Portland Massage and Chiropractic Services LLC

Dr. Jeffrey Dougal, D.C., L.M.T.

Phone: 503-347-7668 Fax: 503-828-1576

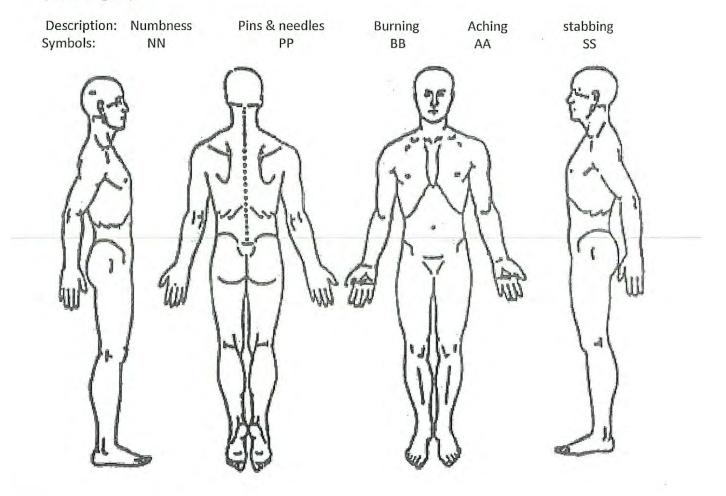
8800 S.E. Sunnyside Rd. Clackamas OR 97015 Email: drjeffdougal@yahoo.com

NPI#: 1669624375 & 1962844324

Chiropractic License #: 3680

	* Required Field.	<u>Please P</u>	<u>rint Clearly</u>		
*Name:			Date:		
First	Middle Initial	Last			
*Address:					
Street Address		City	State	e	Zip Code
*Phone Number:		*Birth Date:		Age: _	
*Work Status (circle one): Employe	ed Full-Time Student	Part-Time Student	*Occupation: _		
Email:		Referr	ed By:		
*Marital Status (circle one): Sin	gle Married	*Gender:	M F		
*In Case of Emergency Contact	•				

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).



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Please Check the Box If You Have Had Trouble With Any Of the Following, Circle NO If None:

Cardiovascular			No	Respiratory			No	Allergic/Immunologic			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								Ear, Nose and Throat			No
Jaw Pain				Eyes			No		Past	Present	1
Irregular											
Heartbeat		,			Past	Present		Difficulty Swallowing			
Swelling of Legs				Glaucoma				Dizziness			
				Double							
				Vision				Hearing Loss			
				Blurred							
Genitourinary			No	Vision				Sore Throat			_
	Past	Present						Nosebleeds			
Kidney Disease				Psychiatric			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infection			
Frequent											
Urination				Depression							
Blood in Urine				Anxiety				Gastrointestinal			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury	-			Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			-
Numbness								Poor Appetite			
Severe Headaches				Hematologic	×		No				
Pinched Nerves					Past	Present		Musculoskeletal			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout .			
Vertigo		177		Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
Commitment	Past	Present	-,0	Fever Chills	+ .			Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain		-		21122228				Joints Replaced			
Low Energy Level			-			1					
Difficulty					-						
Sleeping											

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Name and Date of Birth (required):_______ Date:_____ **FAMILY HISTORY** __ High/Low Blood Pressure Seizures ____ Headaches __ Coronary Artery Disease __ High Cholesterol Mental Illness/Suicide Stroke ____ Alcohol or Drug Addiction **Respiratory Disease** ____ Other:___ **HABITS** Tobacco___ Alcohol _ Ibuprofen ___ Hormones **Over the Counter Drugs** Laxatives **Barbiturates Vitamin/Mineral Supplements** ___ Average Hours Sleep / Night ___ Cups of Coffee / Day **Stimulants** ___ Recreational Drugs **Tranquilizers, Sedatives Narcotics** ___ Exercise **Antacids** Massage Current Medications **Aspirin** Other Please List All Previous Accidents/Injuries/Hospitalizations/Surgeries: Have you ever been treated by a Chiropractor before and how was your experience?: Portland Massage and Chiropractic Services LLC 8800 S.E. Sunnyside Rd. Clackamas OR 97015 Dr. Jeffrey Dougal, D.C., L.M.T.

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CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, as well as diagnostic procedures such as x-rays, on me, or on the patient named below, for whom I am legally responsible.

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

I certify that the preceding questions have been answered truthfully and completely to the best of my knowledge. I understand that in chiropractic, as in medicine there are some risks. Whereas I am relying on the doctor's knowledge, training, and expertise, I do not expect the doctor to be able to anticipate and explain all risks and complications. I also am aware that I am an active participant in all treatments, and I am able to stop treatment any time that it does not feel right for me.

With the full understanding of the above, I request to be a patient of Dr. Jeffrey Dougal D.C., L.M.T., and waive all claims and damages from personal injury, except willful injury. I further understand that health care providers cannot guarantee the result of treatment.

Patients Name (Please Print):

Date:					

The treating physician has verbally explained the procedures that will/could be performed for my treatment, the alternatives to my treatment at this office, the risks of treatment, and gave me an opportunity to ask questions:

Sign: