Central Chiropractic

20 W Central
Spokane WA 99205

PATIENT INFORMATION		
First Name:		**MI:**
Last Name:		
Nickname:		
Address:		
City:	State:	Zip:
DOB:	Age:	Sex: M / F
Email:		
Occupation:		
Employer:		
Employer Phone Number:		
Marital Status: S / M / D / W		
Employment Status: Full / Part / None / Retired / Self		
Student Status: Full / Part / None		

SPOUSE INFORMATION
Name:
DOB:
Phone Number:

EMERGENCY CONTACT INFORMATION
Name:
Relation:
Phone Number:

PHONE NUMBERS
Home:
Work:
Cell:

PLEASE LET US KNOW THE NAME(S) OF ANYONE WE MAY RELEASE YOUR INFORMATION TO:
Name:
Relation:
Phone Number:
Name:
Relation:
Phone Number:

WHO MAY WE THANK FOR REFERRING YOU TO US?
(friend , Doctor, Co-Worker, etc..)

DID YOU HEAR ABOUT OUR OFFICE FROM:
□ NEWSPAPER □ SIGN □ PHONEBOOK □ TV □ MAILING □ COMMUNTIY EVENT □ OTHER:

HIPAA PRIVACY PRACTICE NOTICE

The Practice:

a. Is required by federal law to maintain the privacy of your Personal Health History and to provide you with this Privacy Notice detailing the practice's legal duties and privacy practices with respect to your Personal Health History.
b. Under the privacy rule, may be required by State law to grant greater access or maintain greater restrictions provided under federal law.
c. Is required to abide by the terms of this Privacy Notice.
d. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your Personal Health History that it maintains.
e. Will distribute any revised Privacy Notice to you prior to implementation.
f. Will not retaliate against you for filing a complaint.

This notice is effective as of 04/15/03

By signing my name below I acknowledge receipt of a copy of this Notice and I understand and agree to its terms

All information provided on this document is true and correct to the best of my knowledge.

Signature: _____ **Date:** _____

Central Chiropractic & Massage 20 W. Central Ave. Spokane, WA 99205 Tel: (509) 484-7578

Name: _____ **Date:** _____ **DOB:** _____

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) _____

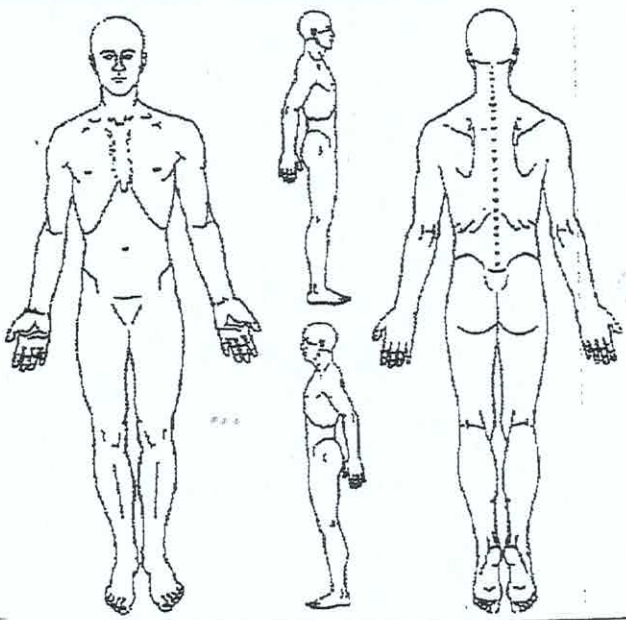
What job activities are you unable to do? _____

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

Have you experienced any of the following the the past 14 days:

☐ Yes ☐ No **Nausea**	☐ Yes ☐ No **Head Trauma**	☐ Yes ☐ No **Difficulty Walking**
☐ Yes ☐ No **Vomiting**	☐ Yes ☐ No **Memory Loss**	☐ Yes ☐ No **Numbness / Tingling**
☐ Yes ☐ No **Fever**	☐ Yes ☐ No **Incoordination**	☐ Yes ☐ No **Pressure in Arms / Legs**
☐ Yes ☐ No **Diarrhea**	☐ Yes ☐ No **Speech Problems**	☐ Yes ☐ No **Double / Blurred Vision**
☐ Yes ☐ No **Stomach Pain**	☐ Yes ☐ No **Vertigo (Spinning)**	☐ Yes ☐ No **Tinnitus (Ringing in Ears)**
☐ Yes ☐ No **Minor Fall**	☐ Yes ☐ No **Personality Change**	☐ Yes ☐ No **Pain Waking You at Night**
☐ Yes ☐ No **Major Fall**	☐ Yes ☐ No **New Type of Headache**	☐ Yes ☐ No **Change in Bladder/Bowel**
☐ Yes ☐ No **Weight Loss**	☐ Yes ☐ No **Worst Headache Ever**	☐ Yes ☐ No **Loss of Strength in Limbs**

Patient Medical History

Name: _____ **Date:** _____ **DOB:**_____

Current Medications:

Name of Medication	Reason for Medication	Prescribing Doctor

□ No Current Medications

Surgeries:

Type of Surgery	Date of Surgery	Reason for Surgery

□ No Past Surgeries

Accidents / Injuries:

Previous Motor Vehicle Accidents
□ Yes □ No Date: _____

Fractures
□ Yes □ No Type: _____

Dislocations:
□ Yes □ No Type: _____

Additional Information

_____
_____
_____
_____
_____
_____
_____

Central Chiropractic
20 W Central
Spokane WA 99205

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20 W Central Ave
Spokane, WA 99205

Patient Name: _____

Consent for Treatment / Release of Liability:

As the patient you understand that there are certain risk factors associated with chiropractic treatment and massage therapy. These risks, while rare, include but are not limited to soreness, bruising, fractures, dislocations, sprains, and stroke. As the patient you do not expect your provider to be able to anticipate or explain all risk factors associated with treatment and understand that by signing you agree to assume full liability associated with all treatment.

I hereby authorize all providers at Central Chiropractic to treat my condition as deemed appropriate. The chiropractor will not be held responsible for any pre-existing medically diagnosed conditions. I certify that the information I provided on all forms is correct to the best of my knowledge. I also will not hold my chiropractor, or any staff member of Central Chiropractic responsible for any errors or omissions that I may have made in the completion of these forms. Having carefully read the above, I hereby give my informed consent to have chiropractic (or massage therapy) treatment administered at Central Chiropractic.

Patient / Guardian Signature: _____ Date: _____

Financial Agreement:

Central Chiropractic will bill your medical insurance as a courtesy and is in no way responsible for your individual insurance coverage. If you have questions regarding your coverage it is your responsibility to contact your insurance company for clarification. **Central Chiropractic does not track visit limitations**. As the patient you authorize the release of any medical information necessary to process insurance claims and agree that payments from your insurance may be made directly to Central Chiropractic. As the patient you understand you are financially responsible for all charges including any portion that is not covered by medical insurance. Patients not using medical insurance are expected to pay when services are rendered.

Patient / Guardian Signature: _____ Date: _____

Cancellation Policy:

We understand that at times it is necessary to cancel appointments and we try to accommodate the need to cancel or reschedule. If you are unable to keep a scheduled appointment, please be aware of our cancellation policies. **Massage Therapy:** A minimum of 24-hour notice is required. If you are unable to provide such notice you will be billed **$30.00** for the no show or late cancellation.

Patient / Guardian Signature: _____ Date: _____