Solutions Chiropractic LLC
Dr. Jim Bowman DC
www.SolutionsChiropractic.net

1009 NW Hoyt St. #100
Portland, OR 97209
(p) 503.964.9096 (f) 503.212.0316

AUTO ACCIDENT QUESTIONNAIRE

Patient's Name ______________________ **Today's Date** ______________________

Date of Accident ______________________ Time of Accident ____________ ☐ AM ☐ PM

Location of Accident ____

Were you the: Driver / Passenger (circle one)

Were you wearing a seat belt? ☐Yes ☐ No

With a shoulder harnesses? ☐Yes ☐ No

Your car: ______________________
Year Make Model

Other car: ______________________
Year Make Model

☐ Front impact ☐ Side impact ☐ Rear impact ☐ Non-collision: ____________

Describe what happened to you upon impact: ____

____

Estimated speed of **your** car: _______ mph ☐ Speeding up ☐ Braking ☐ Totally stopped

Estimated speed of **other** car: _______ mph ☐ Speeding up ☐ Braking ☐ Totally stopped

Did you brace for impact? ☐Yes ☐ No Was your foot on the brake? ☐Yes ☐ No

---

Describe your body position at impact? ☐ head forward ☐ head turned left ☐ head turned right

☐ body forward ☐ body turned left ☐ body turned right

☐ other (describe: ______________________________)

Did any part of your body strike the inside of the car? ☐ No ☐ Yes ______________________

Any cuts, bruises or abrasions? ☐ No ☐ Yes (explain): ______________________

Hit your head or lose consciousness? ☐ No ☐ Yes (explain): ______________________

Were the police summoned? ☐ No ☐ Yes Was an ambulance summoned? ☐ No ☐ Yes

Have you been examined and/or treated for your accident injuries ☐ No ☐ Yes (explain): ____________

____

Circle all that apply: Emergency room / X-rays / CT / MRI / Pain Medication / Muscle Relaxers / Anti-Inflammatory

Response to treatment: ____

____

Continued on back . . .

Solutions Chiropractic LLC
Dr. Jim Bowman DC
www.SolutionsChiropractic.net

1009 NW Hoyt St. #100
Portland, OR 97209
(p) 503.964.9096 (f) 503.212.0316

Questionnaire Continued

Patient's Name ______________________ **Today's Date** ______________________

How did you feel **immediately after** the accident? ______________________________________

____

Could you move all parts of your body? ☐Yes ☐ No (explain): ______________________________

Could you exit the car and walk unaided? ☐Yes ☐ No (explain): ______________________________

______

How did you feel **that night**? ____

____

How did you feel over the **next few days**? ____

____

Check any symptoms that have occurred ***since*** the accident:

☐ headache ☐ neck pain / stiffness ☐ mid-back pain ☐ low back pain

☐ dizziness ☐ numbness (arms / fingers) ☐ shortness of breath ☐ numbness (legs /toes)

☐ fatigue ☐ sleeping problems ☐ nervous / anxious ☐ tension

☐ other: ____

____

Have you missed time for work? ☐ No ☐ Yes Missed **full-time** work: from __________ to __________

Missed **part-time** work: from __________ to __________

Are your work activities restricted as a result of this injury? ☐ No ☐ Yes (explain): ______________

____

Did you have any physical complaints just before the accident? ☐ No ☐ Yes (explain): ______________

____

____

Check any symptoms that you had ***BEFORE*** the accident:

☐ headache ☐ neck pain / stiffness ☐ mid-back pain ☐ low back pain

☐ dizziness ☐ numbness (arms / fingers) ☐ shortness of breath ☐ numbness (legs /toes)

☐ fatigue ☐ sleeping problems ☐ nervous / anxious ☐ tension

☐ other: ____

Your signature below certifies that all of the above information is true and correct

