Stefan M. Herold, DC, DACNB – Tiferet Chiropractic Neurology
8102 SE Rhine St., Portland OR 97206 - Phone: (503) 406-1908 – Fax: (503) 212-4426

PATIENT INFORMATION (Please answer all questions, circle when applicable)

Full Legal Name: _____ Date of Birth: _____

Gender: Male Female Other _____ Pronouns: _____ Dominant hand: Right Left

Address _____ City _____ State____ Zip _____

Phone _____ Email Address _____

Best way to contact you? [ ] home phone, [ ] cell phone, [ ] email, [ ] Text

Emergency Contact _____ Phone _____ Relation _____

Who referred you to Dr. Herold? _____

Is your condition the result of an auto accident claim? Yes No or active work injury claim? Yes No

If yes, please request additional forms to fill out. Date of injury: _____

General Health Information

Have you received chiropractic care in the past? Yes No Explain: _____

What are your goals for care: (check boxes) [ ] Decrease symptoms or pain, [ ] Prevent future pain or other health problems, [ ] Improving health & quality of life, [ ] other:_____

Do you get regular exercise? Yes No
If yes, what kind of exercise and how often? _____
Is there anything that prevents you from exercising as much as you would like? _____

Would you consider your diet to be mostly (please circle): healthy (organic, mostly vegetables, whole foods), unhealthy (junk food, prepackaged items or restaurant food) or a mixture of the two.
Do you have any specific dietary restrictions or known food sensitivities? _____

What is your average hours of sleep per night? _____ What time do you go to bed? _____
What time do you fall asleep? _____ How often do you wake in the night? _____
How long to fall back asleep? _____ How do you feel when you wake up? Rested Tired _____

Current Condition/s: Please list your main health concerns below in order of significance, rate intensity (0-10/10) and timing (% of day) you have the symptom and when the problem started.

1._____ Severity? (0-10 & %) _____ Onset? _____

2. _____ Severity? (0-10 & %) _____ Onset? _____

3. _____ Severity? (0-10 & %) _____ Onset? _____

Have you seen another health professional for this condition? Yes No Whom? _____

Describe treatment or recommendations: _____

Have you been treated for any other health condition in the past two years? Yes No

Please describe treatments and when: _____

Name of Medical Doctor: _____ May we contact about care? Yes No

List any medications you are currently taking: _____

_____ Are you interested in alternatives to medication? Yes No

List current supplements, herbs or other remedies you are currently or frequently use. _____

_____

Review of Systems: check box for past and/or current, circle if only one specific applies

Past	Current		Past	Current		
[ ]	[ ]	Fatigue	[ ]	[ ]	Fever/Chills	General
[ ]	[ ]	Weakness	[ ]	[ ]	Cancer: _____	
[ ]	[ ]	Enlarged lymph nodes	[ ]	[ ]	Frequent infections	
[ ]	[ ]	Abnormal bruising	[ ]	[ ]	Hives/Rash	Immune
[ ]	[ ]	Weight: unusual Loss/Gain	[ ]	[ ]	Anemia:	&Endoc
[ ]	[ ]	Heat intolerance	[ ]	[ ]	Cold Intolerance	
[ ]	[ ]	Excessive hunger or thirst	[ ]	[ ]	HIV Positivive	
[ ]	[ ]	Depression	[ ]	[ ]	Anxiety	Psych
[ ]	[ ]	PTSD	[ ]	[ ]	Bipolar	
[ ]	[ ]	Migraines / Cluster Headaches	[ ]	[ ]	Concussions: #_____	Neuro
[ ]	[ ]	Memory Trouble	[ ]	[ ]	Altered Sensation	
[ ]	[ ]	Personality Changes	[ ]	[ ]	Poor Concentration	
[ ]	[ ]	Trouble speaking	[ ]	[ ]	Tremors, involuntary movement	
[ ]	[ ]	Double Vision / Blurry Vision	[ ]	[ ]	Light Sensitivity	Eyes
[ ]	[ ]	Vision loss one or both eyes	[ ]	[ ]	Macular degeneration	
[ ]	[ ]	Sound Sensitivity	[ ]	[ ]	Misophonia	ENT
[ ]	[ ]	Ringing: Right Left ear (tinnitus)	[ ]	[ ]	Hearing loss	
[ ]	[ ]	Earache/pressure or discharge	[ ]	[ ]	Sinus Infections	
[ ]	[ ]	Poor balance	[ ]	[ ]	Vertigo – spinning or rocking	Neuro
[ ]	[ ]	Trouble swallowing	[ ]	[ ]	Poor coordination of movement	
[ ]	[ ]	Change in taste or smell	[ ]	[ ]	Light headed / Fainting episode	
[ ]	[ ]	Chest pain or pressure	[ ]	[ ]	Racing or skipping heartbeats	CV
[ ]	[ ]	Blood clots/DVT	[ ]	[ ]	Stroke / TIA / Aneurism	
[ ]	[ ]	Apnea – disturbed sleep snoring	[ ]	[ ]	Shortness of Breath	Resp
[ ]	[ ]	Wheezing / Asthma	[ ]	[ ]	COPD / Emphysema	
[ ]	[ ]	Chronic diarrhea	[ ]	[ ]	Chronic constipation	GI
[ ]	[ ]	Indigestion / GERD-heart burn	[ ]	[ ]	Nausea / Vomiting	
[ ]	[ ]	Loss of Appetite	[ ]	[ ]	Excessive Appetite	
[ ]	[ ]	Pain relieved by eating	[ ]	[ ]	Pain 30-90 min after eating	
[ ]	[ ]	Gall stones	[ ]	[ ]	Diverticulitis	
[ ]	[ ]	bloating after meals	[ ]	[ ]	fatigue after meals	
[ ]	[ ]	Blood in urine	[ ]	[ ]	urinary urgency	GU
[ ]	[ ]	urinary frequency/excessive	[ ]	[ ]	foul smelling urine/discharge	
[ ]	[ ]	Kidney stones	[ ]	[ ]	infertility	
[ ]	[ ]	Joint pain or stiffness	[ ]	[ ]	Muscle spasms	MusSkel
[ ]	[ ]	joint swelling	[ ]	[ ]	arthritis: _____	
[ ]	[ ]	neck and/or back pain	[ ]	[ ]	Tension headaches	
[ ]	[ ]	loss of strength	[ ]	[ ]	Disc herniation: levels _____	
[ ]	[ ]	Poor wound healing	[ ]	[ ]	Skin lesions / skin cancer	Derm
[ ]	[ ]	Eczema	[ ]	[ ]	unusual hair distribution	

