Intake & History

CLEAR CHIROPRACTIC redmond

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ City: _____ State: Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ ext. _____
Email: _____ Reminder Emails/Text: □ Yes □ No Cellphone Carrier: _____
Sex: □ Male □ Female Date of Birth: _____ Marital Status: _____ Spouses Name: _____
Employer/School: _____ Occupation: _____ How did you hear about us? _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Primary Care Doctor : _____ Affiliated Office/Hospital: _____
Is this visit due to an auto or work-related injury? □ Yes □ No *If yes, please get an injury report from the front desk*

How can we help you?

What brings you in today? _____
Have you sought care for this issue before? □ Yes □ No If "yes", where? _____
What makes it better? _____
What makes it worse? _____
Problem started on: _____
Most recent aggravation: _____

How bad is it? How intense are your symptoms? (circle below)

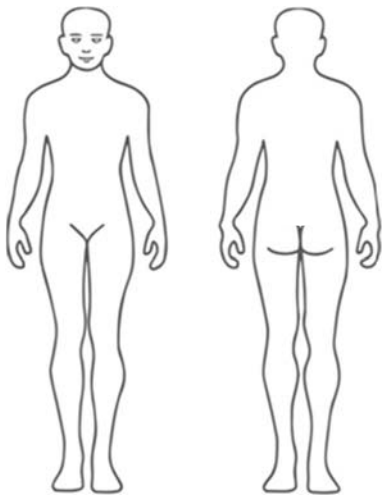
0 1 2 3 4 5 6 7 8 9 10
None *Extreme*

Height _____ Weight _____

Quality of Pain: What does it feel like? (check all that apply)

- □ Numbness
- □ Tingling
- □ Stiffness
- □ Throbbing
- □ Aching
- □ Cramping
- □ Nagging
- □ Sharp
- □ Shooting
- □ Burning
- □ Dull
- □ Stabbing
- □ Swelling
- □ Other _____

Please circle the areas on the figure to the right where you are having pain or other symptoms:



Doctor's Notes Only:

Daily : _____
4xs : _____
3xs : _____
2xs : _____
1x : _____
E-O : _____
Mth : _____

Initial: _____
Cerv : _____
Thor: _____
Lum: _____
Adj: _____
Fup: _____
FupXr: _____
Traxn: _____
Exer: _____
Extrm: _____

Doctor's Notes Only:

Impact of Your Symptoms

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Recreation	❑	❑	❑	❑
Relationships	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	❑	❑	❑	❑
Attitude	❑	❑	❑	❑
Patience	❑	❑	❑	❑
Productivity	❑	❑	❑	❑
Creativity	❑	❑	❑	❑
Other	❑	❑	❑	❑

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10
Not Committed *Very Committed*

Patient Wellness Assessment

Illness-Wellness Continuum

On the arrow diagram above:

A. What number do you think represents you health today? _____

B. In what direction is your health currently headed? _____

What are your Health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

Children & Pregnancy

How many children do you have?_____ Are you currently pregnant? ☐ No ☐ Yes, I'm due: _____

Childrens' ages?_____ Number of past pregnancies? _____

Childrens' health concerns?_____ Health concerns regarding pregnancy?_____

Health & Wellness

Please check the box beside any codition that you have or have had.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____

Allregies, Medications & Supplements

Allergies (list)	Medications (list)	Supplements(list)
_____	_____	_____
_____	_____	_____
_____	_____	_____

CLEAR Chiropractic

Notices of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

CLEAR Chiropractic is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations (example),

"On occasion, it may be necessary to seek consultation regarding your treatment from other health care providers associated with CLEAR Chiropractic"

"It is our policy to provide a substitute health care provider, authorized by CLEAR Chiropractic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness or other emergency situation."

