Dunn Chiropractic Clinic
A Pain & Wellness Practice Since 1922

George Siegfried, D.C.
Chiropractic Physician
Since 1983
301 NE Dunn Place
McMinnville, OR 97128
Ph: 503-472-6550
Fax: 503-472-1039
dunnchiropracticclinic@gmail.com

Welcome to the Clinic!

Thank you for taking time to fill this out. It will reduce your wait at the clinic.

New Patient Consultation Form

Filled out by:_____ Date: _____

Name: _____ **DOB**: _____**Age**:_____
Home Address: _____**City:**_____ **State**: _____**Zip**:_____
Mailing Address: _____ **City:**_____ **State**: _____**Zip**:_____
Cell#: _____ **Work#**: _____**Occupation**: _____
Email: _____
(your email is confidential and will NOT be given out)
For Appointment Reminders what is your Preferred Method of Contact? Text ☐ Call ☐ Email ☐
Emergency Contact Name:_____ **Phone#** _____
Whom may we thank for referring you? _____

What brings you to the clinic today?
☐ Chiropractic Care ☐ Car Accident ☐ Work Injury ☐ Nutrition Consultation

MVA Only:

Date of Injury: _____Your Insurance Carrier/WC Ins: _____
Claim#:_____ Policy#: _____
At Fault Ins: _____ Claim#: _____
Were you: ☐ Hit by another car ☐ At fault ☐ Ran off the road ☐ Hit a deer
☐ Other: _____
Was the car insured at the time of the accident? Yes ☐ No ☐ If no, why:_____
Were you on the job at the time of the accident? Yes ☐ No ☐ If yes, for who:_____
Attorney: _____**Phone:**_____

Have you been to a chiropractor before? Yes ☐ No ☐ Who? _____
For what condition**?** _____When? _____
Were you satisfied with your care? Yes ☐ No ☐
What is your main complaint today? _____

My pain/complaint started:_____**Have you had this pain before?** Yes ☐ No ☐
Have you lost any workdays? Yes ☐ No ☐ How Many? _____
How does this affect your daily life?_____
What makes your pain better & when is it better?_____
What makes your pain worse & when is worse? _____
What movements bother you/hurt? _____

Are you taking any medications? Yes ☐ No ☐
If so, for what condition(s)?_____
Are you taking any supplements/vitamins? Yes ☐ No ☐
Please list them here:_____

_____

What other doctors or treatment have you seen for your condition? (Medical, Naturopathic, etc.)

_____

Were X-rays or MRI's Taken? Yes ☐ No ☐ **When?**_____ **Where?**_____
Do you use arch supports/orthotics in your shoes? Yes ☐ No ☐
Do you sleep well? Yes ☐ No ☐ Sometimes ☐
Do you have good energy? Yes ☐ No ☐ Sometimes ☐
Do you have a good appetite? Yes ☐ No ☐ Sometimes ☐
Are you under a lot of stress? Yes ☐ No ☐ Sometimes ☐
Do you smoke? Yes ☐ No ☐ Cigarettes? Marijuana? Vape? How often? _____
Do you drink alcohol? Yes ☐ No ☐ How often? _____
Do you exercise? Yes ☐ No ☐ What kind? _____
Are you under care for any other conditions? Yes ☐ No ☐ Which ones? _____

_____

Have you had any surgeries? Yes ☐ No ☐ For what? _____

_____

Any broken bones? Yes ☐ No ☐ Which ones? _____
What kind of water do you drink? ☐ Tap ☐ Bottled ☐ Spring ☐ Distilled ☐ Filtered
Females: Are you currently pregnant? Yes ☐ No ☐ Due Date: _____
Check the following conditions you have NOW or HAVE HAD:

☐ Arthritis	☐ Cancer	☐ Heart Disease	☐ Back Problems	☐ Ulcers	☐ Stroke
☐ Alcoholism	☐ Constipation	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	
☐ Diarrhea	☐ Convulsions	☐ Emphysema	☐ Epilepsy	☐ Migraines	☐ Menstrual Cramps
☐ Diabetes	☐ Goiter	☐ Nervousness	☐ Heart Attack	☐ Scoliosis	☐ Thyroid Problems
☐ Gout	☐ Miscarriage	☐ Neuritis	☐ Depression	☐ Cold sores	☐ Irregular Periods
☐ Pleurisy	☐ Pneumonia	☐ Gall Bladder	☐ Whooping Cough	☐ High Blood Pressure	

