New Patient Packet
Patient name: _____
Date: _____
Patient DOB: _____

Empowered Chiropractic
(971) 200-1828
drjojo@empoweredchiropdx.com
616 NE Lawrence Ave, Portland, OR 97232

Welcome to Empowered Chiropractic

My intention is to hold space for my patients to check in with themselves; their body, mind, emotion, and spirit, to deepen with their state of inner awareness and temporal cause and effect, and to co-create strategies to reduce stress and increase ease in their life's expression. This work we do together is for the purpose of self-empowerment.

What I offer is based on the premise that healing comes from co-collaboration between humans and with unseen characteristics of life. We work together and with our joined knowledge and experience, help each other through life conflict in generative ways. In working together through what life has to offer, I believe we grow through our most difficult experiences. I am here to support my patients in any stage of life through providing education, hands-on attention, conversation, exercises, and outside resources. Part of the self-education of my patients is identifying and defining the benefits of our service for yourself as physical, emotional, mental, or spiritual in nature. Open communication and conversation will assist in giving feedback and reflections about your perception and belief about your wellness and states of being.

I do not diagnose or treat any physical, emotional, mental, or spiritual symptom or condition. I have relevant licenses and degrees but I am not offering treatment in that capacity in this environment.

Any physical contact that I may have with you will be non-intrusive and is for the non-therapeutic and non-palliative purpose of educating you in observation of your movement, body or breath sensation and perception, and for the promotion of greater ease and self-awareness. Your participation in the educational process that I facilitate constitutes your agreement to this physical contact.

My desire is to serve you in meeting your personal educational and evolutionary goals. Open communication allows us to customize our training and sponsorship to fit your needs. Please let me know if you have any questions or comments.

I, _____, acknowledge and agree to this disclosure.
Print name

_____ _____
Sign name Date

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New Patient Registration

Patient's Full Legal Name: _____

Patient's Full Functional Name: _____ Patient's Pronouns: _____

Patient's Date of Birth (MM/DD/YYYY): _____ Gender: _____

Address: _____

Billing preference: ☐ Venmo ☐ Paypal ☐ Cash ☐ Other (describe here): _____

Phone: _____ Please circle: Cell/ Home/ Other: _____ Ok to txt? ____

Email address: _____ Communication preference: ☐ Text ☐ Call ☐ Email

Emergency Contact Person: _____ Relationship: _____

Best way to contact this person: _____ Person's Pronouns: _____

Do you have a PCP? Y / N Clinic _____ Provider _____

Circle: Are you currently employed? Y / N Occupation & Status: _____

Please describe your work/how it affects your body-mind (also indicate here if you are self-employed or have more than one job). Example: do you sit, stand, or move a lot?

_____

_____

_____

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Informed Consent for Chiropractic Care

Empowered Chiropractic intends to inform and educate all patients on the nature of chiropractic and other procedures and to engage and involve patients in said care. Knowledge of potential benefits and risks is a part of informed consent. In this way, we can continue to be in conversation about the best ways to move forward with tailored care.

Chiropractic procedures, including spinal manipulations and manipulations of other joints, is generally safe and non-invasive. The majority of chiropractic patients experience improvement. Improvement is not expected to be immediate, though sometimes it can be. Pain, stiffness and soreness are typical responses after chiropractic treatments, especially with a lapse in care. These responses can also occur after self-care exercises and rehabilitation recommendations and should resolve within a few days. Procedures concerning the soft tissues; muscle, skin, and nerve junctions, may cause skin irritation, reddening, superficial bruising, and/or local discomfort or soreness within a few days of application depending on the technique.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. The risk of injury is very low when it comes to neurovascular complications, injuries to the spinal discs, dislocations, or fractures. The risk in aggravating existing conditions varies depending on the conditions, severity of such conditions, existence of cancer, osteoporosis, prior injury or surgeries, lifestyle choices, medication and other substance use. Please inform Dr. Jojo of your health history, current conditions you are working with and what medications and substances you may be in relationship with.

