AmpLife Chiropractic and Sports **2456 E Powell blvd Gresham, OR 97080**
Dr Tyler J Burke **7701 NE. Vancouver Plaza Drive Vancouver WA 98662**
www.amplifechiro.com **Phone: 503.298.9986**

Name: _____Date:_____Age:_____Ht._____Wt._____Birth date:_____
Address:_____City:_____State:___Zip:_____
Telephone:_____Email Address:_____
Emergency Contact:_____Number:_____Relationship:_____
Employment:_____ Been treated by a Chiropractor before?_____
List any medications/vitamins/supplements (prescribed, or over-the counter) with the reason taken, dosage, and duration:_____
Any diagnosed health conditions?_____

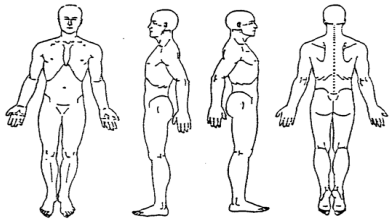
If you are here for WELLNESS, please check here ☐ and continue to "Past Health History"

INSURANCE COMPANY_____ **ID#**_____ **GROUP#**_____
COPAY_____ **PRIMARY SUBSCRIBER**_____ **PRIMARY BIRTHDAY**_____

Today's main complaint(s)

Reason(s) for consulting this office:_____
Date problem **began**:_____Is this work related?_____Auto related?_____
Does it seem to be getting: Worse Better Staying the same
It interferes with: Sitting Work Sleep Walking Hobbies Leisure Other
Anything that alleviates the pain?_____
Any other health GOALS (physical, mental, emotional, functional)?_____

Mark current problem areas on these pictures and please CIRCLE the current level of discomfort



none 1 2 3 4 5 6 7 8 9 10 worst ever

LIFESTYLE

Mark YES if applies

Do/did you smoke/use any tobacco/drugs?_____☐
Do/did you drink alcohol?_____☐
Do you consume caffeine?_____☐
Do you consume a lot of sugar?_____☐
Do you eat a lot of vegetables?_____☐
Do you eat fast/processed foods?_____☐
Do you exercise?_____☐
Do you drink a lot of water?_____☐

FAMILY HEALTH HISTORY

Cancer ☐ High Blood Pressure ☐ Heart Problems ☐ stroke☐ Diabetes☐ Other ☐_____

HEALTH HISTORY-**Please check all symptoms you have ever had*

	YES	Notes
Surgery/Hospitalization	☐	
Serious injuries or traumas	☐	
Allergies	☐	
Migraine headache	☐	
Change in bowel habits	☐	
Abnormal weight gain/loss	☐	
Ulcers	☐	
Heartburn/indigestion	☐	
Cold/flu often	☐	
Sinus infection	☐	
Asthma	☐	
Chronic cough	☐	
Breathing difficulty	☐	
Dizziness/fainting	☐	
High blood pressure	☐	
High cholesterol	☐	
Visual disturbances	☐	
Aortic Aneurysm	☐	
Metal/surgical implants	☐	
Rash or hives	☐	
Slow healing	☐	
Suspicious mole(s)	☐	
Currently pregnant	☐	
Due Date:		
Kidney infections	☐	
Bladder infections	☐	
Prostate problems	☐	
Osteoporosis	☐	
Stroke	☐	
Corticosteroid use	☐	
Cancer/tumor	☐	
Neck pain	☐	
Jaw pain	☐	
Arm/elbow/wrist pain	☐	
Shoulder pain	☐	
Mid back pain	☐	
Low back pain	☐	
Scoliosis	☐	
Hip pain	☐	
Leg pain	☐	
Knee pain	☐	
Ankle pain	☐	
Foot pain	☐	
Bursitis	☐	
Tendonitis	☐	
Numbness/tingling	☐	
Menstrual pain	☐	

AMPLife Chiropractic and Sports
Dr Tyler J Burke
Phone: 503.298.9986
amplifechiro@gmail.com
www.amplifechiro.com

