CHIROPRACTIC
WELLNESS CENTER
MASSAGE AND SUPPLEMENTS

618 N Sullivan Rd. Ste 21
Spokane Valley, WA 99037
509.926.7789

CONFIDENTIAL PATIENT HEALTH RECORD

First Name _____
Middle Initial _____
Last Name _____
Nick Name _____
Street Address _____
City _____
State _____ Zip _____
Home Phone ( ) _____-_____
Work Phone ( ) _____-_____
Cell Phone ( ) _____-_____
Would you like text reminders? Y____ N____

Email _____

Birth Date _____/_____/_____
Age _____
Gender M____ F____
SSN _____-____-_____
Occupation _____
Employer _____
Marital Status S M W D
Spouse Name _____
Spouse Employer _____
Spouse Phone ( ) _____-_____
Emergency Contact Name _____
Emergency Contact ( ) _____-_____
Physician Name _____
Physician Phone ( ) _____-_____

Referred By _____
May we thank them for your referral? Y____ N____

CURRENT HEALTH CONCERNS

What is your main complaint? _____
When did you first notice symptoms? _____
Is the complaint related to past injuries/accidents? NO _____ YES _____
If yes, please explain: _____
On a 1-10 scale (0 = no pain), rate your pain **currently** _____ At its **worst** _____
How often are you bothered by pain? _____
Are there regular activities you **cannot** do because of pain? _____
Check any that apply:
Pain travels _____ Worse in evening _____ Worse in morning _____ Limits movement _____
Are you on medications? No _____ YES _____
If yes, please specify all: _____
Would you classify your condition as: **Minor** ____ **Moderate**____ **Serious** _____ **Severe** _____

I declare that these statements are true to the best of my knowledge.

Signature _____ **Date** _____/_____/_____

Please check/circle all that apply

Structure

Headaches (circle all that apply)

___ Stress Migraine
___ Jaw pain/Clicking/Popping
___ Neck Pain
___ Mid-back pain
___ Pain between shoulder blades
___ Chest pain
___ Lower back pain/sciatica
___ Hip/Groin pain

Are you experiencing any pain in these areas? (circle all that apply)

L R Shoulder L R Upper arm
L R Elbow L R Forearm
L R Wrist L R Knee
L R Ankle L R Foot

___ Numbness/Tingling
___ Location: _____
___ Stiff or Swollen joints
___ Muscle weakness
___ Muscle soreness
___ Muscle Cramps/Spasms
___ Muscle Tension/Tightness
___ Dizziness
___ Seizures
___ Confusion
___ Convulsions
___ Problems Walking
___ Limited/Painful movement
___ Pain limits doing what you like

Family Health History

___ Diabetes
___ High Blood Pressure
___ High Cholesterol
___ Heart Disease
___ Anemia
___ Stroke
___ Thyroid Disease
___ Arthritis
___ Osteoporosis
___ Alzheimer's
___ Cancers _____

_____

Other _____

_____

Exercise

Type of exercise you do...

___ Aerobic/Cardio
___ Endurance
___ Toning
___ Strength
Other _____

How often? _____

Level of Intensity _____

Is there any type of exercise you would like to participate in, but currently can't? _____

_____

Stress

___ Depression
___ Nervous/Anxious
___ Stressed
___ Fatigue
___ Irritability
___ Forgetfulness
___ Sick often
___ Allergies/Hay Fever
___ Sinus Infections
___ Asthma/Bronchitis

Nutrition

___ Weight Gain/Loss
___ Appetite Change
___ Always Thirsty
___ Eczema/Psoriasis
___ Itchy Skin
___ Vision Changes
___ Eyes bothered by light
___ Ringing in ears
___ Loss of hearing
___ Earaches
___ Increase/decrease in urination
___ Eating Disorders
___ High Cholesterol
___ High LDL/Low LDL
___ Indigestion/Heart Burn
___ Acid reflux/Stomach ulcer
___ Diverticulitis/Colitis
___ Irritable Bowel
___ Crohn's Disease
___ Mood swing changes

Posture

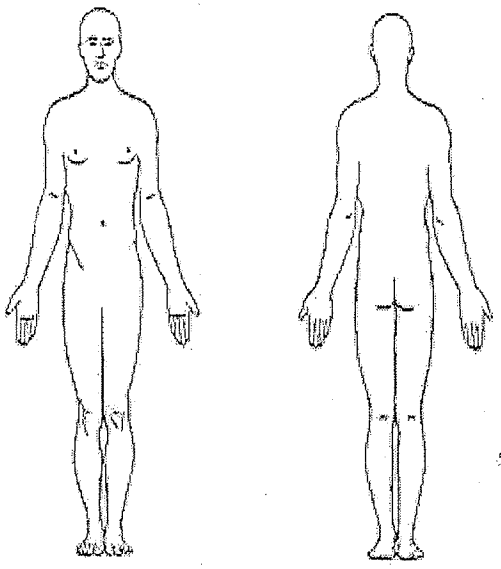
Have you been told or have you noticed any of the following?

