

**PLEASE NOTIFY THE RECEPTIONIST IF YOU ARE HERE FOR A WORKERS COMPENSATION  
CASE OR IF YOU WERE INVOLVED IN A MOTOR VEHICLE ACCIDENT.**

Your Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Mailing Address \_\_\_\_\_ Sex M \_\_\_ F \_\_\_ # Children \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security Number \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Marital Status M \_\_\_ D \_\_\_ S \_\_\_ W \_\_\_  
Please include area code

Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Student Yes \_\_\_\_\_ No \_\_\_\_\_ School \_\_\_\_\_

Insurance Subscribers Name \_\_\_\_\_ DOB \_\_\_\_\_

Spouse/Parent name \_\_\_\_\_ Phone# \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone# \_\_\_\_\_  
**MUST BE COMPLETED**

How did you hear about us? \_\_\_\_\_

**Authorization and Assignment** I authorize you to release any information necessary to process claims and I assign to the physicians all payments for medical services. I understand that I am ultimately responsible for payment, regardless of insurance coverage. This authorization is valid until revoked in writing.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Beutz Family Chiropractic 1170 Molala Ave. Oregon City, OR 97045 (503) 656-9877



# Patient Health Questionnaire

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

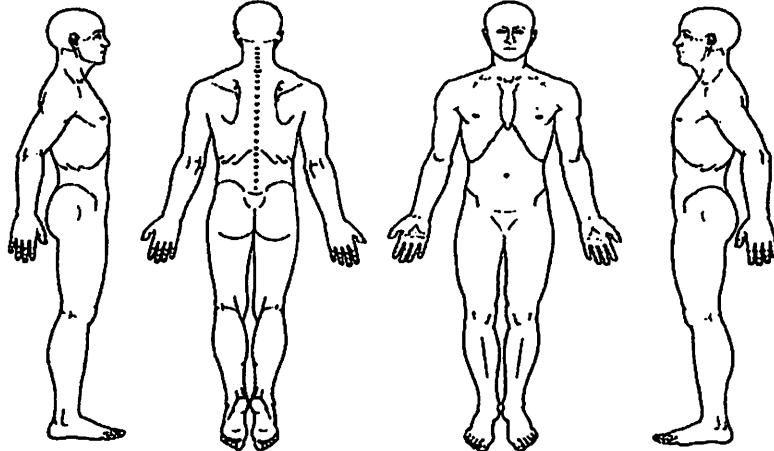
1. When did your symptoms start: \_\_\_\_\_

Describe your symptoms and how they began:

---

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



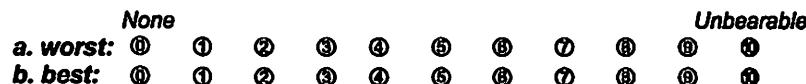
3. What describes the nature of your symptoms?

- ① Sharp      ④ Shooting
- ② Dull ache    ⑤ Burning
- ③ Numb       ⑥ Tingling

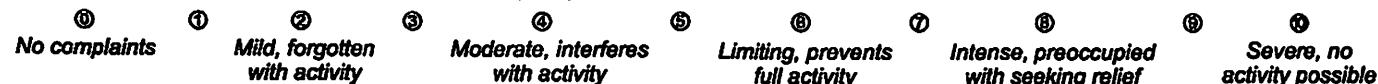
4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. How bad are your symptoms at their:



6. How do your symptoms affect your ability to perform daily activities?



7. What activities make your symptoms worse:

---

8. What activities make your symptoms better:

---

9. Who have you seen for your symptoms?

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. When and what treatment?

---

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_
- ③ CT Scan date: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ④ Other date: \_\_\_\_\_

10. Have you had similar symptoms in the past?

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① Yes
- ② No

- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

11. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson

- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time

- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

12. What do you hope to get from your visit/treatment (select all that apply):

- ① Reduce symptoms
- ③ Explanation of condition/treatment
- ② Resume/increase activity
- ④ Learn how to take care of this on my own
- ⑤ How to prevent this from occurring again
- ⑥ Other

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

## **Patient Health Questionnaire - page 2**

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**What type of regular exercise do you perform?**      ① None      ② Light      ③ Moderate      ④ Strenuous

**What is your height and weight?**

Height 

--	--	--

      Feet      Inches

Weight 

--	--	--

 lbs.

