



Dr. Jess Barr Desbrow, DC LLC 4613 SE Ivon Street, Portland, OR 97206 (503)869-3389 fax:(270)918-6129 Jess@Desbrow.net  
 Zenana Spa 2024 SE Clinton St., Portland, OR 97202 (503)238-6262 (503)473-8057

**PATIENT REGISTRATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Number of Children: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Employment: \_\_\_\_\_ Like your job? \_\_\_\_\_  
 Married  Single  Partnered  Divorced  Widowed  Separated  Other

Whom may we thank for referring you? \_\_\_\_\_  
 Been treated by a Chiropractor before? \_\_\_\_\_ Date of Last visit: \_\_\_\_\_  
 List practitioner names and specialties of other health care providers: \_\_\_\_\_

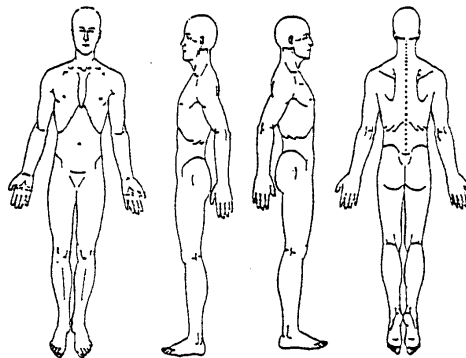
Do I have your permission to contact them to coordinate your care?  Yes  No  
 List any medications/vitamins/supplements (prescribed, or over-the counter) with the reason taken, dosage, and duration: \_\_\_\_\_

Any diagnosed health conditions? \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**MAIN COMPLAINT**

If you are here for wellness, please check here  and continue to "Past Health History"  
 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   
 Any other health GOALS (physical, mental, emotional, functional)? \_\_\_\_\_

Mark current problem areas on these pictures:



Please circle the current level of discomfort your problem causes you, when it is at its worst:  
 none 1 2 3 4 5 6 7 8 9 10 worst ever

**LIFESTYLE**

	<u>YES</u>	<u>Notes, if YES</u>
Do/did you smoke/use any tobacco? _____	<input type="checkbox"/>	
Do/did you drink alcohol? _____	<input type="checkbox"/>	
Do/did you use drugs? _____	<input type="checkbox"/>	
Do you consume caffeine? _____	<input type="checkbox"/>	
Do you consume a lot of sugar? _____	<input type="checkbox"/>	
Do you eat a lot of vegetables? _____	<input type="checkbox"/>	
Do you eat fast/processed foods? _____	<input type="checkbox"/>	
Do you exercise? _____	<input type="checkbox"/>	
Do you drink a lot of water? _____	<input type="checkbox"/>	
Do you consider yourself to hold much stress? _____	<input type="checkbox"/>	

*\*Please rate how willing you are to make lifestyle changes to help accomplish your goals\**

Unwilling to change at all    1   2   3   4   5   6   7   8   9   10    completely willing

**FAMILY HEALTH HISTORY**

Cancer  High Blood Pressure  Heart Problems  Stroke  Diabetes  Other  \_\_\_\_\_

**HEALTH HISTORY**

*\*Please check all symptoms you have ever had, even if they do not seem related to your current problem\**

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



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### Insurance Information (if applicable)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 ID #: \_\_\_\_\_ Group or Plan#: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_  
 Insurance Address: \_\_\_\_\_  
 Customer Service Phone #: \_\_\_\_\_ Insurance Fax: \_\_\_\_\_  
 Primary Subscriber (if not Patient): \_\_\_\_\_ Employer: \_\_\_\_\_  
 SSN of Insured: \_\_\_\_\_ DOB of Insured: \_\_\_\_\_  
 Insured Relationship to Patient: \_\_\_\_\_ Insured is:  Male  Female

### Please call your insurance company to obtain the following information

1. Beginning date of coverage: \_\_\_\_\_ Ending date of coverage: \_\_\_\_\_
2. Does your plan have Chiropractic benefits?  Yes  No
3. If yes:

	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		

4. Is there any coverage for  Massage Therapy  Acupuncture  Naturopathy  Physical Therapy  
 Notes: \_\_\_\_\_  
 \_\_\_\_\_

5. Annual date of renewal: \_\_\_\_\_  
 6. Name of representative spoken with: \_\_\_\_\_ Date: \_\_\_\_\_



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## Consent Form, Business Agreement, Insurance Information

### 1. Consent to Treatment

The nature of Chiropractic care is directed toward balancing the muscles, joints and nerves of your body. To achieve this, the doctor will use her 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, Craniosacral therapy, traction, taping and exercise/nutritional instruction may also be employed.

There are inherent risks in any and all treatment delivered by any health care provider, ranging from administering a single aspirin to complicated brain surgery. Chiropractic is no exception. Though we take every precaution, there are some risks associated with Chiropractic. The most common is muscle soreness the first couple days after treatment. A list of rare possibilities 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 or 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.

### 2. Privacy Policy

I understand that Dr. Desbrow 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.

### 3. Cancellation and No Show Policy

I understand that without giving Dr. Desbrow 24 hours notice to cancel or change an appointment, full payment for the missed appointment will be due prior to my next appointment.

### 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 medical records relating to claim for benefits submitted.

Signature of Patient or Guardian\_\_\_\_\_

Date\_\_\_\_\_

Patient Name (please print)\_\_\_\_\_