By signing below, I hereby request and consent to the performance of chiropractic adjustments and other physical contact described to me in relationship to my care (or the care of the patient named below, for whom I am legally responsible) by an Empowered Chiropractic chiropractic physician and/or other licensed doctors of chiropractic who now or in the future will treat me while employed by, associated with, or serving as a substitute for Dr. Jojo.

I have had or will have an opportunity to discuss with the doctor and/or other office or clinic, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks, including

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Informed Consent for Chiropractic Care Continued

but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of care and choose approaches which the doctor feels at the time, based upon facts then known, to be in my best interest.

I have read or have had read to me completely the information contained in this document and hereby authorize my consent of all the content of this document with the knowledge that I have also had or will have an opportunity to ask questions about its content. By signing below I agree to the conditions stated above and intend this consent to extend to the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

_____ _____

Patient Signature Date

_____

Patient's Name (PRINT)

Notice of Uses and Disclosures of Protected Health Information

I acknowledge that I have been provided with Empowered Chiropractic's Notice of Privacy Practices which describes the types of uses and disclosures of my protected health information that may occur, as well as my individual rights and the duties of Empowered Chiropractic with respect to my protected health information.

I understand that Empowered Chiropractic may use or disclose my protected health information to diagnose or provide treatment for me, to obtain payment for health care expenses, or to conduct health care operations. "Protected Health Information" includes information created, maintained, or received by Empowered Chiropractic that identifies me, or from which my identity could be determined, and which relates to my past, present, or future physical or mental health, condition, treatment, or payments for medical services. Empowered Chiropractic reserves the right to change the privacy practices that are described in its Notice of Privacy Practices.

_____ _____

Patient Signature Date

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Financial Agreement

Review and sign the following Financial Agreement in its entirety prior to your first appointment. This financial agreement will remain in place, unless given notice by Empowered Chiropractic of any payment changes. Such notice may be delivered via email newsletter and it's the patient's responsibility to keep Empowered Chiropractic updated with their most current contact information.

Services provided by Empowered Chiropractic are not billable through your insurance provider; meaning Empowered Chiropractic will not accept your insurance information and bill any patient charges for you through them. By eliminating this third party, it allows Empowered Chiropractic to serve in the patient's best interest. It is Empowered Chiropractic's policy that payment is collected same day of service or prior to service. Empowered Chiropractic does not accept personal checks for payment on your account.

Fee Schedule: I understand that Empowered Chiropractic charges a per appointment rate of $120 for all returning office sessions and $300 for all portable sessions in the event of an appointment at my home. In the event of a care plan or event agreement, advanced payment will be required and an additional form will be acknowledged. Furthermore, I understand that, by signing below, I agree to pay for services in full at the time of service, or prior to service rendered. If I am unable to pay in full, I understand that a payment plan may be established in writing prior to appointment or establishment of care plan. It is the responsibility of the authorized signature below to inform the office of Empowered Chiropractic of any financial or legal changes.

_____ _____

Patient's Signature Date

Cancellation Policy: Empowered Chiropractic requires a 24 hour advance cancellation for all appointments. If I am unable to give 24 hours advance notice the following fees will be charged $75. No-shows to office appointments and patients who are being travelled to are subject to full payment in the case of a no-show. I have read and understand the cancellation policy.

_____ _____

Signature Date

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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 relate 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 and others outside of the Empowered Chiropractic entity 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 payment from event staff may require that your relevant protected health information be disclosed to a lead staff member to obtain approval for a committed number of people to treat at the event.