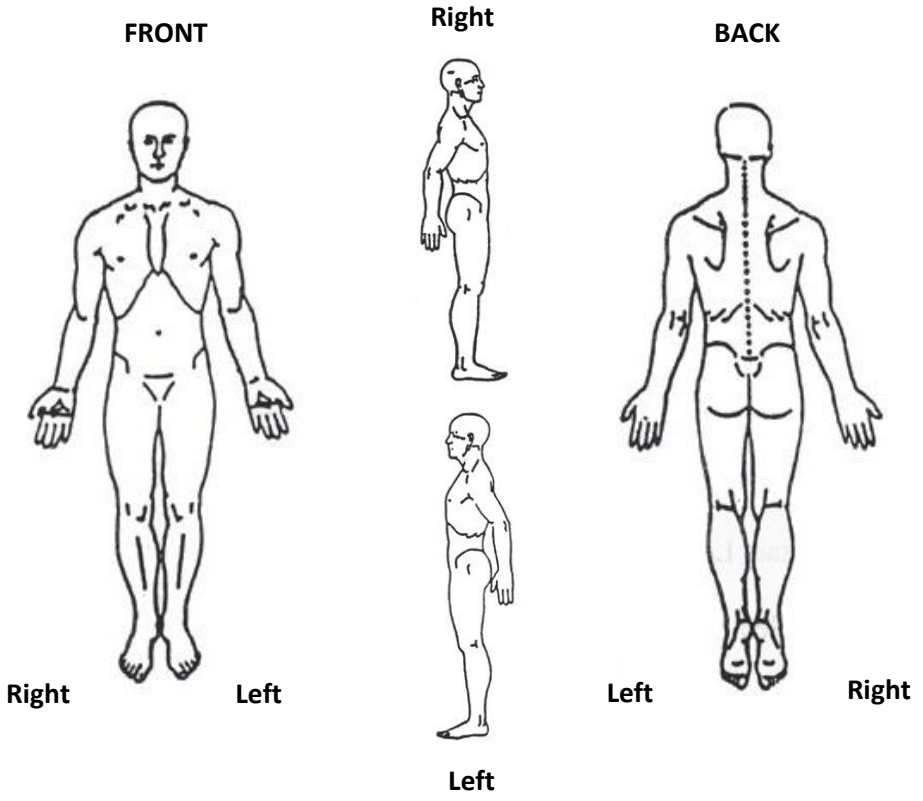
ONLY APPLIES TO CHIROPRACTIC PATIENTS:

Dr. Siegfried may need an x-ray for proper spinal evaluation. He will discuss it with me. I may/may not agree. If I choose not to get a spinal x-ray, I take full responsibility for any spinal pathology that may exist. **Please initial: _____

If you are in pain <u>NOW</u>, how bad is it?
Please circle the appropriate number on this scale.

Use the letters to the right to indicate the type and location of the pain.

(No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)



A = Aching

B = Burning

N = Numbness

S = Stabbing

T = Tingling

W = Weakness

O = Other

What is your health goal for your complaint?

____ Patch care = pain relief = 3x a week for 2 weeks & revaluate
____ Fix Care = trying to get your body as near to normal as possible, 3x a week for 4 weeks (12 visits) minimum & revaluate.

***Any other comments that may help us improve you care? We are here to help you.**

_____
_____
_____
_____

OFFICE POLICIES: The information on this application is accurate to the best of my knowledge. If I am accepted as a patient at the clinic, I understand that this is a cash clinic and that Dr. Siegfried is out-of-network for all private insurances except for work and car accident injuries. Meaning that payment is due at the time of service unless other arrangements are made. No information from my care here will be released to anyone without my written consent according to the HIPPA laws.

MEDICARE PATIENTS: Dr. Siegfried is NOT a participating provider with Medicare. Therefore, if the patient is of medicare age they will be asked to sign a Advance Benificiery Notice of Noncoverage (ABN FORM) and the patient is responsible for payment in full at time of service for treatment received.

CONSENT TREATMENT: Although Doctor will do his best to help me, I also understand that no cures are promised or implied and any risks regarding care at this office will be explained to me upon my request. I now authorize the Doctor to proceed with any necessary treatment after all my questions have been answered. I have read the clinic's office policies and consent to treat information, and I agree with them by signing below:

Name (Print): _____

Signature: _____

Date: _____

Parent/Guardian's (required if patient is a minor):

Print: _____

Signature: _____

Date: _____

Again, thank you kindly for taking your time to fill out these forms.
We look forward to helping you and earning your referrals!

Dedicated To Your Health and Wellness,

Dr. Siegfried

Chiropractic Physician