20 W. Central Ave. Spokane, WA 99205
Phone (509) 484-7578 Fax (509) 4849441
www.spokanechiro.com

Patient Application for Treatment

Name_____ **Nickname**_____

Address_____

City_____ **State**_____ **Zip Code**_____

Cell Phone _____**Carrier**_____ **Home Phone** _____**Work Phone**_____

Home email _____ **Work Email**_____

Date of Birth_____ **Age**_____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

How did you hear about us? ❑ Patient Referral _____ ❑ Dr. Referral _____
❑ Law Firm _____ ❑Google ❑Webpage ❑Other_____

What is the best way to contact you? *(check one)* ❑ Home Email ❑ Work Email ❑ Cell Phone ❑ Work Phone ❑ Home Phone

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **Children** ❑ Yes ❑ No How Many _____

Employment Status *(check one)* ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Occupation_____**Employer**_____ **Employer Phone** _____

Emergency Contact:_____ **Phone #:**_____

Do you have insurance? ❑ Yes ❑ No **Insurance Name:**_____ID#_____**SSN** _____

Primary insured? ❑ Yes ❑ No **If no, primary insured name and relationship to self:** _____

Race *(check one)*
❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian ❑Samoan
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino ❑Other_____
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian ❑ I choose not to specify

Primary Care Physician _____**Address**_____ **Phone**_____

Would you like our physicians to communicate your condition & course of care with your PCP? ❑ Yes❑ No❑ Not Sure

When was your last Physical examination? _____

When did you last have blood work? ❑ Within a Year ❑ Over a Year ❑ Not Sure

Have ever been referred to a specialist? ❑ Yes ❑ No If yes, describe:_____

Have you ever had chiropractic care? ❑ Yes ❑ No

If Yes, how long has it been since you've seen a chiropractor? _____

Has any of your family received chiropractic care? ❑ Yes ❑ No

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker
❑ Current every day smoker ❑ Current sometimes smoker

If yes, how often do you smoke:

What type of mattress do you have?_____ ***How old?***_____ ***Do you sleep on your stomach?***_____

How many pillows do you sleep on?_____

Height: _____ inches **Weight:** _____ pounds **BP:** _____ /_____

PATIENT SIGNATURE: _____ DATE: _____ Dr. Initial _____

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PATIENT NAME_____

Current medications, including dosage if known:

1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4) _____ 9) _____
5) _____ 10) _____

List any known allergies you have had to any medications, foods or environment:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 7) _____
4) _____ 8) _____

Have you had allergy testing done before? ❑ Yes ❑ No

FAMILY HISTORY: Please check any condition that YOU or YOUR FAMILY have or have had in the past. Please state (P) for Patient or (F) for family****

❑ Alcoholism	(P or F)	❑ High Blood Pressure	(P or F)	❑ Stroke	(P or F)
❑ Anemia	(P or F)	❑ Kidney Disease	(P or F)	❑ Suicide Attempt	(P or F)
❑ Asthma	(P or F)	❑ Liver Disease	(P or F)	❑ Thyroid Disease	(P or F)
❑ Cancer/Tumor	(P or F)	❑ Hepatitis	(P or F)	❑ Tuberculosis, TB	(P or F)
❑ Diabetes	(P or F)	❑ Lung Disease	(P or F)	❑ Ulcers	(P or F)
❑ Drug Abuse	(P or F)	❑ Mental Illness	(P or F)	❑ Venereal Disease	(P or F)
❑ Depression	(P or F)	❑ Osteoarthritis	(P or F)	❑ High Cholesterol	(P or F)
❑ Epilepsy/Seizures	(P or F)	❑ Osteoporosis	(P or F)	❑ HIV or Other Immune Disease	(P or F)
❑ Glaucoma	(P or F)	❑ Phlebitis	(P or F)	❑ Other _____	
❑ Heart Disease	(P or F)	❑ Rheumatic Arthritis	(P or F)		