Signature (Patient or Guardian) **Date**

Solutions Chiropractic LLC
Dr. Jim Bowman DC
www.SolutionsChiropractic.net

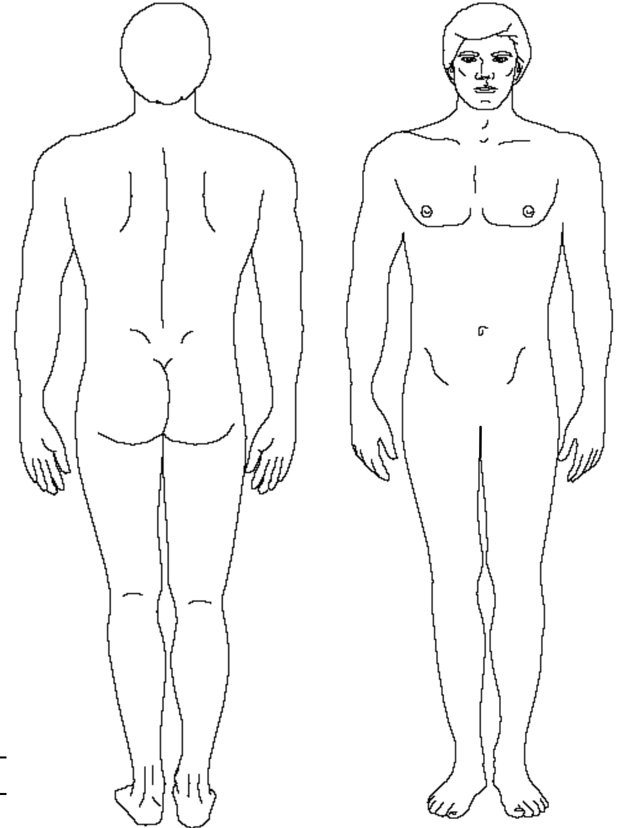
1009 NW Hoyt St. #100
Portland, OR 97209
(p) 503.964.9096 (f) 503.212.0316

Patient Initial Intake

Name: ______________________________ DOB: ___/___/______ Date: ___/___ /______

Describe your symptoms: ______________________________
____
____
____

Indicate the location of your symptoms:



Describe any activities affected by your symptoms: __________
____
____

When did your symptoms begin? ____________________
____

Are your symptoms getting worse? **No / Yes**
Does it keep you from working? **No / Yes**
Does it keep you from sleeping? **No / Yes**

Have you seen a chiropractor before? **No / Yes**

Are you currently under the care of a physician? **No / Yes**
Name of primary care physician: ______________________

☐ **Current medications:**	**Reason for taking them:**
______________	______________________
______________	______________________
______________	______________________

☐ **Prior Illness / Injuries:**	**Yes**	**No**	**If yes, briefly explain.**
- Strains or sprains	☐	☐	______________________
- Broken bone(s)	☐	☐	______________________
- Fallen / struck unconscious	☐	☐	______________________
- Auto accident / work injury	☐	☐	______________________
☐ **Hospitalization / Surgeries**	☐	☐	______________________
☐ **Major health conditions**	☐	☐	______________________

☐ **Present Lifestyle Habits:**	**None**	**Light**	**Moderate**	**Heavy**
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐

Do you have any reason to believe that you are currently pregnant?

No / Yes

Signature (Patient or Guardian) **Date**

JSB ☑: Indicates reviewed by the doctor with the patient at the time of the exam

Solutions Chiropractic LLC
Dr. Jim Bowman DC
www.SolutionsChiropractic.net

1009 NW Hoyt St. #100
Portland, OR 97209
(p) 503.964.9096 (f) 503.212.0316

Review of Systems

Patient's Name ______________________________ DOB ____________ Date ____________

Please indicate all CURRENT or PAST conditions.
All information will be kept strictly confidential.