**For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.**

**Past      Present**

- Headaches
- Neck Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Shoulder Pain
- Elbow/Upper Arm Pain
- Wrist Pain
- Hand Pain
- Hip/Upper Leg Pain
- Knee/Lower Leg Pain
- Ankle/Foot Pain
- Jaw Pain
- Joint Swelling/Stiffness
- Arthritis
- Rheumatoid Arthritis
- General Fatigue
- Muscular Incoordination
- Visual Disturbances
- Dizziness

**Past      Present**

- High Blood Pressure
- Heart Attack
- Chest Pains
- Stroke
- Angina
- Kidney Stones
- Kidney Disorders
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems
- Abnormal Weight Gain/Loss
- Loss of Appetite
- Abdominal Pain
- Ulcer
- Hepatitis
- Liver/Gall Bladder Disorder
- Cancer
- Tumor
- Asthma
- Chronic Sinusitis

**Past      Present**

- Diabetes
- Excessive Thirst
- Frequent Urination
- Smoking/Use Tobacco Products
- Drug/Alcohol Dependence
- Allergies
- Depression
- Systemic Lupus
- Epilepsy
- Dermatitis/Eczema/Rash
- HIV/AIDS

### **Females Only**

- Birth Control Pills
- Hormonal Replacement
- Pregnancy

### **Other Health Problems/Issues**

- 
- 
- 
- 

**Indicate if an immediate family member has had any of the following:**

Rheumatoid Arthritis     Heart Problems     Diabetes     Cancer     Lupus     \_\_\_\_\_

**List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:**

\_\_\_\_\_

**List all the surgical procedures you have had and times you have been hospitalized:**

\_\_\_\_\_

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

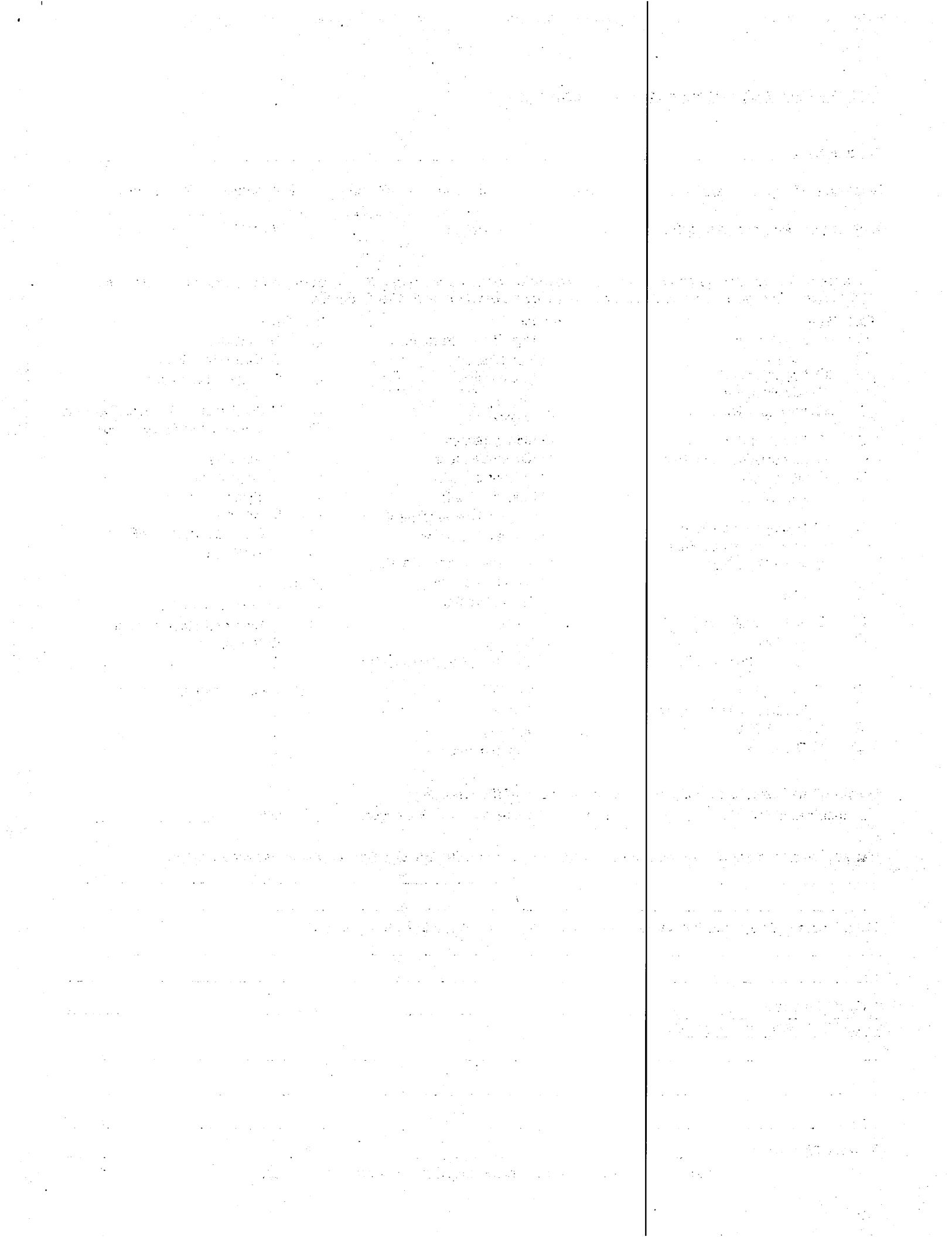
**Doctor's Additional Comments**

\_\_\_\_\_

\_\_\_\_\_

**Doctors Signature** \_\_\_\_\_

**Date** \_\_\_\_\_





## **OFFICE FINANCIAL POLICY**

### **FOR PATIENTS WITHOUT INSURANCE**

- Payment is expected at the time of treatment. If other arrangements are necessary, please inquire. We are happy to accept cash, checks, Visa, MasterCard, Discover or American Express. We offer a 20% billing discount if all services are paid in full at the time of treatment.