Please check any conditions that you have now or have had in the past

GENERAL
- ❑ Weight Loss / Gain
- ❑ Fatigue
- ❑ Fever

EYES
- ❑ Glasses/Contacts
- ❑ Eye Pain
- ❑ Double Vision
- ❑ Cataracts

EAR, NOSE, THROAT
- ❑ Difficulty Hearing
- ❑ Ringing in Ears
- ❑ Vertigo/Dizziness
- ❑ Sinus Trouble
- ❑ Nasal Stiffness
- ❑ Frequent Sore Throat

CARDIOVASCULAR
- ❑ Heart Murmur
- ❑ Chest Pains
- ❑ Palpitations
- ❑ Fainting Spells
- ❑ Shortness of Breath
- ❑ Difficulty Lying Flat
- ❑ Swelling Ankles

ENDOCRINE
- ❑ Loss of Hair
- ❑ Heat/Cold Intolerance

RESPIRATORY
- ❑ Coughing
- ❑ Coughing Blood
- ❑ Wheezing

GASTROINTESTINAL
- ❑ Heartburn/Reflux
- ❑ Nausea/Vomiting
- ❑ Constipation
- ❑ Change in BMs
- ❑ Diarrhea
- ❑ Jaundice
- ❑ Abdominal Pain
- ❑ Black/Bloody BM

GENITOURINARY
- ❑ Painful Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Erectile Dysfunction
- ❑ Abnormal Discharge
- ❑ Bladder Leakage

ALLERGIES
- ❑ Food
- ❑ Environmental
- ❑ Medication
- ❑ Hives/Eczema
- ❑ Hay fever

PYSCHIATRIC
- ❑ Anxiety/Depression
- ❑ Mood Swings

HEMATOLOGY
- ❑ Easy Bruising
- ❑ Bleeding Gums
- ❑ Enlarged Glands

MUSCULOSKELETAL
- ❑ Joint Pain/Swelling
- ❑ Stiffness
- ❑ Numbness in toes/fingers
- ❑ Weakness in hands, feet, arm or legs
- ❑ Muscle Pain
- ❑ Loss of muscle Strength
- ❑ Back Pain

SKIN
- ❑ Rash/Sores
- ❑ Itching/Burning
- ❑ Lesions

NEUROLOGICAL
- ❑ Headaches
- ❑ Tremors
- ❑ Memory Loss

FEMALES ONLY

Date of Last Mammogram _____
Normal Abnormal
Date of Last Pap_____
Normal Abnormal
Date of Last Period_____
Are you pregnant? Y / N

PATIENT SIGNATURE: _____ DATE: _____ Dr. Initial _____

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1. **Chief Complaint :** _____
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start? _____ Gradual / Sudden
Circle the percentage of day you experience the complaint:
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worst? (1 – 10) _____

2. **Chief Complaint :** _____
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start? _____ Gradual / Sudden
Circle the percentage of day you experience the complaint:
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worst? (1 – 10) _____

3. **Chief Complaint :** _____
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start? _____ Gradual / Sudden
Circle the percentage of day you experience the complaint:
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worst? (1 – 10) _____

