Patient File No._____

1605 W. Garland Ave
Spokane Wa 99205

509-467-2888

Patient Information:

First Name: _____ **Nick Name:**_____ **MI:** _____**Last Name:**_____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Date of Birth: _____ Age: _____ **Occupation:** _____

Marital Status: _____ **Gender: F M** **I have** _____ **child/children**

Language: _____ Ethnicity: _____ Race: _____

Emergency Contact:

Name:

_____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Experience with Chiropractic:

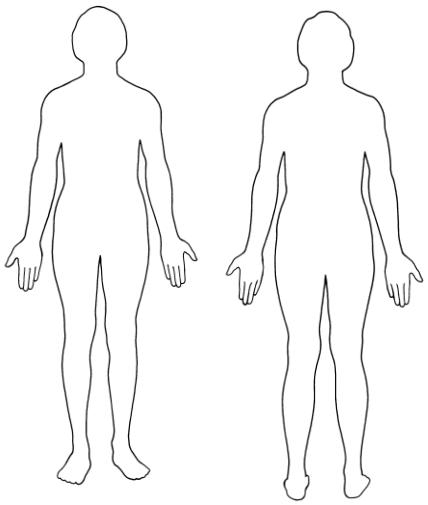
Have you ever seen a Chiropractor before? N Y

When was your last adjustment? _____

Who may we thank for referring you to our office? _____

Why are we seeing you today?

Primary:



Front View Rear View

Mark areas of concern with an "X"

Location of Pain: _____

When it began: _____

How it began: _____

Circle those that apply:

Pain is:

Sharp Dull Burning Pressure

Itching Pins & Needles Other (Describe) _____

Intensity of pain: 0 no pain—2—4—6—8—10 unbearable

Frequency of pain (% of time):

0—10—20—30—40—50—60—70—80—90—100 constant pain

Condition is aggravated by:

_____

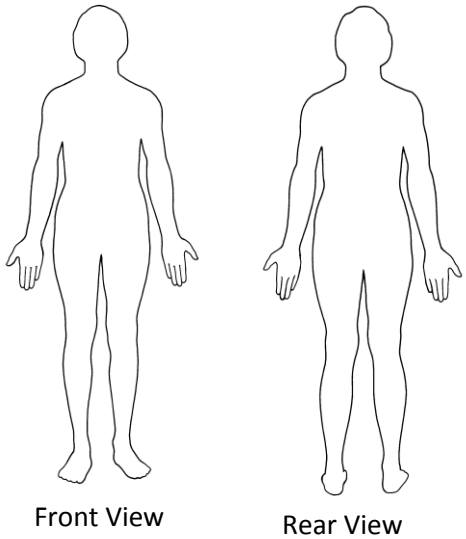
Relieved by:

_____

Has this happened before? Yes No

Secondary:

Mark areas of concern with an "X"



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Location of Pain: _____

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Condition is aggravated by:

_____

Relieved by:

_____

Has this happened before? Yes No

Check any of the following you have presently or have had in the last 6 months.
Circle any current health situations/problems.

Musculo-skeletal
- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm pain
- ☐ Joint pain/stiffness
- ☐ Walking problems
- ☐ Difficulty chewing/clicking jaw

Nervous System
- ☐ Convulsions
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Shingles
- ☐ Convulsions
- ☐ Confusion/depression
- ☐ Cold/tingling extremities
- ☐ Forgetfulness
- ☐ Fainting

General
- ☐ Allergies
- ☐ Loss of sleep
- ☐ Fever
- ☐ Headaches

Gastro-intenstinal
- ☐ Poor/excessive appetite
- ☐ Excessive thirst
- ☐ Frequent nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Weight gain/loss
- ☐ Abdominal pain
- ☐ Gas/bloating after meals
- ☐ Heartburn
- ☐ Black/bloody stools
- ☐ Colitis

Genito-Urinary
- ☐ Bladder trouble
- ☐ Painful/excessive urination
- ☐ Discolored urine

