Sequim Family Chiropractic Center

415 N Sequim Avenue, Sequim, WA 98382
360-504-3376

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail _____

Height _____ Weight _____ Gender: Male □ Female □ Marital Status Single □ Married □ Other □

Preferred Language _____ Employment Status: Employed Full Time □ Employed Part Time □ Student □ Retired □

Employer/School _____ Occupation _____ Phone _____

Emergency Contact _____ Relationship to Emergency Contact _____

Emergency Contact Phone Number(s) _____

(If Applicable) Spouse or Partner's Name _____ Date of Birth _____

How did you hear about our office? _____ Referred By _____

Please list your chief complaints in order of severity, approximate the percentage of time you experience pain, rate the intensity of the pain (0 being no pain, 10 being unbearable pain), and describe your sensations.

1. Complaint _____ Date the symptoms began _____

Percent of time you experience pain _____ (Please underline the frequency) per day, per week, or per month.

Rate your pain level 0 1 2 3 4 5 6 7 8 9 10 + How did your pain begin? _____

Describe what you feel in relation to this condition (Please check all that apply) Sharp □ Dull □ Achy □ Burning □ Numbness □ Tingling □ Stabbing □ Shooting (from _____ to _____) Stiffness □ Throbbing □ Deep □

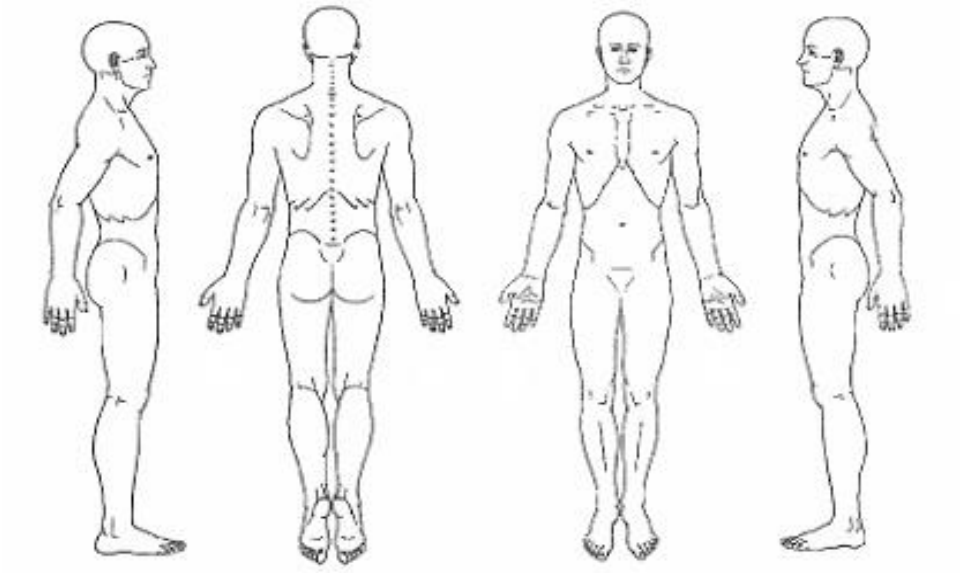
2. Complaint _____ Date the symptoms began _____

Percent of time you experience pain _____ (Please underline the frequency) per day, per week, or per month.

Rate your pain level 0 1 2 3 4 5 6 7 8 9 10 + How did your pain begin? _____

Describe what you feel in relation to this condition (Please check all that apply) Sharp □ Dull □ Achy □ Burning □ Numbness □ Tingling □ Stabbing □ Shooting (from _____ to _____) Stiffness □ Throbbing □ Deep □

Please use the diagram below to circle all areas of complaint.



