke Daily If smoking, start date: ___/___/_____

3. Please note the following **DIETARY HABITS**

How many ounces or glasses of water do you drink per day? _____

How many servings of vegetables do you eat in a day? _____

Do you skip meals? YES NO if yes, which meal(s) and how often? _____

Do you eat within 3 hours of bedtime? YES NO if yes, how often? _____

4. Do you **EXERCISE?** **YES** **NO**

If No, would you like to? **YES** **NO**

If Yes, answer the following:

a) What **type**? □ Walking □ Running □ Cycling □ Swimming □ Weightlifting □ Yoga □ Other _____

b) **How many days** per week? 1 2 3 4 5 6 7

c) How many **minutes** per session? 15-30 30-60 60-90 90-120 >120

d) What is the **Intensity** level? LOW MED HIGH

e) How many **years** have you exercised like this? _____

5. Do you **SLEEP WELL** at night? **YES** **NO**

If No, answer the following:

Do you have trouble falling asleep? **YES** **NO**

Do you wake-up frequently during the night? **YES** **NO**

Do you grind your teeth at night? **YES** **NO**

Do you feel rested in the morning? **YES** **NO**

CERTIFICATE OF AUTHENTICITY

I hereby certify that the above information is true and correct within the best of my knowledge.

Signature of Patient: _____ Date: _____

Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*

PROTECTED HEALTH INFORMATION DISCLOSURE

PLEASE REVIEW THE FOLLOWING CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

- My health information may be created or received by Falling Waters, LLC and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

- We may use health information about you to provide you with medical treatment of services. We may disclose health information about you to doctors, nurses, technicians, office staff, personnel or anyone who is involved in taking care of you and your health.

- I understand that I have the right to receive and review a written description of how Falling Waters, LLC will handle my health information. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of Falling Waters, LLC and my rights regarding my health information.

- I understand that the Notice of Privacy Practices may be revised periodically. We will not disclose your health information unless we have received written consent. I understand that a copy of summary of the most recent version of Falling Waters, LLC's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

By signing this agreement I attest that I understand the information above. Our posted Privacy Health Information provides more detailed information about the usage and disclosure of your (PHI). You have the right to review and/or request a copy of this policy before you sign this consent.

Signed: _____ Date: _____

Special Permission Request:
I give my permission for Falling Waters, LLC to leave messages regarding appointments on my home/mobile telephone answering machine.

Signed: _____ Date: _____

I give my permission to have messages regarding treatment, billing and/or appointment status left with my spouse, partner, caregiver _____ _____ _____
Name of spouse/partner/caregiver Date of birth Telephone #

Signed: _____ Date: _____

This release will revoke by written permission only. I understand that I must send a written request to Falling Waters, LLC in order to revoke this release.

Signed: _____ Date: _____

TREATMENT CONSENT, FINANCIAL POLICY & DISCLOSURE

Name (Printed)**: _____ Date: _____**

Please read this agreement and sign at the end indicating that you have understood and agree to the following. Please feel free to ask any questions if you would like clarification or additional information.

- Information revealed during counseling and discussion sessions is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.
- All procedures and treatment interventions (medications, nutraceuticals, therapies, spinal manipulation, injections, minor surgical procedures, etc.) carry with them both risks and benefits. Risks include, but are not limited to injury, fracture, burns, worsening of condition, adverse reactions, stroke and/or death. Not receiving or accepting treatment recommendations also carries inherent risks, including but not limited to possible worsening of condition or disease progression, which may result in reduced quality of life and/or premature death. If unsure regarding a recommended treatment or procedure, there may be additional or alternative treatments available. Therefore, you are encouraged to ask questions if you would like additional information. No guarantees can be assured regarding the outcomes of any treatment(s) or procedure(s) recommended or performed.
- **Fees are charged for professional services, and full payment with cash, check, or credit card is due at the time these services are rendered.** Treatments, consultations (whether by phone, e-mail, or in the office), detailed correspondence on your behalf are examples of professional services.
- **You are responsible for payment for office fees, treatments, and lab tests regardless of insurance coverage.** As a courtesy, we provide insurance billing service; however, each insurance plan offers different levels of reimbursement and/or coverage for services. Many "preventive approaches" to healthcare are not covered by insurance plans. **Any expense not covered by your insurance plan is your responsibility to pay in full.** At your request, you will receive a detailed receipt to request reimbursement from your insurance carrier.
- If you have a serious health problem that requires immediate attention, you should call 911, or have someone take you to the nearest hospital emergency room. If you notice an adverse effect from one of the components of your health plan, you should discontinue it then call our office and inform the provider of your concerns.
- Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Please let the doctor / provider know if you are being treated by other healthcare providers (Physicians, Counselors, Therapists, etc.). Consult your prescribing Doctor before discontinuing medications. **It is your responsibility to disclose new injuries, symptoms, conditions, treatments, medications, supplements, surgeries or diagnostic procedures performed, as well as any changes in your symptoms, conditions, medications, supplements, contact information, or treatments by other providers between visits**.
- You are welcome to bring a friend or relative to your visits if such companionship is comfortable to you.
- You are encouraged to ask questions on any health-related topic and to take an active role in your health care. Ours is a team approach, and treatment recommendations may involve encouraging you to make changes to your diet and lifestyle that can help you improve your level of health.
- Falling Waters, LLC is owned by Mark W. Davies, DC and has financial interest in its ancillary services. If you would prefer to have any ancillary services performed elsewhere we will assist you to make arrangements.

CERTIFICATE OF CONSENT

My signature below signifies my consent to treatment and assures that the contact information, health history, and other information that I have provided on my intake forms are complete and accurate. I have read, understand and agree to the information in this packet and my questions, if any, were answered to my satisfaction.

Signature of Patient: _____ Date: _____

Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*