Cardio/respiratory
- ☐ Congenital heart defect
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blood pressure problems
- ☐ Irregular heartbeat
- ☐ Lung problems/congestion
- ☐ Varicose veins
- ☐ Ankle swelling

EENT
- ☐ Vision problems
- ☐ Stuffy nose
- ☐ Hearing difficulty
- ☐ Earaches
- ☐ Sore throat
- ☐ Dental problems

Male/Female
- ☐ Menstrual irregularity
- ☐ Menstrual cramping
- ☐ Vaginal pain/infections
- ☐ Breast pain/lumps
- ☐ Prostate/sexual dysfunction
- ☐ Genital herpes
- ☐ Currently pregnant
- ☐ Currently have breast implants

Other health challenges
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Asthma
- ☐ Arthritis
- ☐ Alcohol/drug abuse
- ☐ Anemia
- ☐ Rheumatic fever
- ☐ HIV/AIDS
- ☐ Multiple Sclerosis
- ☐ _____

Health Habits: Circle those that apply

Do you smoke? No Yes Frequency: _____

Do you drink alcohol? No Yes Frequency: _____

Do you drink coffee? No Yes Frequency: _____

Do you exercise regularly? No Moderate Daily

Patient History:

Are you seeing anyone else for other problems or health conditions? No Yes

Condition: _____ Date began: _____

Provider treating condition: _____

Have you ever been diagnosed with Diabetes? No Yes: Type I or Type II

Past Injuries or surgeries:

	Date	Description
Falls	_____	_____
Auto Accident	_____	_____
Head Injury	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Allergies:

Food-

_____
_____
_____

Environment-

_____
_____
_____

Medication-

_____
_____
_____

Medications: Please list all prescription drugs, over-the-counter drugs, vitamins, herbs, supplements, etc. that you are currently taking.

_____
_____
_____
_____
_____
_____
_____
_____

Family history:

Please list any pertinent family health history problems such as heart disease, cancer, rheumatoid arthritis, etc.

	Age	**Pertinent health problem**
Father		
Mother		
Brother		
Brother		
Brother		
Sister		
Sister		
Sister		

PROFESSIONAL FEE STATEMENT FOR SERVICES

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Consultation and Comprehensive Orthopedic/Neurological Exam	$60 - $150
Routine X-Ray Series (Cervical and Lumbar)	$120
X-Ray per Area	$40-110
Basic Office Visit (Adjustment)	$40 - $120
Neuromuscular Re-education/Therapeutic Exercise	$40
Manual Traction	$25
House Calls, After Hours or Emergency	$50 - $150

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your Chiropractic care at our office and you may choose the plan that you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being and we will do our best to help you.

Agreement: I agree to the fees above. At Salina Family Chiropractic we do our best to estimated correct payments by third parties. At times a client will have a balance. For your and our convenience we require authorization to bill your credit or debit card for services rendered.

I have read and agree to the above fee statement and credit authorization.

_____

(Patient's Signature) (Date)

Authorization: In addition, if applicable, this authorizes my provider of medical services, including but not limited to: physicians, hospitals, therapists, chiropractors to disclose and furnish all types of medical information pertaining to my condition and to their care and treatment of me, including charges for the purpose of this authorization. I authorize the medical personnel to release and provide copies of the requested information for the financial settlement, referral of, treatment, processing claims, evaluation of, settling or litigation of my case/condition. This authorization shall remain valid unless I choose to revoke it earlier in writing. My signature below specifically allows the release of medical records (if signing as parent/guardian, please indicate) for purposes of account collection/patient referral.

_____

(Patient's Signature) (Print Name) (Date)

Acknowledgement of Notice of Privacy Practices:

My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Provider's Notice of Privacy Practice. I acknowledge that I have the right to request a restriction of my protected health information.

Signature_____ **Date**_____

To restrict your health information in our office, please check mark those that apply:

_____I do not want my information shared with anyone

_____I would like the following entities to have access to my information:

_____ _____

Signature_____ **Date**_____

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at Salina Family Chiropractic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____ _____

Patient Name (printed) Relationship to patient

_____ _____

Patient or legal Guardian Signature Date

_____ _____

Witness Signature (office staff) Date