C = Current problem **P** = Past problem

☐ **C P Head / Spinal Pain**
- ☐ ☐ Headache
- ☐ ☐ Eye
- ☐ ☐ Ear
- ☐ ☐ Neck pain, stiffness
- ☐ ☐ Pain between shoulders
- ☐ ☐ Abdomen
- ☐ ☐ Chest
- ☐ ☐ Low back pain
- ☐ ☐ Sciatica
- ☐ ☐ Painful tailbone
- ☐ ☐ Poor posture
- ☐ ☐ Spinal curvature
- ☐ ☐ Foot trouble
- ☐ ☐ Swollen joints
- ☐ ☐ Bursitis

☐ **C P Numbness**
- ☐ ☐ Shoulders
- ☐ ☐ Upper Arm
- ☐ ☐ Forearm
- ☐ ☐ Hand
- ☐ ☐ Thigh
- ☐ ☐ Shin / calf
- ☐ ☐ Feet

☐ **C P Extremity Pain**
- ☐ ☐ Shoulders
- ☐ ☐ Upper Arm
- ☐ ☐ Elbows
- ☐ ☐ Forearm
- ☐ ☐ Hand
- ☐ ☐ Hips
- ☐ ☐ Thigh
- ☐ ☐ Knee
- ☐ ☐ Shin
- ☐ ☐ Ankle
- ☐ ☐ Feet

☐ **C P Cardiovascular**
- ☐ ☐ Hardening of arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heartbeat
- ☐ ☐ Slow heartbeat
- ☐ ☐ Swelling of ankles

☐ **C P Respiratory**
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spit up blood

☐ **C P Constitutional**
- ☐ ☐ Dizziness
- ☐ ☐ Fainting
- ☐ ☐ Concussion

☐ **C P Skin**
- ☐ ☐ Allergy
- ☐ ☐ Skin rash
- ☐ ☐ Enlarged glands

☐ **C P Gastrointestinal**
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Jaundice
- ☐ ☐ Liver trouble
- ☐ ☐ Nausea
- ☐ ☐ Vomiting

☐ **C P Genitourinary**
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Loss of bladder control
- ☐ ☐ Kidney infection
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble

☐ **Family history of serious illness:** ____
____
____
____

Signature (Patient or Guardian)

Date

JSB ☑: Indicates reviewed by the doctor with the patient at the time of the exam

Solutions Chiropractic LLC
Dr. Jim Bowman DC
www.SolutionsChiropractic.net

1009 NW Hoyt St. #100
Portland, OR 97209
(p) 503.964.9096 (f) 503.212.0316

REGISTRATION INFORMATION

Name ____ Today's Date ____________
Last First MI

Address ____
(Complete Mailing) Street Apt# City State Zip

Date of Birth: _____ / _____ / ________

Primary Phone* (______) _______ - _________ ☐ home ☐ cell ☐ work

Secondary Phone* (______) _______ - _________ ☐ home ☐ cell ☐ work

Employer__________________________ Occupation______________________________________

Emergency Contact___________________ Relationship_____________ Phone (______) _______ - ________

E-mail: __________________________

☐ YES: You may contact me by e-mail, but I can opt out anytime.

☐ NO: Please, don't contact me by e-mail

Please choose one:

☐ I will pay my balance in full at time of service

☐ I prefer to make payment arrangements prior to services being rendered

☐ I intend to bill insurance:

Ins Company [ ] Representative [ ]

Ins Phone # [ ]

Group # [ ] Policy ID # [ ]

Payment Policy

By signing below, I understand that full payment for all services and products I receive from Solutions Chiropractic LLC is required at the time of service, except that portion billed to my insurance company. I understand that Solutions Chiropractic LLC may bill my insurance carrier directly, if I so request, and that I am responsible for any services not covered by my insurance company, as well as, any co-pay, coinsurance, or deductible required by my insurance. I instruct my insurance carrier to pay this office directly for all services and authorize the release of any information necessary to secure payment.

By signing this application I affirm that I have given true and complete information.

Signature (Patient or Guardian) **Date**

Solutions Chiropractic LLC
Dr. Jim Bowman DC
www.SolutionsChiropractic.net

1009 NW Hoyt St. #100
Portland, OR 97209
(p) 503.964.9096 (f) 503.212.0316

CONSENT: TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, the undersigned, consent to the use and disclosure of my Protected Health Information by Solutions Chiropractic LLC for the purpose of providing treatment to me, obtaining payment of services rendered to me, and for general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, collected or received by Solutions Chiropractic LLC, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of Solutions Chiropractic LLC, but that Solutions Chiropractic LLC is not required to agree to these restrictions. However, if Solutions Chiropractic LLC agrees to a restriction that I request, the restriction is binding on Solutions Chiropractic LLC.