Healthcare Operations: Empowered Chiropractic may disclose, as needed, your protected health information in order to support the business activities of your

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physician's practice. These activities include, but are not limited to, quality assessment activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities in the office and at events. For example, your protected health information may be disclosed to medical school students that see patients with the physician or at events. In addition, a sign-in sheet may be used at the registration desk where you will be asked to sign your name and indicate your physician. You may be visible to other patients while at an event while receiving treatment, sharing a tent, room, or other structure, but not a table. You may be called by your name in the waiting room when your physician is ready to see you. Your protected health information may be used or disclosed, 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 Dr. Jojo DC or Empowered Chiropractic has taken an action in reliance on the use or disclosure indicated in the authorization.

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New Patient Intake Form

What is it that you would like to address in this new environment? What comes up in your body that you may want to collaborate on?

_____

_____

What do you want to us to focus on today?

_____

_____

Please circle: Were you a C-section birth? Y / N Breastfed? Y / N
Are you pregnant? Y / N Trying to get pregnant? Y / N

Medical Conditions: (Check all that apply to you or may have applied to you)

Arthritis ☐	Metabolic Syndrome ☐	Heart Disease ☐
Rheumatoid Arthritis ☐	Metabolic issues ☐	Hypertension ☐
Cancer ☐	Insulin Resistance ☐	Skin Disorder ☐
Diabetes ☐	Glucose dysregulation ☐	Bleeding Disorder ☐
Pre-diabetes ☐	Obesity ☐	Asthma ☐
		None of the above ☐

Anything other (please list): _____

Height: _____ Weight: _____ [BMI: _____] office use only

List any surgeries you've had with dates included:

_____

Please list any medications you are currently taking: _____

_____

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Other Diagnoses: (Check all that apply to you)

Celiac disease ☐
Fructose malabsorption ☐
SIBO ☐
Lactose intolerance ☐
Gluten sensitivity ☐
Crohn's disease ☐
Leaky gut ☐
Fibromyalgia ☐
Chronic pain syndrome ☐
Complex regional pain syndrome ☐
Irritable Bowel Syndrome (IBS) ☐
Peptic Ulcer Disease ☐
GERD ☐
Diverticular disease ☐
Ulcerative Colitis ☐
Gut Dysbiosis ☐
Lymes Disease ☐
Systemic Lupus Erythematosus (SLE) ☐
None of the above ☐

Allergies: (Check all that apply to you)

Eggs ☐
Fish and Shellfish ☐
Milk or Lactose ☐
Peanuts ☐
Soy ☐
Sulfites ☐
Wheat ☐
Stone fruit ☐
Nuts ☐
None of the above ☐

Any other allergies (please list): _____

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

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

If headaches, describe: _____

Briefly describe your daily eating habits and how much water you drink: _____

_____

Social History: (Circle all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Chew Tobacco:	occasional	often	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Wear Seat Belts:	occasional	always	never

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Family History: (Circle all that apply)

Arthritis:	Parent	Sibling	Maternal	Paternal	Whom: _____
Cancer:	Parent	Sibling	Maternal	Paternal	Whom: _____
Diabetes:	Parent	Sibling	Maternal	Paternal	Whom: _____
Heart Disease	Parent	Sibling	Maternal	Paternal	Whom: _____
Hypertension	Parent	Sibling	Maternal	Paternal	Whom: _____
Stroke	Parent	Sibling	Maternal	Paternal	Whom: _____
Thyroid	Parent	Sibling	Maternal	Paternal	Whom: _____

