Patient Information Today's Date: _____

Name _____ Age _____ Gender: M F (Pregnant: Yes No)

Home Address _____ Home Phone _____

City, State, Zip _____ Cell Phone _____

Email Address _____

Birth date _____ Social Security Number _____ Marital Status: S M D W P

Occupation, Employer _____How many people in your household? _____

Emergency Contact _____ Phone _____

How were you referred to this office? _____

Who is your Primary Care Doctor? _____

Is This Visit Related To A: Work Injury Car Collision Injury Home Injury Non-Injury Symptoms Gradual Onset Other

Experience with Chiropractic **DO YOU HAVE P.I.P.?** Yes No Not Sure

Have you seen a Chiropractor before? □Yes □No Who? _____

Reason for visit(s) with previous provider: _____

Did your previous provider take x-rays? □Yes: Year _____ □No What was the diagnosis? _____

Did they recommend a specific course of treatment? □Yes □No

Did they recommend a home health care program? □Yes □No If yes, what? _____

How long were you treated? _____ Last treatment date: _____

How did you respond? _____ Have you ever had Massage Therapy Treatments? Yes No

Health & Lifestyle

Do you exercise? □Yes □No How often? _____ day(s) per week; Do You Play An Instrument:_____

What are your current Hobbies? _____

Do you smoke? □Yes □No How much/how often? _____

Do you drink alcohol? □Yes □ No How much/how often? _____

Do you drink coffee? □Yes □No How much/how often?_____

How much water do you drink daily? _____ cups (1 cup = 8oz)

Do you take supplements? □Yes □No Please list: _____

Do you sleep on your: □ Back □ Side □ Stomach

Health History

Indicate whether **F**ather, **M**other, **S**ister, **B**rother, or **S**elf has been diagnosed with the following:

___ **STROKE**	___ Diabetes	___ Neurological Problems	___ Lung Disease	___ Lumbago
___ Heart Disease	___ Circulatory Problems	___ Whooping Cough	___ Heat Murmur	___ Eczema/Psoriasis
___ Cancer	___ Broken Bones/Fractures	___ Pneumonia/Bronchitis	___ Osteoporosis	___ Varicose Veins
___ High Blood Pressure	___ Paralysis	___ Arthritis	___ Rheumatic Fever	___ Small Pox
___ Liver Disease	___ Metal Implants	___ Infectious Disease	___ Gall Bladder	___ Measles
___ Migraine Headaches	___ Appendectomy	___ Tonsillectomy	___ Hernia	___Pleurisy
___ Kidney Disease	___ Polio	___ Tuberculosis	___ Anemia	___ Mumps
___ Epilepsy/Seizures	___ Chicken Pox/Shingles	___ Blood Sugar Problems	___ Influenza	___Thyroid Problems

___ Other: _____

Injury History

List ALL past **Auto Collisions**, Month/Year, type of collision (rear-end, side impact) and if care was given.

1._____

2._____

List ALL **Worker's Compensation** claims, Injured Body Regions, Month/Year, and what type of care received.

1. _____

2. _____

List ALL past **Hospitalizations and Surgeries** (including augmentation), Month/Year, and type of injury.

1. _____

2. _____

3. _____

Please list all **medications** you are currently taking:_____

Is This Visit Related To A:	Work Injury	Car Collision Injury	Home Injury	Non-Injury Symptoms	Gradual Onset	Other

Patient Name:

What brought you in to see us today?

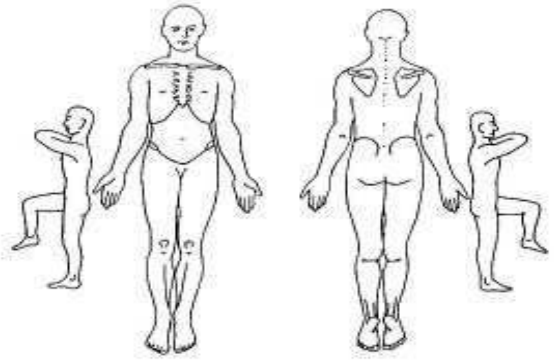
How did you hurt yourself?

