Cle Elum chiropractic

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PATIENT INFORMATION

Name:_____ Date:_____
(Last) (M.I.) (First)

Sex: ___M ___ F Marital status: (circle) single married divorced partnered widowed

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Please **Circle** best # to call

Email: _____

Occupation: _____ Employer: _____

Name of Spouse: _____ Referred by: _____

Emergency Contact: _____
(Name) (Phone) (Relationship to Patient)

HEALTH INFORMATION DISCLOSURE

I, _____, give permission to Cle Elum Chiropractic to disclose the following health information to _____:

_____ Scheduling Information
_____ Medical Information ***(Please initial any/all applicable categories)***
_____ Financial Information

I understand that this gives Cle Elum Chiropractic permission to disclose only the above-mentioned health information to only those above-mentioned individuals.

PARENT/LEGAL GUARDIAN AGREEMENT FOR MINORS

I, _____, am the individual who authorizes treatment and is responsible for the financial obligations of _____. I authorize treatment and agree to pay for all services provided to _____ here at Cle Elum Chiropractic.

Printed Name: _____

Signature: _____ Date: _____

Name: _____ Date: _____

HEALTH HISTORY

Have you ever seen these types of practitioners?

Doctor of Chiropractic ___Y ___N
Massage Therapist ___Y ___N
Nutritional Therapist ___Y ___N
Acupuncturist ___Y ___N

Main Complaint: _____

_____

When did this condition begin? _____ How did this condition begin? _____

_____

Do you have any prior history of this problem? ___Y ___N
If Yes, please explain: _____

Is this condition injury related? ___Y ___N If Yes, is it: ___ Work related? ___ Motor vehicle collision related?

Other injury- Please describe: _____

Other doctors/practitioners seen for this condition: _____

_____

What makes this complaint **worse**? _____

What makes the complaint **better**? _____

Pain Intensity (circle the #)	**None**	**Minimal Discomfort/ache/stiff**			**Slight to Moderate Hurts/sore/bearable**				**Severe Sharp/intense pain**		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck discomfort	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back discomfort	0	1	2	3	4	5	6	7	8	9	10
Low Back discomfort	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot symptoms	0	1	2	3	4	5	6	7	8	9	10
Other:	0	1	2	3	4	5	6	7	8	9	10

Pain Frequency	**None**	**Occasional**			**Intermittent**			**Frequent**		**Constant**	
Neck	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid Back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Other:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Do you get headaches? ___Y ___N How frequently? _____
How many hours does your typical headache last? _____

Do you get migraines? ___Y ___N How frequently? _____
How many hours does your typical migraine last? _____
What is/are the cause(s) of your migraines? _____

Name: _____ Date: _____

Please check symptoms with which your pain has been associated:

- ☐ Numbness, tingling or pain into your shoulder, upper arm, lower arm, or hand/fingers? **Circle areas.**
- ☐ Numbness, tingling or pain into your hip/buttock, groin, front of thigh, back of thigh, knee, calf, shin, or foot/toes? **Circle areas.**
- ☐ Increased low back pain with coughing, sneezing, or bearing down to have a bowel movement
- ☐ Excessive fatigue-malaise
- ☐ Weight loss
- ☐ Low grade fever
- ☐ Bowel or bladder disorders (such as urinary or bowel incontinence or difficulty urinating or having bowel movements)
- ☐ Ovarian pain
- ☐ Kidney pain/painful urination
- ☐ Night pain or night time sweats
- ☐ Abdominal pain
- ☐ Balance problems
- ☐ Flu/cold
- ☐ Inflammation
- ☐ Infection
- ☐ Contagious disease

Allergies: _____

Food sensitivities: _____

Describe any allergic/sensitivity reactions: _____

_____

Date of last physical exam and results: _____

Job description: _____
Have you been able to work? ____Y ____N

Recreational activities/hobbies: _____

Do you exercise? ___Y ___N If Yes, please describe: _____

Do you, or have you, smoke cigarettes or use tobacco products? ___Y ___N If Yes, for how long? _____

Medications and reason taken: _____

_____

Vitamins, minerals, or other supplements: _____

_____

Name: _____ Date: _____

Past Surgeries	**Date**	**Reason for surgery**

Past Accidents, Falls or Injuries	**Date**	**Description of injury**

Past Fractures/broken bones	**Date**	**Description/location of fracture**

Health problems of relatives: _____

_____

Other health related concerns or comments: _____

_____

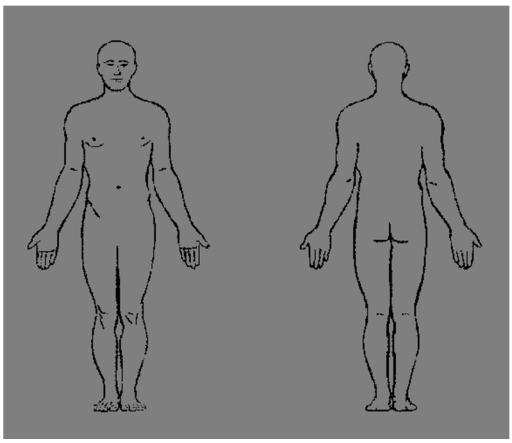
_____

WOMEN: Are you pregnant? ___ Y ___ N If so, how far along are you? _____

Please list any pregnancy complications or restrictions? _____

_____

Name: _____ Date: _____



Please indicate on the drawing where you experience the following:

pain (P), aches (A), numbness (N), swelling (S)

Please check any of the following that currently affect you or that you have experienced.