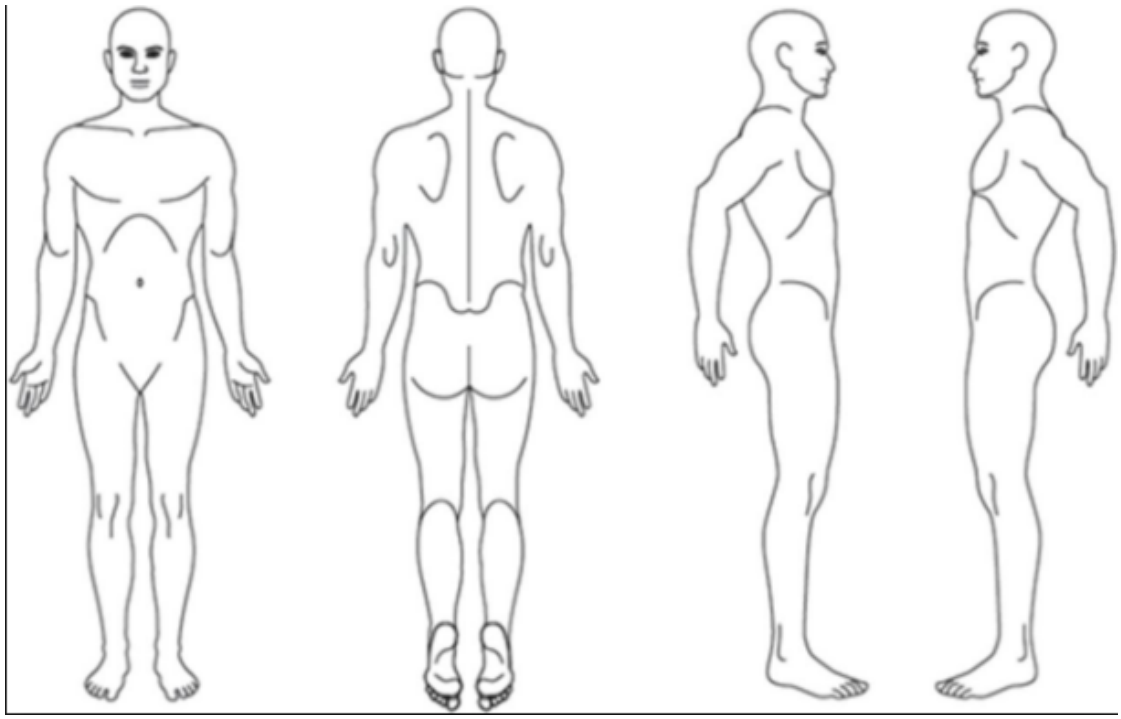
Other: _____

Additional health information you'd like to share?

_____

_____

Using the key below, indicate on the very impersonal body diagram where you may be experiencing the following symptoms: A=Dull Ache N=Numbness T=Tightness B=Burning S=Stabbing X=Tingling



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Describe what you're experiencing starting with the 'loudest' experience:

_____

_____

Approximately when did you become aware of these experiences? _____

Is the reason you're seeking care a result of:
Motor Vehicle Accident Work related Accident Other_____

To the best of your knowledge, how did this experience in your body begin for you?

_____

_____

How often do you experience what you are seeking care for? (Circle)
Constantly Frequently Occasionally
Intermittently (if so, choose one):
(76-100% of the day) (51-75% of the day) (26-50% of the day) (0-25% of the day)

Current relationship to movement, exercise, or activity (incl. length of time and frequency):

_____

_____

What treatments, including self-care mechanisms, do you currently have?

_____

_____

What do you wish to get out of your first session and in the long term?

_____

_____

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By signing below, I _____ (patient's printed name) indicate that the health information provided above is true and honest to the best of my knowledge and ability. I waive Empowered Chiropractic of liability if any fields are left blank or incomplete and assume full responsibility for communicating any and all health ailments at the time of treatment. I hereby authorize Empowered Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

_____ _____

Patient Signature Date

By signing, I indicate that I have read over the above health information with the patient indicated above and clarified all information relevant to the care being considered today.

_____ _____

Doctor Signature Date

Photo and Written Testimonials agreement (optional)

From time to time Empowered Chiropractic would like to use your testimonials for marketing purposes including information such as name, likeness, and quotes should you be willing to provide them for limited use on marketing websites, social media, and brochures.

This agreement does not effect any services offered by our company.
I _____ consent to the testimonials by me in promotional material as stated above.

Signed: _____ Dated: _____