### **FOR PATIENTS WITH INSURANCE**

- There have been a lot of recent changes with health insurance. Even if you have not changed insurance companies, there may have been changes made to your existing plan. Your plan may have a different copay, deductible, or coverage maximum. As a courtesy to you we verify your insurance benefits. Once we have obtained this information from your insurance company, we relay this information to you. However, a quote of benefits is not a guarantee that services will be paid for. It is important for you to understand that any insurance you have is an agreement between you and your insurance company. All charges not covered by your insurance company are your responsibility.  
If you believe that any of the information we were given regarding your insurance benefits was incorrect, we encourage you to contact your insurance company, to verify your benefits yourself. We are happy to provide you with a form, with all of the questions you need to ask, to fully understand your chiropractic benefits. If we were given any incorrect information, please let us know.

### **FOR PATIENTS WITH MEDICARE**

- We accept Medicare assignment. We will bill Medicare on your behalf. Medicare covers spinal manipulation only, but does not cover an exam or therapies. All services other than the spinal manipulation will be your responsibility and payment will be expected at the time of service.

### **FOR AUTOMOBILE ACCIDENTS OR PERSONAL INJURY**

- Automobile insurance and personal injury does cover chiropractic care. Please provide your auto insurance information at your first visit. If at any time your insurance stops paying for your care, all subsequent visits will require payment at the time of service. If necessary, payment arrangements can be made. See our billing staff for any questions. If an attorney is handling your case, please notify our billing staff as soon as possible.

### **"ON THE JOB" INJURY**

- Workers' compensation laws allow limited chiropractic care for documented work injuries. Please be sure to notify your employer and fill out the appropriate forms. We will be happy to bill your workers' compensation insurance carrier and work within the guidelines of the workers compensation laws.

I have read the above financial policy and have initialed the section that applies to me. I understand the terms as stated above.

---

Signature

---

Date

1. *Leucosia* *leucosia* (L.)  
2. *Leucosia* *leucostoma* (L.)  
3. *Leucosia* *leucostoma* (L.)  
4. *Leucosia* *leucostoma* (L.)

5. *Leucosia* *leucostoma* (L.)  
6. *Leucosia* *leucostoma* (L.)  
7. *Leucosia* *leucostoma* (L.)

8. *Leucosia* *leucostoma* (L.)  
9. *Leucosia* *leucostoma* (L.)  
10. *Leucosia* *leucostoma* (L.)  
11. *Leucosia* *leucostoma* (L.)  
12. *Leucosia* *leucostoma* (L.)

13. *Leucosia* *leucostoma* (L.)  
14. *Leucosia* *leucostoma* (L.)  
15. *Leucosia* *leucostoma* (L.)

16. *Leucosia* *leucostoma* (L.)  
17. *Leucosia* *leucostoma* (L.)  
18. *Leucosia* *leucostoma* (L.)

19. *Leucosia* *leucostoma* (L.)  
20. *Leucosia* *leucostoma* (L.)  
21. *Leucosia* *leucostoma* (L.)

22. *Leucosia* *leucostoma* (L.)  
23. *Leucosia* *leucostoma* (L.)  
24. *Leucosia* *leucostoma* (L.)

25. *Leucosia* *leucostoma* (L.)  
26. *Leucosia* *leucostoma* (L.)  
27. *Leucosia* *leucostoma* (L.)

28. *Leucosia* *leucostoma* (L.)  
29. *Leucosia* *leucostoma* (L.)  
30. *Leucosia* *leucostoma* (L.)

31. *Leucosia* *leucostoma* (L.)  
32. *Leucosia* *leucostoma* (L.)  
33. *Leucosia* *leucostoma* (L.)



## **Beutz Family Chiropractic**

1170 Molalla Avenue  
Oregon City, Oregon 97045  
(503) 656-9877  
Fax (503) 657-1225  
beutzchiropractic@gmail.com

Andy Beutz D.C.  
Holly Beutz D.C.

## **Massage Cancellation and No Show Policy**

We ask that our patients give us 24 hours notice for any cancelled massage appointments. When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients. When a patient fails to show for an appointment, our valuable time and resources remain idle. More importantly, a patient care opportunity is missed.

We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances or a scheduling conflict that is beyond his or her control. Giving us at least 24-hour notice affords us the opportunity to schedule another patient who needs massage care.

After one no show or late cancellation we will review our Cancellation and No Show policy with you. After that, there will be a fee. We trust that you understand that we have this policy so we can best serve our patients.

Sincerely,

Beutz Family Chiropractic

Date: \_\_\_\_\_

Patient printed name: \_\_\_\_\_

Patient signed name: \_\_\_\_\_