Notes:_____

_____

What activities are affected by the above listed complaints? _____

_____

_____

What activities or movements aggravate your pain? _____

What activities or movements alleviate your pain? _____

How are your symptoms changing with time? Getting Worse □ Staying the Same □ Getting Better □

Have you been involved in an automobile accident in the last 36 months? Yes □ No □ Date of Injury _____

Have you been involved in a work related accident in the last 12 months? Yes □ No □ Date of Injury _____

Who else have you seen for this problem? Chiropractor □ ER Physician □ Massage Therapist □ Primary Cary Physician □

Neurologist □ Orthopedist □ Physical Therapist □ Other □ _____

What treatment(s), specifically, have you already received for your condition(s)? _____

_____

To the best of your ability, please list the approximate date of most recent: Chiropractic Adjustment _____

Primary Care Physician Visit _____ Hospitalization _____ Physical Exam _____

Surgery _____ Physical Therapy _____ Imaging (X-ray, MRI, CT) _____

Please list all significant injuries, surgeries, and hospitalizations you have had.

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

Indicate all medications (over the counter and prescription), vitamins, and supplements you are currently taking.

Medications _____

_____

_____

Vitamins/Herbs/Minerals/Supplements _____

_____

_____

Please list all allergies (include food, environmental, medications, other) _____

_____

_____

Please answer the following questions and check all options that apply.

How would you rate your overall heath? Excellent □ Very Good □ Good □ Fair □ Poor □

Are you currently as healthy as you would like to be? Yes □ No □ If no, what would you like to improve? Relief of symptoms □

Overall health □ Quality of life □ Correction of my underlying problem □ Perform better at work or recreational activities □

Specific goal □ _____

How is your diet (the foods you eat)? Excellent □ Very Good □ Good □ Fair □ Poor □

Do you smoke or chew tobacco? Yes □ No □ If yes, how much? _____ How often? _____

Do you drink alcoholic beverages? Yes □ No □ If yes, how much? _____ How often? _____

Have you had any major traumas or falls? Yes □ No □ If yes, when? _____

Have you ever had a sports related injury? Yes □ No □ If yes, when? _____

What type of exercise, if any, do you do? Strenuous □ Moderate □ Light □ None □

Typically, how many hours do you sit per day?_____ How many hours a day do you stand? _____

Do you perform any repetitive motions on a regular basis? Yes □ No □ If yes, please describe _____

_____

Do you perform heavy labor on a regular basis? Yes □ No □ If yes, please describe _____

_____

(If Applicable) Are you pregnant? Yes □ No □ Due Date _____

Please mark all that apply; mark C for Current or P for Past.