Past Health History

List any known allergies (medication/food/environmental):_____

List any known birth defects or any major childhood injuries:_____

List any surgeries you have had and when:_____

List any major injuries/accidents you have sustained and when:_____

Social History

Marital Status: Single Married Partnered Divorced Separated Widowed

Number of Children and ages: _____

With whom do you currently live? _____

Education Level/Degree: _____ Occupation _____

Hours per day _____ Days/week _____ Employer _____

Do you use tobacco? Yes No How much/day & form?_____

Do you drink alcohol? Yes No How much/how often? _____

Recreational drugs? Yes No Which ones, how often? _____

Caffeine: circle Coffee Tea Soda Chocolate How much/day? _____

Hobbies current _____ Hobbies avoiding due to health_____

Family History: (Only close blood relatives – siblings, parents or children)

Diseases in your family: _____

Mother's Age _____ Deceased?_____ Medical Problems?_____

Father's Age _____ Deceased?_____ Medical Problems?_____

Females Only: Date of last menstrual cycle _____ Regular / Irregular

Number of Pregnancies: _____ Number of births: _____

Are you using birth control pills or other hormonal contraception (implants/shots)? Yes No

Are you pregnant at this time? Yes No (If you become pregnant during care, please inform the doctor immediately, as it may limit some of the types of physiotherapies that can be used.)

_____ _____

Patient Signature Date

Please initial the following and sign/date at the bottom of the form.

Full Legal Name: _____ Date of Birth: _____

Assignment and Release of Information

_____ I hereby authorize this clinic to release any information pertinent to my case to other medical professionals, insurance companies, adjustors or attorneys as requested who become involved in this case. I further authorize this clinic to request and obtain medical records from my past, current and future physicians, hospitals, clinics, rehabilitation facilities or other practitioners as deemed necessary by the treating physician at that time. I hereby release this clinic of any consequences thereof. A photocopy of this assignment shall be considered as effective and valid as the original.

Financial Responsibility

_____ I agree to be personally responsible for all charges incurred at this clinic. I understand that billing insurance is not a guarantee of payment and any services not covered by my insurance will be my responsibility. Dr. Stefan Herold is not contracted with any insurance companies and any benefits I may be eligible for will be based on out-of-network coverage. I authorize my insurer to make payments directly to Tiferet Chiropractic Neurology at 8102 SE Rhine Street, Portland OR 97206. If I choose, I may obtain a free membership with Patient Options to receive a same day 'cash discount' on services if I pay for services on the day care is rendered. In this case, I have been informed that Tiferet Chiropractic Neurology will not directly bill my insurance company, but that I can be provided with an itemized bill showing all applicable charges and CPT codes that I may submit to my insurance company to obtain reimbursement directly to me.