Insurance Information

Patient Name: _____ Date of Birth: _____

ID #: _____ Claim, Group or Plan#: _____

Insurance Company: _____ Ins Phone #: _____

Primary Subscriber (if not Patient): _____ DOB of Insured: _____

Insured Relationship to Patient: _____ Insured is: □ Male □ Female

Please call your insurance company to obtain *all* of the following information

1. Does your plan have benefits for: Notes

EVICORE pre-authorization needed: □ Yes □ No _____

Chiropractic or Rehab? □ Yes □ No _____

Massage? □ Yes □ No _____

	In- Network Benefits	Out-of Network Benefits
Deductible Amount met so far		
Co-pay/ Co-insurance amount		
% Covered		
Maximum coverage $ amount $ met so far		
Maximum # visits per year # met so far		

If there is ANY coverage for massage: Notes

2. Can it be performed by an LMT? □ Yes □ No _____

3. Will these CPT codes be covered when billed up to 4 units?

97124 □ Yes □ No _____

97140 □ Yes □ No _____

97112 □ Yes □ No _____

97110 □ Yes □ No _____

4. Date of annual plan renewal: _____ *Thank You for taking the time to do this, it really helps us!*

AMPLife Chiropractic and Sports includes chiropractic care. By signing this, you consent to chiropractic care we provide.

❒ Initials: _____1. Consent to Treatment by AMPLife Chiropractic and Sports

The nature of chiropractic care is directed toward balancing the muscles, joints and nerves of your body. To achieve this, the doctor will use his hands or tools to adjust your joints and align your soft tissues. You may hear a "click or pop", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, massage, traction, taping, massage therapy and exercise/nutritional instruction may also be employed.

Though we take every precaution, there are some risks associated with chiropractic and massage therapy. The most common is muscle soreness the first couple days after treatment. A list of rare possibilities with chiropractic includes muscular strain, ligamentous strain, and fractures. Injury to the intervertebral discs, nerves or spinal cord is possible, though are considered even less likely. The risks involved with treating the neck may include any of these, but also includes the remote possibility of cerebrovascular injury possibly causing stroke. Current literature states the chances of this occurring to be one in one million to one in ten million. The ancillary physical therapy procedures could produce skin irritations, burns or bruising. Other treatment options may include over the counter analgesics, which carry with them the risks of irritation to the stomach, liver, kidneys, and various other side effects.

This consent form is intended to cover the entire course of treatment for my present conditions, and any future conditions for which I may seek treatment at this office. I accept the risks and benefits, and hereby give my full consent to treatment.

❒ Initials: _____2. Privacy Policy

I understand that the treating providers may disclose health information about me for purposes of treatment, payment or health care procedures. I have the right to receive a written Notice of Privacy Practices should I request it. I also understand that I am being treated in an office in a gym and that I may be shown exercises and care outside of the office in a public area (gym floor).

❒ Initials: _____3. Internal Release of Information

I understand that without giving AMPLife Chiropractic and Sports 24 hours notice to cancel or change an appointment, **there is a $40 charge for the missed appointment**, which will be due prior to my next visit.

❒ Initials: _____4. Release of Records/Payment Policy

Full payment is expected at the time of service. In the case that you are using health or auto insurance to pay for a portion of your care in this office, arrangement may be made to omit payment to await reimbursement. We are often unable to predict these costs exactly, and may not know for 12 weeks up to six months after the date of service, once your company has processed the claim. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my company and I authorize the doctor to release my related medical records to claim for benefits submitted. I understand that AMPLife Chiropractic and Sports does not bill my insurance (except for: motor vehicle accident claims, workers compensation, or personal injury) and that payment is due upon date of service. I agree to the terms of payment.

Initials:____ I want AMPLife Chiropractic and Sports to bill my insurance.

❒ Initials: _____6. Authorization to Communicate via E-mail

Communication via e-mail can be convenient for all parties; however, e-mails may not be encrypted and could be read by some outside party with the skills to access this information. By initialing here, I consent AMPLife Chiropractic and Sports to communicate via e-mail in spite of the above.

My signature re-iterates and confirms the initialed consent to each of the points made in this document

Signature of Patient, Parent or Guardian_____Date:_____

Patient Name (please print):_____