___ Reversed Cervical curve
___ Forward Neck
___ Hunched Back
___ Rounded Shoulders
___ Swayback
___ Scoliosis/Kyphosis
___ Foot flare Right Left
___ Low/High Hip
Low/High Shoulder

Sleep

Sleeping position(circle one)

___ Side Back Stomach
___ Sleep Disturbance
___ Number of hours per night
___ Difficulty falling asleep
___ Wake up and can't go back to sleep
___ Restless Leg Syndrome
Snoring/Sleep Apnea
Insomnia



PAIN DIAGRAM

Please mark your areas of pain on these figures, indicating which type of pain you are experiencing.

B = Burning D = Dull
S = Sharp T = Tingling
N = Numbness

next to the letter by using the following scale:

0 = No Pain
8 = Brings tears to your eyes
10 = Severe medical emergency

I declare these statements are true to the best of my knowledge.

_____ _____
Signature *Date*

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New Patient Payment Plan

Please choose ONE option & initial next your method of payment for services rendered.

_____ **Cash:** Payment is expected at the time services are rendered.
We accept **Cash, Check, MasterCard, and Visa.**

_____ **Insurance:** You will need to provide our office with a **copy of your insurance card**. Our office will bill your insurance company as a courtesy to you with the understanding that **you are ultimately responsible for your account in our office**. In the event that your insurance company denies payment of services rendered, **you are responsible for any unpaid balances**. If you have co-insurance, where you would pay a percentage of your bill, the amount owed will be estimated and billed to you as services are rendered. Should any credit be incurred, that amount will be returned to you upon completion of care. **You are responsible for your annual deductible**.

Let us know if you have not met your deductible prior to care.

_____ **Medicare: You are responsible for services rendered that are not covered by Medicare**. Medicare does not typically pay for exams, x-rays, and the MYO-XR machine charges. You will be responsible for any charges Medicare will not cover when services are rendered.

You are responsible for your annual deductible.

_____ **Personal Injury: It is your responsibility to provide our office with any and all pertinent insurance information** (I.E. PIP, third party, or health insurance.) We need all insured persons names, addresses, and phone numbers. We also need all claim numbers, claim adjuster's names, addresses, and phone numbers. If you are being represented by an attorney, we will gladly work with them. We accept third party liens for those without PIP coverage. However, we require a $75.00 non-refundable fee to administer the lien. Any accounts over 60 days will accrue interest at a rate of 1% per month (12% per year).

You are responsible for the payment of all services rendered by our office, regardless of settlement outcome. Our fees are consistent with industry standards and are usual and customary. If you decide to stop care or transfer to another doctor before you have completed your treatment schedule *payment becomes due immediately*.

_____ **Work Related Injury:** You are responsible for filling out the self-insured Labor and Industries long form or the self-insured L & I form. You also need to file an accident report with your employer prior to your appointment with our office. If you are transferring care from another physician, we have transfer cards available. **If your claim is not accepted for any reason, you will be responsible for your account balance.**

_____ _____
Signature Today's Date

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NOTICE OF PRIVACY PRACTICES/CONSENTS AND AGREEMENTS

AUTHORIZATION TO RELEASE INFORMATION:

I, the undersigned, hereby authorize Provider and staff to release any information concerning my health acquired in the course of history, consultation, examination, and treatment by the Provider to my insurance company which may be necessary to help process my insurance claims. Occasionally it is necessary to communicate with other medical providers, employees of Chiropractic Wellness Center, or other referring health care professionals in the best interest of the patient. I authorize release of records to any other physician who is, was, or may be one of my treating physicians. In addition, I authorize release of information from previous physicians to Provider. This includes lab reports, test results and reports, x-rays, MRI's, etc. These authorizations include phone discussions between Provider and said physician. I release Provider of any liability resulting from such information transference.

_____ _____

Signature of patient or parent/guardian of patient **Date**

AUTHORIZATION TO RECEIVE COMMUNICATION:

I, the undersigned, hereby authorize Provider and staff to communicate with me via internet, mail, telephone, or text pertaining to upcoming events, promotions, updates, newsletters, and health status checkups. As a courtesy to our patients, we may call, text, or email prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we may leave a message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this message other than the date and time of your scheduled appointment.

_____ _____

Signature of patient or parent/guardian of patient **Date**

NOTICE OF PRIVACY PRACTICES:

You have the right to request restrictions on certain uses and disclosures of your health information.
You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method or communication or delivery upon your request.
You have the right to inspect and copy your health information.
You have the right to receive an accounting of disclosures of your protected health information.
You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

I provide Chiropractic Wellness Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described above.

_____ _____

Signature of patient or parent/guardian of patient **Date**

CONSENT TO TREAT A MINOR:

I hereby authorize the doctor to render chiropractic care as deemed necessary to:
Child's Name _____ Date _____
Guardian's Name (please print) _____ Relationship to Child _____
Guardian's Signature _____

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Notice of Cancellation Policy

Massage Therapy

Our office requires **24-hour notice** for a massage therapy cancellation.

If we fail to receive notice of cancellation 24 hours prior to the scheduled appointment time,

a Missed Appointment Fee of $50.00 will be billed to you personally.

The missed appointment fee cannot be billed to or paid by your insurance company.

We will make every effort to give you a reminder text or call, but ultimately you are responsible for your scheduled appointment.

Thank you for your understanding and consideration.
We look forward to serving you!

I have read, understand, and agree to the *Notice of Cancellation Policy*:

Date : _____

Patient Signature : _____

Print name: _____