_____ I understand that there is a 24 hour notice requirement for cancellation of appointments. Unless the clinic receives 24 hour notice, I will be charged up to $60 for a late cancel or missed appointment. Insurance plans will not cover this charge. It is at the doctor's discretion to wave this fee in lieu of reasonable circumstances preventing you from provided the required notification.

Privacy Policy Acknowledgement of Receipt of Notice of Privacy Practices

_____ I have received a copy (pages 5 & 6 of this document) or have been given an opportunity to read/review the privacy practices and policies of Tiferet Chiropractic Neurology.

_____ _____

Patient Signature Date

Tiferet Chiropractic Neurology - Stefan M. Herold, DC, DACNB

8102 SE Rhine Street – Portland, OR 97206 – Office: (503) 406-1908 - tiferetchiro.com

Informed Consent and Terms of Acceptance to Treatment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physiotherapy, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic.
I understand that, as with any health care procedure, there are certain complications, however rare, which may arise during a chiropractic manipulation. Such complications could include, but are not limited to: rib fractures, joint injuries, muscle strain, vascular injury and cervical myelopathy. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understands both the objective and the method that will be used to attain it.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of joint subluxation. Our chiropractic method of correction is by specific adjustments of the spine and extremities.
Health: The state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
Vertebral subluxation: A misalignment of one or more of the bones of the spinal column which involves an alteration of nerve system function, resulting in a lessening of the body's innate ability to express its maximum health potential.

The goal of care is not to treat disease. We offer to diagnose vertebral subluxation and neurological and neuro-musculoskeletal conditions. Our treatments aim to improve body alignment, restore afferent feedback to the brain and reduce nerve function imbalances to maximize the self-healing and regulating forces in the body. Many disease states will naturally resolve when the body begins to function normally again.

If during the course of a chiropractic examination we encounter non-chiropractic or unusual findings, we will advise you of this. If you require advice, diagnosis or treatment for those findings that are outside the scope of chiropractic, we will recommend the services of another health care provider specializing in that particular area of concern.

Regardless of what the disease is called, we do not offer to treat the disease. OUR PRACTICE OBJECTIVE is to heal the whole person, eliminate major interference to the expression of the body's innate wisdom, and to provide advice to help you prevent future challenges. Our method involves specific adjusting and other sensory stimuli to correct vertebral and extremity subluxation and improve brain function/balance. Additionally, we use other modalities and teach you strategies or exercises to help your body hold those adjustments and maintain brain synchronization.

I, _____ acknowledge that I have read the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

X_____
Signature of Patient (or Patient's Representative) Date

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ (signature of parent or guardian)

NOTICE OF PRIVACY PRACTICES

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

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1) Your clinician or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer.
3) Your clinician and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control or for other administrative purposes to efficiently and effectively run his/her practice.
4) Your clinician and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

   You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
   You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use/disclose your health information to the extent that we are required by applicable federal or state laws.
2) We are permitted to use/disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information under state or federal law.
3) We are permitted to use/disclose your health information to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect or domestic violence.
4) We are permitted to use/disclose your health information for state and federal health oversight activities of the health care system and government benefit programs.
5) We are permitted to use/disclose your health information in response to a court order or, in response to a subpoena, discovery request, or other lawful purpose.
6) We are permitted to use/disclose your health information to a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries or, to comply with court orders, a grand jury subpoena, or administrative requests authorized by the law.
7) We are permitted to use/disclose your health information to an appropriate law enforcement authority if the disclosure is necessary to prevent or lesson a serious and imminent threat to the health or safety of a person or the public.
8) We are permitted to use/disclose your health information to a correctional institution if we provide health care services to you as an inmate.
9) We are permitted to use/disclose your health information if we provide health care services to you in an emergency.
10) We are permitted to use/disclose your health information if we provide care to you that is related to a work place injury to the extent necessary to comply with Oregon's worker's compensation laws.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding which is anticipated to occur in a time frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except

1. those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2. those disclosures made to you.
3. those disclosures we are permitted to make without your consent or authorization as described above.
4. those disclosures made based on an authorization you signed.
5. those disclosures necessary to maintain a directory of the individuals at root or to individuals involved with your care.
6. those disclosures for national security or intelligence purposes.
7. those disclosures made to correctional officers or law enforcement officers.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

This notice is effective as of January 31, 2024. This notice will expire seven years after the date upon which the record was created.

To contact us

If you would like further information about our privacy policies and practices please contact:
Tiferet Chiropractic Neurology 8102 SE Rhine St. Portland, OR 97206 Phone: 503.406.1908