C □ P □ Abdominal Pain	C □ P □ Glandular or Hormone Problem	C □ P □ Pinched Nerve
C □ P □ AIDS/HIV	C □ P □ Glaucoma	C □ P □ Pneumonia
C □ P □ Alcoholism	C □ P □ Gout	C □ P □ Polio
C □ P □ Anemia	C □ P □ Headaches	C □ P □ Poor Posture
C □ P □ Aortic Aneurysm	C □ P □ Head injury	C □ P □ Prostate Disease
C □ P □ Appendicitis	C □ P □ Hearing Loss	C □ P □ Prosthesis
C □ P □ Artificial Joint	C □ P □ Heart Attack	C □ P □ Psychiatric Care
C □ P □ Arthritis	C □ P □ Heart Disease	C □ P □ Rapid Heart Rate
C □ P □ Asthma	C □ P □ Heat or Cold Intolerance	C □ P □ Rash or Itching
C □ P □ Bleeding Disorder	C □ P □ Hernia	C □ P □ Rheumatoid Arthritis
C □ P □ Blood Clots	C □ P □ Herniated Disc	C □ P □ Ringing in Ears
C □ P □ Blood in Stool	C □ P □ High Blood Pressure	C □ P □ Sciatica
C □ P □ Blood in Urine	C □ P □ High Cholesterol	C □ P □ Scoliosis
C □ P □ Blurred or Double vision	C □ P □ Hot Flashes	C □ P □ Shortness of Breath
C □ P □ Burning or Painful Urination	C □ P □ Insomnia	C □ P □ Sinus Problems
C □ P □ Cancer	C □ P □ Jaw Pain	C □ P □ Sleep Problems
C □ P □ Chemical Dependency	C □ P □ Kidney Disease	C □ P □ Slow to Heal
C □ P □ Chest Pain (Angina)	C □ P □ Leg Cramps	C □ P □ Spinal Disc Disorder
C □ P □ Chicken Pox	C □ P □ Liver Disease	C □ P □ Sprain/Strain
C □ P □ Chronic Congestive Heart Failure	C □ P □ Loss of Skin Sensation	C □ P □ Stroke
C □ P □ Chronic Cough	C □ P □ Low Back Pain	C □ P □ Surgical Implants
C □ P □ Chronic Headaches	C □ P □ Low Blood Pressure	C □ P □ Swelling of Feet, Ankles, Hands
C □ P □ Circulatory Disorder	C □ P □ Lung Disease	C □ P □ Swollen Joints
C □ P □ Contagious Skin Condition	C □ P □ Measles	C □ P □ Tendonitis/Bursitis
C □ P □ Depression	C □ P □ Memory Loss	C □ P □ Thyroid Disease
C □ P □ Diabetes	C □ P □ Mid Back Pain	C □ P □ TMJ
C □ P □ Dizziness	C □ P □ Migraines	C □ P □ Tremors
C □ P □ Easily Bruise or Bleed	C □ P □ Multiple Sclerosis	C □ P □ Tumors/Growths
C □ P □ Eating Disorder	C □ P □ Mumps	C □ P □ Ulcers
C □ P □ Emphysema	C □ P □ Nausea or Vomiting	C □ P □ Varicose Veins
C □ P □ Epilepsy	C □ P □ Neck Pain	C □ P □ Wheezing
C □ P □ Eye Disease or Injury	C □ P □ Neuropathy	C □ P □ Whiplash
C □ P □ Fainting	C □ P □ Nervousness	
C □ P □ Fatigue	C □ P □ Osteoporosis	
C □ P □ Fibromyalgia	C □ P □ Pacemaker	
C □ P □ Fractures	C □ P □ Parkinson's Disease	
C □ P □ Frequent Coughing	C □ P □ Phlebitis	

I certify that all of the above information is complete and accurate. I hereby authorize the Doctor(s) of Chiropractic and/or associates of Sequim Family Chiropractic Center to examine me and to perform any necessary diagnostic procedures in order to fully evaluate my condition for the presence of vertebral subluxation.

Patient Signature _____ Date _____

OFFICE POLICIES AND PROCEDURES

Welcome to Sequim Family Chiropractic Center. We would like to familiarize you with our office policies and procedures. Once you have read and fully understand each policy, please sign your name in the space provided on the final page of this document. By signing, you are indicating that you have read, understand, and consent to the policies and procedures of this office. Please be sure to read each policy carefully; should any questions or concerns arise, do not hesitate to request clarification from the front office staff or practitioner in order to prevent any misunderstandings in regard to the policies and procedures of this office. It is our intention to provide complete transparency and full explanation of our policies.

INFORMED CONSENT TO CHIROPRACTIC TREATEMENT

As with any healthcare procedure or treatment, there are certain complications, which may arise during chiropractic manipulation and therapy. Results are not guaranteed and there is no promise to cure. Doctors of Chiropractic are required to advise patients that there are risks associated with treatment. These risks include but are not limited to: fractures, disc injuries, muscle spasms for a short period of time, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote; however, you are being informed of the possibility regardless of the extreme remote chance. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

Fractures and other complications are rare occurrences and generally result from some underlying weakness of the bone or tissue, which the Doctor of Chiropractic will check for during the taking of your history and during examination. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

Other treatment options for your condition may include, but are not limited to: self-administered, over-the-counter analgesics and rest; medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers; Physical Therapy; steroid injections; hospitalization; surgery.