I have been given the opportunity to review Solutions Chiropractic LLC Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice’s duties regarding the types of uses and disclosures of my Protected Health Information. This document is posted in plain view on the front desk near the intake window. Please notify our front desk if you wish to have a copy of our Notice of Privacy practices.

I have the right to revoke this consent, in writing, at any time, except to the extent that James Bowman DC or Solutions Chiropractic LLC has acted in reliance on this consent.

Print (Patient Name)

Signature (Patient or Guardian)

Date

PLEASE READ & INITIAL EACH ITEM BELOW

(1) I hereby authorize Solutions Chiropractic LLC to provide Chiropractic services for me.

(2) I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Solutions Chiropractic LLC.

(3) If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney’s fees and cost of collections.

(4) I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Solutions Chiropractic LLC

(5) I authorize release of patient’s records to third parties requiring these records for determination of financial liability.

Solutions Chiropractic LLC
Dr. Jim Bowman DC
www.SolutionsChiropractic.net

1009 NW Hoyt St. #100
Portland, OR 97209
(p) 503.964.9096 (f) 503.212.0316

INFORMED CONSENT: DIAGNOSIS & TREATMENT

Chiropractic examination and therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. ***Any procedure intended to help may have complications.*** While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them.

I, the undersigned, hereby request and consent to the performance of chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) on me (or the patient named above, for whom I am legally responsible) by Dr. James Bowman, and/or his relief doctor who now or in the future treats me in the office.

I understand and am informed that in the practice of chiropractic there are some rare risks to treatment, including but not limited to soreness, inflammation, soft tissue injury, fractures, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above consent regarding treatment side-effects. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures. 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. I also understand that there is no guarantee or warranty for a specific cure or result.

Signature (Patient or Guardian) **Date**

Signature (Dr. Jim Bowman DC) **Date**

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

Print (Patient Name) **Date of Birth**

for any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment. This authorization will be effective for one year.

Signature (Parent or Guardian) **Witnessed by**

Solutions Chiropractic LLC
Dr. Jim Bowman DC
www.SolutionsChiropractic.net

1009 NW Hoyt St. #100
Portland, OR 97209
(p) 503.964.9096 (f) 503.212.0316

Business Agreement

(1) I understand that all responsibility for chiropractic services provided in this office for myself or my dependents is entirely mine, due and payable at the time services are rendered unless other arrangements have been made with Solutions Chiropractic LLC.

a. In the event that payments are not paid in full within 30 days of the treatment date, I understand that a 1.5% service charge (i.e. 18% per annum) shall be added to my account.

b. I further understand that any dishonored checks will be assessed a statutory handling and collection fee of $25.00 and any related bank fee incurred.

(2) I have signed and understand the authorized consent form given by Solutions Chiropractic for the modalities used within the office.

(3) I acknowledge that no guarantee, warranty or assurance has been given by anyone as to the treatment results that may be obtained.

(4) I grant my permission to Solutions Chiropractic LLC agents to telephone me at my home or at my workplace to discuss matters related to this consent, appointments, my treatment, or my account.

(5) I hereby authorize Solutions Chiropractic LLC to release any information necessary to process my family's medical claims.

(6) I acknowledge that I will give at least **24 hours notice** for cancellation of appointments and that I will be charged a late fee for all broken appointments, no shows and short notice cancellations. I understand that if I break an appointment for a third time that I will not be rescheduled and will be provided with medical care for 30 days only, to allow time to find another health care practitioner.

(7) The Fee Schedule maintained by Solutions Chiropractic LLC is based upon the full amount of code fees (associated with services provided and type of office visit) that are considered "usual and customary" for practitioners in the local area. Any party that pays in full on the day services are rendered qualifies to receive the "Time of Service" discount. All prices are subject to change and available upon request.

Signature (Patient or Guardian)

Date