MUSCULOSKELETAL
___ Low Back Pain
___ Mid Back Pain
___ Neck Pain
___ Pain between shoulders
___ Arm Pain
___ Shoulder Pain
___ Elbow Pain
___ Wrist pain
___ Finger Pain
___ Hip Pain
___ Thigh Pain
___ Knee Pain
___ Leg Pain
___ Foot Pain
___ Toe pain
___ Ankle pain
___ Jaw Pain
___ Difficulty Chewing
___ Joint Stiffness (Where: _____)
___ Joint Swelling (Where: _____)
___ Fibromyalgia
___ Osteoporosis or Osteopenia
___ Arthritis
___ Rheumatoid Arthritis
___ Postural Deviations
___ Headache
___ Muscle Weakness or Weak Grip
___ Disc bulge/herniation (Where: _____)
___ Vertebrae Condition

NERVOUS SYSTEM
___ Multiple Sclerosis
___ Paralysis
___ Spinal Cord Injury
___ Stroke
___ Seizures/Convulsions
___ Numbness/tingling in extremities
___ Cold extremities
___ Twitching/Ticks
___ Fainting
___ Depression
___ Poor balance/coordination

CIRCULATORY
___ Anemia
___ Abdominal Aneurysm
___ Hemophilia
___ High Blood Pressure
___ Low Blood Pressure
___ Raynaud's Disease
___ Varicose Veins
___ Hemorrhoids
___ Heart Condition/Attack
___ Blood Clots/Phlebitis
___ Chest Pain
___ Irregular heartbeat
___ Ankle Swelling
___ Light Headedness
___ Body too cold
___ Body too hot

DIGESTIVE
___ Abdominal pain
___ Constipation
___ Frequent Nausea
___ Gall bladder problems
___ Liver problems/hepatitis
___ Vomiting
___ Diarrhea
___ Gas/Bloating
___ Indigestion/heartburn
___ Black or bloody stool
___ Excessive thirst
___ Excessive appetite

URINARY
___ Bladder trouble/infection
___ Discolored urine
___ Painful urination
___ Excessive urination
___ Scant urination
___ Kidney Problems

RESPIRATORY
___ Lung Congestion
___ Sinus Congestion/infection
___ Asthma
___ Difficulty Breathing
___ Dizziness
___ Lung Condition

SKIN
___ Fungal Infections
___ Dermatitis/Eczema
___ Psoriasis
___ Open Wound or Sore
___ Rashes
___ Warts/Moles
___ Athletes Foot
___ Ring Worm

OTHER
___ Diabetes or Hypoglycemia
___ Anxiety/Nervousness
___ Muscle Cramping
___ Trouble Sleeping
___ Menstrual Problems
___ Cancer
___ Substance Abuse
___ Herpes
___ Fatigue
___ HIV/AIDS
___ Lupus
___ Postoperative Situation
___ Swelling
___ Prosthetics
___ Implanted device (ie: pacemaker)
___ Joint Replacement
___ Transplanted Organ
___ Other:
_____
_____

Name: _____ Date: _____

PATIENT COMPLIANCE FORM

My initials and signature on this document indicates that:

1) I acknowledge that all the information I have given is accurate to the best of my knowledge and is necessary in order to receive the best possible care. I agree and take responsibility for notifying my practitioner if any physical or mental changes occur with my health (ie: injury, illness, pregnancy, etc) to ensure that the most appropriate and effective care continues to be given.

_____

2) I hereby acknowledge that I have read and fully understand the **NOTICE OF PRIVACY PRACTICES** outlining the policies and procedures concerning the privacy of my Patient Health Information and if there is anyone I do not want to receive my medical records, I have informed the office in writing. I agree to allow this office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations and not share my health information with anyone, unless I have signed a Records Release Form.

_____

3) I understand that it is **my responsibility to make it to all scheduled appointments and to notify the office/practitioner at least 24 hours in advance if a situation arises that leads to cancellation or rescheduling. I agree to pay the $50 missed appointment fee in the event I miss my appointment or cancel last minute.**

_____

4) I have read and fully understand this wellness center's **FINANCIAL POLICIES** and know that I am ultimately responsible for any charges incurred at this office. I know that it is my responsibility to pay at the time of service if a cash patient or a co-payment for regular insurance patients. I know that in the event that I am on an injury claim and the claim closes or stops being paid by the insurance company, that I am responsible for payment, which is due at the time of service. I authorize the use of this signature on all insurance submissions.

_____

5) I give my permission and consent to the general procedure or treatment I will receive and know that if at any time I no longer wish to receive a specific treatment (or an aspect of), I have the right to inform my practitioner. I will ask my practitioner if have any questions concerning the general procedure.

_____

Signature: _____ Date: _____