Due to the nature of CLEAR Chiropractic's open adjustment areas, others may overhear conversations between the doctor and patient although every effort will be made to avoid loss of confidentially. At any time you may request a private consultation with the doctor.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (Example)

"As a courtesy to our patients, we will submit an itemized statement to your insurance center for the purpose of payment to CLEAR Chiropractic for health care services rendered. If you pay for your health care services personally we will, as a courtesy to you, provide and itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information including diagnosis, date of injury or condition, and codes which may describe the health care services received."

Worker's Compensation

We may disclose your health information as necessary to comply with State Workers compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or your death.

Public Health

As required by law, we may disclose your health information to public health authorities for the purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infectious exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order of subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by the Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lesson a serious and imminent threat to the health or safety of a particular person or to the general public

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

"It is our practice to participate in charitable events to raise awareness, food donations, etc. During these times, we may need to send you a letter, post card or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of CLEAR Chiropractic sponsored fund- raising events."

Change of Ownership

In the event that CLEAR Chiropractic is sold or merged with another organization, your health information will become the property of the new owner.

Your Health Information Rights

· You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that CLEAR Chiropractic is not required to agree to the restriction you requested.

· You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

· You have the right to inspect and receive a copy of your health information.

· You have the right to request that CLEAR Chiropractic amend your protected health information. Please be advised, however, that CLEAR Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

· You have the right to receive an accounting of disclosures of your protected health information made by CLEAR Chiropractic

· You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

CLEAR Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all the information that it maintains. Until such an amendment is made, CLEAR Chiropractic is required by law to comply with this Notice. CLEAR Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Emily Paxton by calling 425-820-8837. If she is not available you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or how CLEAR Chiropractic has handled your health information should be directed to Angela Ritson
by calling 425-820-8837. If she is not available you may make an appointment for a personal conference in person or by telephone within
2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, SW Room 509F HHH Building Washington, D.C. 20201

This notice is effective as of (01/14/2010)

I have read the Privacy Notice and understand my rights contained in the notice

By way of my initial, I provide CLEAR Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of the treatment, payment and health care operations as described in the Privacy Notice.

Initial _____ **Date** _____

FININACIAL RESPONSIBILITY

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if CLEAR Chiropractic extends credit to me and I understand that if I suspend or terminate my care, fees for professional services rendered to me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors of CLEAR Chiropractic and whomever they may designate as their assistants to administer treatments as they so deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Patient Name (please print) _____

_____

Patient Signature **Date**

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both 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 that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the 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 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 services 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 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.

I,_____, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient Name (please print) _____

_____

Patient Signature **Date**

CANCELLATION POLICY

Our office requires at least 24 hours notice if you need to cancel or change a **massage** appointment. If less than 24 hours notice is given, you will be charged for your appointment in the amount of $45.00. This fee is not covered by your insurance, and is your responsibility to pay immediately. We understand emergencies do occur and in special circumstances this fee may be waived.

I have read and understand the above information.

Patient Name (please print) _____

_____

Patient Signature **Date**

Auto Insurance Information (not personal medical insurance)

Your Insurance Company:_____ Claim Number:_____
Agent/Adjustor:_____ Contact Number:_____
Responsible Party's Name:_____ Insurance Company:_____
Policy Number:_____ Phone Number:_____ Ext:_____

Attorney

Office:_____ Office Number:_____
Paralegal:_____ Phone Number:_____Ext:_____

Nature of Accident

Date of Accident:_____ Time of Day:_____ Were there any Witnesses? □ Yes □ No
Were you: □ Driver □ Passenger □ Front Seat □ Back Seat. Number of people in the vehicle?_____
Were you wearing a seat belt? □ Yes □ No. Were you struck from: □ Behind □ Front □ Left Side □ Right Side
What direction were you headed? □ North □ South □ East □ West.
Street Name:_____
What direction was the other car headed? □ North □ South □ East □ West.
Street Name:_____
Approximate speed of your car:_____MPH Other Car:_____MPH
Were you knocked unconscious? □ Yes □ No. If yes, for how long?_____
Were police notified? □ Yes □ No. Was there a police report? □ Yes □ No.
Please describe the accident:_____
_____
Did you have any physical complaints **PRIOR to the accented?** □ Yes □ No. If yes, please describe in detail: _____
_____
_____
Please Describe how you felt:

a. DURING the accident:_____
b. IMEDIATELY AFTER the accident:_____
c. LATER THAT DAY: _____
d. THE NEXT DAY: _____

What are your PRESENT/CURRENT complaints and symptoms?_____
_____
_____
Medication taken SINCE the accident:_____
_____
Where were you taken after the accident:_____
Have you been Treated by another doctor since the accident? □ Yes □ No.
If yes, please list doctor's name, specialty, and phone number:_____
_____
What type of treatment did you receive?_____
Do you have any congenital (from birth) factors or previous illnesses which may relate to your symptoms? □ Yes □ No.
If yes, please describe:_____
Have you ever been involved in an accident before? □ Yes □ No. If yes, please describe, include date(s), type of accident(s) and treatment(s) received: _____
_____

Check Symptoms you have had noticed since the Accident

General

□ Unexplained Weight Loss or Gain □ Fevers/Chills □ Recent Trauma □ Fatigue □ Past Trauma □ Irritability
□ Trouble Sleeping/ Sleep Disorder □ Nervousness

Skin

□ Rashes □ Itching □ Color Change □ New/Change in Mole □ Lumps □ Dryness □ Hair/ Nail Changes

Head/ Eyes/ Ears/ Nose/ throat

□ Visual Changes □ Sinus Problems □ Hearing Loss □ Difficulty Swallowing/ Chewing □ Double Vision
□ Head Injury/Trauma □ Ringing in Ears □ TMJ/ TMD □ Headaches □ Concussion

Cardiovascular

□ Chest Pain □ Shortness of Breath □ High/Low Blood Pressure □ Blood Clots □ Palpitations □ Fainting
□ Heart Disease □ Cold Hands/Feet □ Poor Clotting

Respiratory

□ Cough □ Coughing up Blood □ TB □ Sputum □ Asthma/ Wheezing □ COPD/Emphysema □ Face Flushed

Gastrointestinal

□ Abdominal Pain □ Vomiting □ Diarrhea □ Nausea □ Constipation □ Indigestion □ Upset Stomach

Musculoskeletal

□ Neck/Back Pain □ Stiff Neck □ Joint Pain/ Stiffness □ Hip/Knee/Ankle Pain □ Plantar Fasciitis □ Scoliosis
□ Joint Swelling □ Shoulder/Elbow/Wrist Pain □ Tension

Neurologic

□ Dizziness □ Seizures □ Weakness □ Numbness/Tingling □ Migraine/Cluster Headaches □ Loss of Memory
□ Loss of Taste □ Loss of Smell □ Pins & Needles □ Cold Sweats

Other

□ Diabetes □ Cancer □ Fibromyalgia □ Nervous/Anxiety □ Depression □ AS □ Arthritis □ Osteoporosis
□ Varicose veins □ Head Seems Heavy □ Anaphylaxis □ MS

Female Only

□ Painful Menstruation □ Irregular Cycle □ Breast Problems □ Menopause

Are You Pregnant?

□ Yes □ No □ Maybe

Since this injury occurred, are your symptoms: □ Improving □ Getting Worse □ Same

Have you lost time from work as a result of this accident? □ Yes □ No. If yes, please complete the question.

a. Last Day Worked:_____
b. Type of Employment:_____
c. Present Salary:_____
d. Are you being compensated for time lost from work? □ Yes □ No.
   If yes, please state type of compensation you are receiving:_____

Do you notice any daily activity restrictions as a result of this injury? □ Yes □ No.

If yes, please describe, in detail:_____

_____

Other pertinent Information:_____

_____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and form to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to may account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand than agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be check if CLEAR Chiropractic extend credit to me and I understand that if I suspend or terminate my care and treatment, and fee for professional services rendered to me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors at CLEAR Chiropractic and whomever they may designate as their assistants, to administer treatments as they so deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Print Name_____ DATE_____

Patient Signature_____ DATE_____