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. You are hereby informed that you have the right to seek and secure other opinions if you have concerns as to the nature of your symptoms and treatment options.

Chiropractic adjustment and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

Consent To Treatment (Minor)

I hereby request and authorize any Doctor of Chiropractic at Sequim Family Chiropractic Center to perform diagnostic tests and render chiropractic adjustments and other treatment to my child _____ (child's name). This authorization also extends to all other doctors and office staff members.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed any questions or concerns related to this policy with a Doctor of Chiropractic at Sequim Family Chiropractic Center and have had my questions answered to my satisfaction. I certify that I understand the nature of chiropractic treatment, including the risks and possible complications, and the choices I have about other treatment(s). By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I do not expect the Doctor of Chiropractic to be able to anticipate or explain all risks and complications, and I wish to rely on the Doctor to exercise judgment during the course of the procedure, which the Doctor feels at the time, based upon the facts then known, is in my best interest. Having been informed of the risks, I hereby give my consent to treatment. I intend this consent to apply to the entire course of treatment for

my present condition(s) and for any future condition(s) for which I seek treatment.

FINANCIAL POLICY

Chiropractic benefits are available through many insurance plans and policies. If you have questions regarding your insurance coverage, please contact your insurance carrier directly to verify eligibility and the benefits available to you through your policy. This office cannot guarantee insurance coverage or that payment will be made by your insurance carrier. Please present your insurance card to our front office staff during your initial visit. If your insurance coverage changes, please inform our staff and provide our office with updated coverage information. Sequim Family Chiropractic Center will bill your insurance carrier for services rendered, however, you are responsible for all charges incurred in this office, regardless of insurance benefits, payments, or coverage.

By signing this form, you are authorizing payment of medical benefits to be made directly to this office. If your insurance carrier sends payment to you for services rendered in this office, you agree to send or bring those payments to this office upon receipt, and you permit this office to endorse co-issued remittances.

If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are, ultimately, your financial responsibility regardless of your insurance coverage.

In the event your account becomes delinquent or you fail to pay outstanding charges for services rendered to you or your dependent(s), you are responsible for and agree to pay all late fees, attorneys fees, and collection fees if this account is turned over for collection.

By signing below, you agree to and accept the terms of this policy.

CANCELLATION AND NO-SHOW POLICY

There will be a fee if you are a no-show or fail to cancel or reschedule at least 24 hours prior to your scheduled appointment time. We understand emergencies happen and will gladly accommodate any patient if there are truly extenuating circumstances which prevent you from keeping your scheduled appointment. Non-emergent cancellations, made the day of your appointment, will be considered no-shows and charged accordingly.

If you are late, your appointment may not be extended. If you arrive too late to be treated during your scheduled appointment, you may be considered a no-show and charged accordingly.

This fee is the patient’s responsibility and cannot be billed to insurance.

By signing below, you agree to and accept the terms of this policy.

HIPAA NOTICE OF PRIVACY PRACTICES — PATIENT ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information (PHI). Protected Health Information (PHI), about you (the patient), is maintained as a written and/or electronic record of your contacts or visits for healthcare services with Sequim Family Chiropractic Center. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Sequim Family Chiropractic Center is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

PRACTICE REQUIREMENTS

- The Practice is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- The Practice is required to abide by the terms of this Privacy Notice.
- The Practice reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

- The Practice will distribute any revised Privacy Notice to you prior to implementation.
- The Practice will not retaliate against you for filing a complaint.

I have received, read, and understand Sequim Family Chiropractic Center's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Sequim Family Chiropractic Center at any time to obtain a current copy of the Notice of Privacy Practices.

By signing below, I acknowledge that I have read, understand, and agree to the office policies and procedures of Sequim Family Chiropractic Center.

Printed Name of Patient	Signature of Patient	Date

Printed Name of Parent/Legal Representative	Signature of Parent/Legal Representative	Date

Relationship of Legal Representative or Guardian to Patient