When did the symptoms begin?

On the picture below, use the **indicated marks** to show areas where you have, at any time, experienced:

Indicator Marks:

Pain:	**XXXX**
Numbness:	**////**
Tingling:	********



Please indicate your pain from 0-10; with 10 being the worst pain and 0 being no pain.
Circle all that Apply

Neck ____/10; At Worst ____/10; At Best ____/10

Is the pain on the: **Left** **Right** **Center**

Type of Pain:

Burning	Numbness	
Stabbing	Dull	Sharp
Throbbing	Tight	Aching
Tingling	Tender	

How Often is Pain during Waking Hours?

Intermittent (0-25%)	Frequent (51-75%)
Occasional (26-50%)	Constant (76-100%)

Are you experiencing Headaches? Yes □ □ No

If yes how often?

Are you experiencing pain down your arms? Yes □ □ No

If yes, Left Arm or Right Arm or Both

How do the following motions affect your pain?

	No Change	Relieves	Increased
Looking Up	□	□	□
Looking Down	□	□	□
Right Head Rotation	□	□	□
Left Head Rotation	□	□	□

Mid-Back ___/10; At Worst ___/10; At Best ____/10

Is the pain on the: **Left** **Right** **Center**

Type of Pain:

Burning	Numbness	
Stabbing	Dull	Sharp
Throbbing	Tight	Aching
Tingling	Tender	

How Often is Pain during Waking Hours?

Intermittent (0-25%)	Frequent (51-75%)
Occasional (26-50%)	Constant (76-100%)

Do you get pain with breathing? Yes □ □ No

If Yes, Where? _____

Does your pain wrap around your ribs? Yes □ □ No

If Yes, Where? _____

How many hours per day do you sit in a chair? _____ hrs

How many hours per day are you at a computer? _____ hrs

Low-Back ___/10; At Worst __/10; At Best ___/10

Is the pain on the: **Left** **Right** **Center**

Type of Pain:

Burning	Numbness	
Stabbing	Dull	Sharp
Throbbing	Tight	Aching
Tingling	Tender	

How Often is Pain during Waking Hours?

Intermittent (0-25%)	Frequent (51-75%)
Occasional (26-50%)	Constant (76-100%)

Do you have pain with coughing, sneezing or going to the bathroom? Yes □ □ No

If Yes, Where? _____

Do you have pain in butt or down the leg? Yes □ □ No

How do the following motions affect your pain?

	No Change	Relieves	Increased
Sitting	□	□	□
Walking	□	□	□
Standing	□	□	□
Lying Down	□	□	□
Lifting	□	□	□
Bending	□	□	□

Patient Initials: _____ Date: _____

List of Extremities:

Shoulder	TMJ/Jaw	Knee
Elbow	Ribs	Ankle
Wrist	Hand	Foot

Please indicate Right or Left by Circling R or L

Extremity: **R L**_____ ___/10

Type of Pain:	Burning	Numbness
Stabbing	Dull	Sharp
Throbbing	Tight	Aching
Tingling	Tender	

How Often is Pain during Waking Hours?

Intermittent (0-25%)	Frequent (51-75%)
Occasional (26-50%)	Constant (76-100%)

Extremity: **R L**_____ ___/10

Type of Pain:	Burning	Numbness
Stabbing	Dull	Sharp
Throbbing	Tight	Aching
Tingling	Tender	

How Often is Pain during Waking Hours?

Intermittent (0-25%)	Frequent (51-75%)
Occasional (26-50%)	Constant (76-100%)

What have you done to try to relieve the pain?

Heat	Ice	Stretching	Nothing Helps
Rest	Medicine	Massage	Other:

Have you seen another professional for this condition?

Medical Doctor: _____

Chiropractor: _____

Physical Therapist: _____

Other: _____

Prior Similar Symptoms

□ I have NOT had prior symptoms similar to my current complaints

□ My current complaints DID exsist before, but have not been bothering me.

□ My current complaints ALREADY existed and were worsened.

Has your History contributed to your current symptoms?

□ My history HAS contributed to my current symptoms.

□ My history HAS NOT contributed to my current symptoms.

□ I'm NOT SURE if my history has contributed.

Circle the TOP 3 activities which are most affected by your pain. Circling an activity does not necessarily mean you are unable to perform it, it simply means your pain affects the activity, even just your enjoyment.

Walking	Sitting	Showering	Jogging	Standing	Dishes
Reading	Driving	Sex	Shaving	Gym	Chores
Working	Swimming	Sleeping	Bending	Dressing	Gardening

Please mark each that apply to your Daily Activities:

□ Stays at home most of the time due to the problem

□ Changes position frequently to try and get comfortable

□ Walks more slowly than usual because of the problem

□ Does not do jobs about the house because of the problem

□ Has to use handrails to get up the stairs

□ Has to lie down and rest frequently due to the problem

□ Has to hold onto something to sit or stand from a chair

□ Has to get other people to do things for you

□ Has difficulty getting dressed due to the problem

□ Can only stand for short periods due to the problem

□ Has difficulty bending or kneeling due to the problem

□ Has difficulty turning over in bed due to the problem

□ Has a loss of appetite due to the problem

□ Can only walk short distances because of the problem

□ Has difficulty sleeping because of the problem

□ Has to get dressed with someone's help

□ Has to sit most of the day because of the problem

□ Has more irritable because of the problem

□ Stays in bed most of the day because of the problem

How often do you have to stop activities to sit or lie down to control your pain?

□ All Day

□ Several times a day

□ Occasionally

□ Approx Once per day

□ Never

Patient Initials: _____ Date: _____

Patient Name:

We would like to take a moment to welcome you to our clinic and assure you that you will receive the very best of care available for your condition. The following are our clinic financial policies please familiarize yourself with our policies, please initial each section. If you have any questions, please contact the front desk. Thank You

Covered/Non-Covered Services

I understand that the services rendered and/or supplies/aides given to me may not be considered eligible for benefits (eg. Services and/or supplies/aides may be determined to be not medically necessary, non-covered or investigational) by my health insurance company. I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies/aides. Since I have chosen to obtain the services and/or supplies/aides, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

Your treatment plan makes it necessary to utilize not only Chiropractic Care codes, but to also utilize what is best described as Physical Rehabilitation codes. Policy benefits for both areas of care vary greatly by insurance policy and we cannot be aware of each person's specific policy benefits. To provide our best level of care, we provide a treatment plan that is specific for you and not based on your insurance policy benefits. Your specific policy benefits will determine what your patient responsibility will be. Our clinic will not quote insurance benefits; therefore, you are encouraged to contact your health plan. **It is ultimately your responsibility to check with your insurance to understand the contract and coverage.**

If you are unsure of your insurance benefits or your deducible, a charge of $50 will be applied for each date of service until benefits can be determined by your insurance carrier. These monies will be placed on your account towards any out of pocket expenses as determined by your insurance plan.

Primary Insurance Company: _____ Secondary Insurance Company: _____

Member ID #: _____ Member ID #: _____

Group #: _____ Group #: _____

____ PLEASE INITIAL AFTER READING

Billing and Payments

You, the patient or legal guardian, are responsible for all claims made to your insurance. Billing is a courtesy service which we provide to our patients at no extra charge. This clinic will provide any necessary reports or required information to aid in insurance reimbursement of services. In the event of the insurance plan's denial of benefits or claim payments, the patient is responsible for the total balance due to the provider. If the insurance carrier requires the patient to send in more information regarding his/her claim and the patient fails to return the required information to the carrier, the patient will be billed for the entire balance on the claim, as the insurance company requires the provider to do.

All co-pays and known co-insurance amounts are due at the time of service.

In the event you do not have health insurance coverage, we do offer a Time of Service reduction of our fee schedule. This reduced fee must be paid at time of service in order to receive the reduction; if payment is not received on the same date of service, then our regular fee schedule rates will be applied to your account.

Patient statements are sent out monthly for the previous months billing and payment activities. Payments on your account are due by the last day of the month in which the statement was sent. Patients are given 90 days to make payments on account before sent to pre-collections. If at any time a payment cannot be made, please call our clinic to set up a payment plan or inform the clinic of your situation as you may qualify for deferred payments.

All accounts with patient portion balance showing no patient payment activity will be charged a $5 monthly Account Maintenance Fee, for each month no payment is made on the account.

Patient Name:

All outstanding unpaid patient account balances over $100 will result in the inability for the patient to schedule future appointments, until the patient portion of the account is paid, or payment arrangements are made.

____ PLEASE INITIAL AFTER READING

Assignment of Benefits

By signing this form you are authorizing payment of medical benefits will be made directly to this clinic. If your insurance carrier sends payment to you for services incurred in this clinic, you agree to send or bring those payments to this clinic upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be send directly to you.

____ PLEASE INITIAL AFTER READING

Reminders/Missed Appointments

With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards, emails and text messages are available to help you save the date and time of your appointments.

Our patient's, staff and doctor's time is valuable, and we wish to provide every patient with an excellent experience. Please provide us the courtesy of a **48 hour cancellation** or change notice if you are unable to keep your appointment time. A $25 missed appointment fee will be charged for a no call, no show appointment, or an appointment change without 48 hour notice.

____ PLEASE INITIAL AFTER READING

Statement of Privacy

We use and disclose the information we collect from you only as allowed by Health Insurance Portability and Accountability Act and Washington State. This includes issues relating to your treatment, payment, and care operations. Your personal health information will never be otherwise given to anyone without your written consent. You may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our clinic and systems are secure from unauthorized access and our team is trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients. We will only request personal information needed to provide our standard of quality chiropractic or massage care, implement payment activates, conduct normal business operations, and comply with the law. This includes name, address, phone numbers, SSN, employment date, medical history, health records, etc. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We may use and/or disclose your information to communicate reminders about your appointments including text messaging, voicemail messages, and mailings. You have a right to request copies of your healthcare information; all requests must be in writing. We may charge for copies in the amounts allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the US Dept of Health and Human Services. We thank you for being a patient at our clinic.

____ PLEASE INITIAL AFTER READING

Release of Information

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

If you pay at the Time of Service and insurance is not billed by our clinic, then your signature below verifies that our clinic will not bill insurance for any services rendered and in turn your health insurance company will not be able to request medical records for services rendered.

____ PLEASE INITIAL AFTER READING

Patient Name:

Terms of Acceptance

When a patient seeks chiropractic care, it is essential for both patient and clinic to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method used to attain it. This will prevent any confusion or disappointment. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Vertebral Subluxation is a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the service of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding the treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. The doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care provider, or are not related to the spinal structural conditions diagnosed at this clinic.

____ PLEASE INITIAL AFTER READING

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to obtain your informed consent before starting treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.

2.) Some types of manipulation have been associated with stroke; strokes from chiropractic adjustments are very rare. I am aware that nerve or brain damage including stroke is reported to occur once in one to ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same change as a normal dose of aspirin or Tylenol causing death.

3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. When osteoporosis, degenerative disc or other abnormality is detected, this clinic will proceed with extra caution.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which Dr. Robinson checks for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I authorize and agree to allow the doctor and his designated staff to work with my case, my spine and the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I intend this consent to apply to all my present and future chiropractic care.

Patient Printed Name: _____ Date: _____

Patient Signature: _____