





**Name and Date of Birth (required):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FAMILY HISTORY**

<input type="checkbox"/> <b>High/Low Blood Pressure</b>	<input type="checkbox"/> <b>Seizures</b>
<input type="checkbox"/> <b>Coronary Artery Disease</b>	<input type="checkbox"/> <b>Headaches</b>
<input type="checkbox"/> <b>High Cholesterol</b>	<input type="checkbox"/> <b>Mental Illness/Suicide</b>
<input type="checkbox"/> <b>Stroke</b>	<input type="checkbox"/> <b>Alcohol or Drug Addiction</b>
<input type="checkbox"/> <b>Respiratory Disease</b>	<input type="checkbox"/> <b>Other:</b> _____

**HABITS**

<input type="checkbox"/> <b>Tobacco</b>	<input type="checkbox"/> <b>Ibuprofen</b>
<input type="checkbox"/> <b>Alcohol</b>	<input type="checkbox"/> <b>Hormones</b>
<input type="checkbox"/> <b>Over the Counter Drugs</b>	<input type="checkbox"/> <b>Barbiturates</b>
<input type="checkbox"/> <b>Laxatives</b>	<input type="checkbox"/> <b>Average Hours Sleep / Night</b>
<input type="checkbox"/> <b>Vitamin/Mineral Supplements</b>	<input type="checkbox"/> <b>Cups of Coffee / Day</b>
<input type="checkbox"/> <b>Stimulants</b>	<input type="checkbox"/> <b>Recreational Drugs</b>
<input type="checkbox"/> <b>Tranquilizers, Sedatives</b>	<input type="checkbox"/> <b>Exercise</b>
<input type="checkbox"/> <b>Narcotics</b>	<input type="checkbox"/> <b>Massage</b>
<input type="checkbox"/> <b>Antacids</b>	<input type="checkbox"/> <b>Current Medications</b> _____
<input type="checkbox"/> <b>Aspirin</b>	_____
	<b>Other</b> _____

**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**  
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Email: drjeffdougal@yahoo.com

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

**NPI #: 1669624375 & 1962844324**

**Phone: 503-347-7668**  
**Fax: 503-828-1576**  
Chiropractic License #: 3680

**Name and Date of Birth (required):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**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):** \_\_\_\_\_

**Signature of Patient or Guardian:** \_\_\_\_\_

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

[DO NOT SIGN BELOW UNTIL INSTRUCTED TO DO SO AFTER VERBAL CONFERENCE WITH THE TREATING PHYSICIAN]:

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: