Portland Massage and Chiropractic Services LLC **Dr. Jeffrey Dougal, D.C., L.M.T.** **Phone: 503-347-7668**
8800 S.E. Sunnyside Rd. Clackamas OR 97015 **Fax: 503-828-1576**
Email: drjeffdougal@yahoo.com **NPI #: 1669624375 & 1962844324** Chiropractic License #: 3680

** Required Field.* *Please Print Clearly*

***Name:** _____ **Date:**_____
First Middle Initial Last

***Address:** _____
Street Address City State Zip Code

***Phone Number:** _____ ***Birth Date:** _____ **Age:** _____

***Work Status** (circle one): Employed Full-Time Student Part-Time Student ***Occupation:**_____

Email: _____ **Referred By:** _____

***Marital Status** (circle one): Single Married ***Gender**: M F

***In Case of Emergency Contact:**

WORK INSURANCE INFORMATION

Your Work Insurance Co.:_____

Insurance Co. Address and Phone #: _____

Claim #:_____

Claim Adjuster Name:_____

Adjuster Phone/Fax:_____/_____

Employer Name, Address, Phone#: _____

PATIENT AND CASE HISTORY Write N/A if Not Applicable

Date of Accident or Injury: _____ Time: _____

Place of Accident/Injury: _____

Did you report the injury? Yes / No Was a report filed? Yes / No

Were there any conditions that may have contibuted to your injury? e.g. Dark conditions, slippery floor, faulty equipment, etc._____

_____

Were you able to move without assistance after the accident? Yes / No (Circle One)

Did Any Emergency Services Come to the Scene (Police, Fire Dept., Ambulance/Paramedics)?: Yes / No

Where Did You Go After the Accident, And How Did You Get There? (Circle one):

Emergency Room / Urgent Care / Your Own Doctor / Home / Somewhere else:_____

How Long After the Accident did you go there?_____

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Name and Date of Birth (required):_____ Date:_____

If You Have You Been Treated By Another Physician, Who? (Name, Address, Phone):_____

_____

_____

Were Any X-Rays, Lab Work, and/or Treatment Done? Please Describe:_____

_____

Dates of Any Hospitalization From This Accident:_____

Have you missed any days of work as a result of this accident? Yes / No How many?_____
If "Yes" please describe:_____

_____

Is the quality of pain worse or different than this prior injury? Yes / No

If "Yes" please describe:_____

What are you not able to do as a result of this accident?:_____

_____

_____

_____

Please List All Previous Accidents/Injuries/Hospitalizations/Surgeries: _____

_____

_____

_____

(CONTINUED ON NEXT PAGE)

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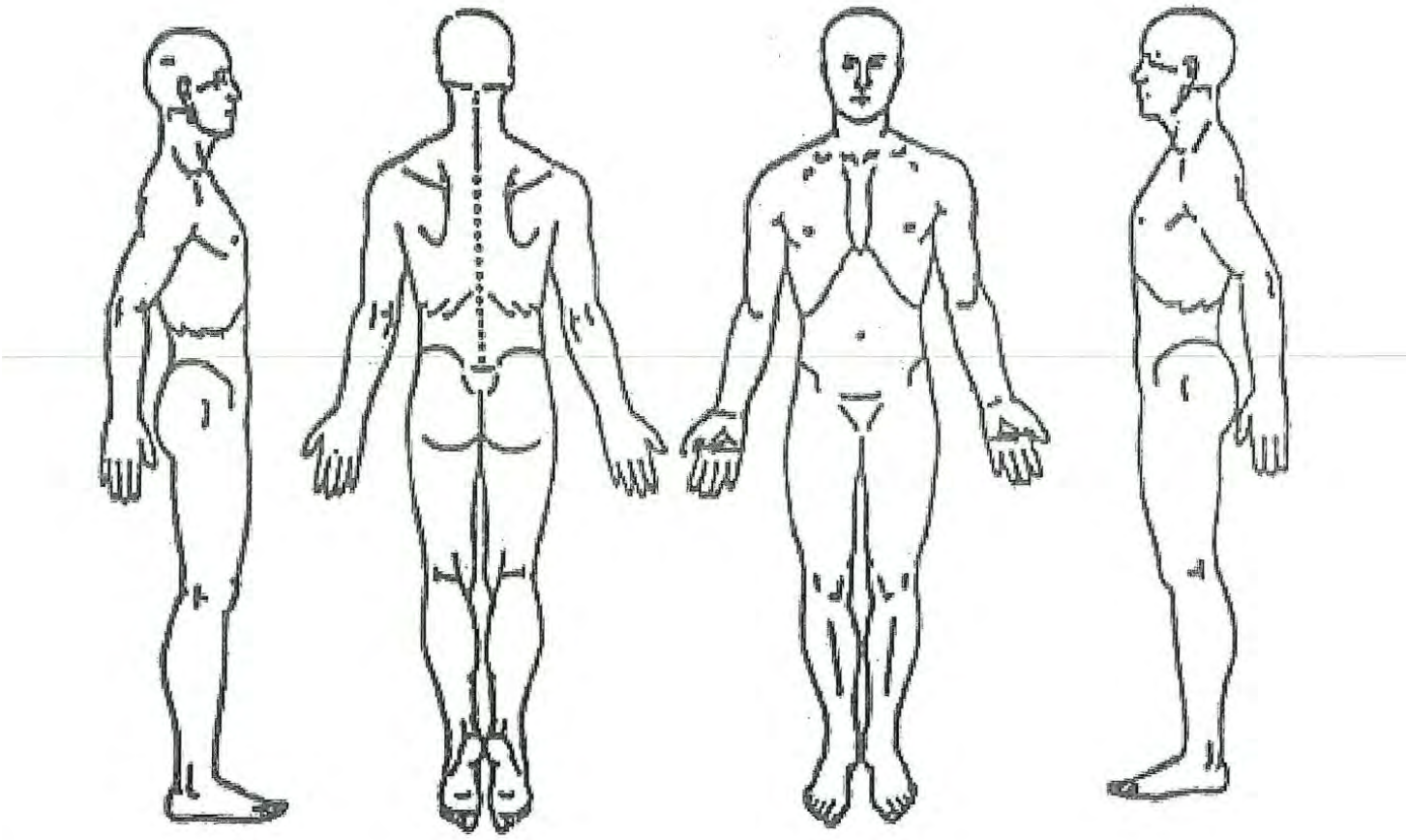
Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description:	Numbness	Pins & needles	Burning	Aching	stabbing
Symbols:	NN	PP	BB	AA	SS



FAMILY HISTORY

____ High/Low Blood Pressure	**____ Seizures**
____ Coronary Artery Disease	**____ Headaches**
____ High Cholesterol	**____ Mental Illness/Suicide**
____ Stroke	**____ Alcohol or Drug Addiction**
____ Respiratory Disease	**____ Other:_____**

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Name and Date of Birth (required):_____ **Date:**_____

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	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of Legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred 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				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

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HABITS

___ Tobacco___ Alcohol	**___ Ibuprofen**
___ Over the Counter Drugs	**___ Hormones**
___ Laxatives	**___ Barbiturates**
___ Vitamin/Mineral Supplements	**___ Average Hours Sleep / Night**
___ Stimulants	**___ Cups of Coffee / Day**
___ Tranquilizers, Sedatives	**___ Recreational Drugs**
___ Narcotics	**___ Exercise**
___ Antacids	**___ Massage**
___ Aspirin	**___ Other _____**

Have you ever been treated by a Chiropractor before and how was your experience?:_____

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: