

**Dr. Richard Layman D.C.**  
1334 Liberty St., S.E.  
Salem, Oregon 97302  
(503) 362-5500

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

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

H. Phone \_\_\_\_\_ W. Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address: \_\_\_\_\_

Sex M F Marital Status M S D W Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Referred by: \_\_\_\_\_

Have you ever received Chiropractic Care? Yes No If yes, when? \_\_\_\_\_

Name of most recent Chiropractor: \_\_\_\_\_

**1. Reasons for seeking chiropractic care:**

Primary reason:

\_\_\_\_\_

Secondary reason:

\_\_\_\_\_

**2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3. Past Health History:**

**A. Please indicate if you have a history of any of the following:**

- Anticoagulant use    Heart problems/high blood pressure/chest pain    Bleeding problems  
 Lung problems/shortness of breath    Cancer    Diabetes    Psychiatric disorders  
 Bipolar disorder    Major depression    Schizophrenia    Stroke/TIA's    Other \_\_\_\_\_  
 None of the above

**B. Previous Injury or Trauma:**

\_\_\_\_\_

**Have you ever broken any bones? Which?**

\_\_\_\_\_

**C. Allergies:** \_\_\_\_\_

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**D. Medications:**

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

**E. Surgeries:**

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

**F. Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

**4. Family Health History:**

- Do you have a family history of? (Please indicate all that apply)
- Cancer  Strokes/TIA's  Headaches  Cardiac disease  Neurological diseases
  - Adopted/Unknown  Cardiac disease below age 40  Psychiatric disease  Diabetes
  - Other \_\_\_\_\_  None of the above

Deaths in immediate family: \_\_\_\_\_  
Cause of parents or siblings death \_\_\_\_\_ Age at death \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social and Occupational History:**

**A. Job description:**

\_\_\_\_\_

**B. Work schedule:**

\_\_\_\_\_

**C. Recreational activities:**

\_\_\_\_\_

**D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**

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**Review of Systems**

Have you had any of the following **pulmonary (lung-related)** issues?

- Asthma/difficulty breathing    COPD    Emphysema    Other \_\_\_\_\_    None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

- Heart surgeries    Congestive heart failure    Murmurs or valvular disease    Heart attacks/MIs    Heart disease/problems    Hypertension    Pacemaker    Angina/chest pain    Irregular heartbeat    Other \_\_\_\_\_  
 None of the above

Have you had any of the following **neurological (nerve-related)** issues?

- Visual changes/loss of vision    One-sided weakness of face or body    History of seizures    One-sided decreased feeling in the face or body    Headaches    Memory loss    Tremors    Vertigo    Loss of sense of smell  
 Strokes/TIAs    Other \_\_\_\_\_    None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

- Thyroid disease    Hormone replacement therapy    Injectable steroid replacements    Diabetes  
 Other \_\_\_\_\_    None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

- Renal calculi/stones    Hematuria (blood in the urine)    Incontinence (can't control)    Bladder Infections  
 Difficulty urinating    Kidney disease    Dialysis    Other \_\_\_\_\_    None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

- Nausea    Difficulty swallowing    Ulcerative disease    Frequent abdominal pain    Hiatal hernia    Constipation  
 Pancreatic disease    Irritable bowel/colitis    Hepatitis or liver disease    Bloody or black tarry stools  
 Vomiting blood    Bowel incontinence    Gastroesophageal reflux/heartburn    Other \_\_\_\_\_    None of the above

Have you had any of the following **hematological (blood-related)** issues?

- Anemia    Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)    HIV positive  
 Abnormal bleeding/bruising    Sickle-cell anemia    Enlarged lymph nodes    Hemophilia  
 Hypercoagulation or deep venous thrombosis/history of blood clots    Anticoagulant therapy    Regular aspirin use  
 Other \_\_\_\_\_    None of the above

Have you had any of the following **dermatological (skin-related)** issues?

- Significant burns    Significant rashes    Skin grafts    Psoriatic disorders    Other \_\_\_\_\_    None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

- Rheumatoid arthritis    Gout    Osteoarthritis    Broken bones    Spinal fracture    Spinal surgery    Joint surgery  
 Arthritis (unknown type)    Scoliosis    Metal implants    Other \_\_\_\_\_    None of the above

Have you had any of the following **psychological** issues?

- Psychiatric diagnosis    Depression    Suicidal ideations    Bipolar disorder    Homicidal ideations    Schizophrenia  
 Psychiatric hospitalizations    Other \_\_\_\_\_    None of the above

Is there anything else in your past medical history that you feel is important to your care here? \_\_\_\_\_

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to [Name of Doctor/Clinic] for services performed.

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Patient or Guardian Signature \_\_\_\_\_  
Date \_\_\_\_\_

**HIPAA NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. “Protected Health Information” is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

**Use and Disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician’s practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.**

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

### NEW PATIENT HISTORY FORM

*Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.*

Symptom 1 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 2 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_

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- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 3 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:  
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 4 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:  
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply): \_\_\_\_\_

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- Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 5 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 6 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_

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- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day