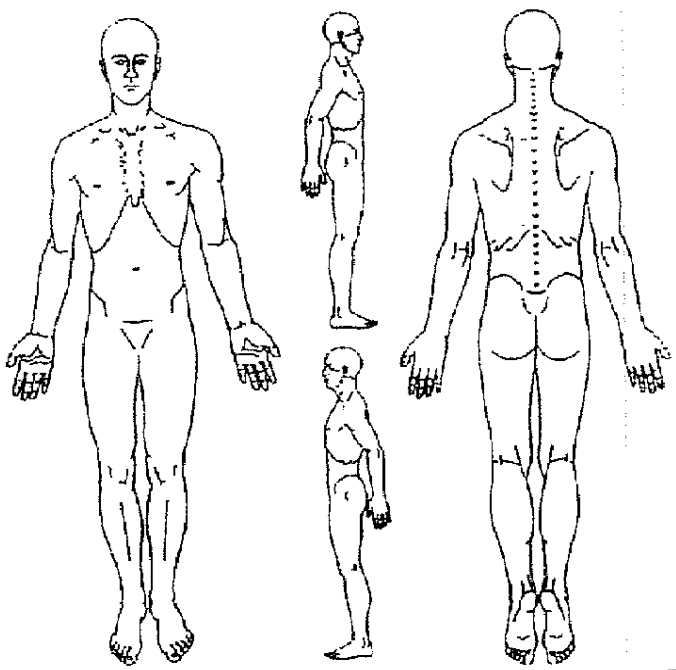
What job activities are you unable to do? _____

When do you feel it most? ☐AM ☐PM When present, how long does the complaint last? _____Mins _____Hrs

What makes it feel better? _____ What makes it feel worse? _____

Using the letters below, please show where you are experiencing all of your current complaints:

A: Ache
B: Burning
C: Cramping
D: Dull Pain
F: Stiffness
N: Numbness
R: Throbbing
S: Soreness
T: Tingling
X: Sharp Pain
SP: Shooting Pain
RP: Radiating Pain



Do you currently have pain and/or difficulty performing any of the following activities? (Circle Y or N)

Walking	Y	N
Standing	Y	N
Running	Y	N
Sleeping	Y	N
Driving	Y	N
Personal Grooming	Y	N
Sitting	Y	N
Kneeling	Y	N
Exercising	Y	N
Bending	Y	N
Lifting Objects	Y	N
Lifting Children	Y	N
Housework	Y	N

1. Have you ever had tests for your present condition? ☐MRI ☐Xray ☐CT ☐ Other _____
2. Do you have a pacemaker? ☐Yes ☐No 2b. What medications are you currently taking? _____
3. Have you ever lost work due to your condition(s)? ☐Yes ☐No If Yes, dates? _____

In the event we can help, please indicate to us what your level of commitment would be to correcting your problem(s)?

Low Medium High
0 1 2 3 4 5 6 7 8 9 10

What is YOUR goal for treatment? _____

By signing below, I acknowledge that the above information is true and accurate to the best of my knowledge:

Patient Name (please print): _____

Patient Signature: _____ Date: _____ Dr. Initials _____

RV 0/14

Consent for Treatment:

I understand that with chiropractic and massage there are some risks to treatment. These include but are not limited to the following: fractures, disc injuries, strokes, dislocations, sprains, and soreness. I do not expect the doctor to be able to anticipate and explain all risks and complications.
I understand the above consent and by signing below I agree that all risks are my liability.

Patient Signature:_____ Date:_____

Financial Agreement:

We submit medical insurance forms as a courtesy to our patients. I authorize Central Chiropractic to release any medical information necessary to process my claim. I also authorize the payment of medical benefits directly to Central Chiropractic. Patients are financially responsible for all charges, including any portion insurance does not cover. Time of service (cash) patients are asked to pay for service on each visit.

The clinic may use my health care information and may disclose such information to the insurance company for the purpose of obtaining payment for services and determining insurance benefits payable to related services. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature:_____ Date:_____

Cancellation Policy:

We understand that sometimes it is necessary to cancel or change an appointment times. In consideration of the others who need care, we ask that if you are unable to keep an appointment with our office, that you please observe our cancellation policy:
Our office requires at least a 24 hour notice for massage cancellations. If you are unable to provide such notice, you will billed a $30.00 charge at our discretion.

Patient Signature:_____ Date:_____

HIPAA Privacy Practices:

I acknowledge that I have received and/or have been given the opportunity to review this Chiropractic Offices Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name_____

Patient Signature_____ Date:_____

Consent to Treat a Minor (Minor's Name)_____

Guardian/Spouse Signature Authoring Care_____ Date_____