

# About the Patient



## Emergency Contact

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Birth date \_\_\_\_\_  
Home Phone \_\_\_\_\_ Social Sec. # \_\_\_\_\_  
E-Mail Address \_\_\_\_\_  
Age \_\_\_\_\_ Gender \_\_\_\_\_ M \_\_\_\_\_ F Number of Children \_\_\_\_\_  
Marital Status Married Single Divorced Separated Widowed  
Employer \_\_\_\_\_  
Work Address \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Type of Work \_\_\_\_\_

Name \_\_\_\_\_

Relationship to you \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work/Home Phone \_\_\_\_\_

## Health Habits

Do you smoke? \_\_\_ No \_\_\_ Yes

Do you drink coffee? \_\_\_ No \_\_\_ Yes

Do you exercise regularly?

\_\_\_ No \_\_\_ Moderate \_\_\_ Daily

Do you wear?

\_\_\_ Heel Lifts \_\_\_ Orthotics

## Experience With Chiropractic

Who referred you to this office? \_\_\_\_\_

Have you been adjusted by a chiropractor before? \_\_\_ Yes \_\_\_ No

Reason for those visits? \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Approximate Date of Last Visit \_\_\_\_\_

Has any *adult* in your family seen a chiropractor? \_\_\_ Yes \_\_\_ No

Has any *child* in your family seen a chiropractor? \_\_\_ Yes \_\_\_ No

## E-mail Preferences

I am interested in receiving information on the following by e-mail:

\_\_\_ Newsletters (stretching, exercise, etc.)

\_\_\_ Special Offers (massage, chiropractic, etc.)

\_\_\_ Don't even think about e-mailing me!

## Awareness of Chiropractic Principles

Were you aware that:

- ...Doctors of Chiropractic work with the nervous system?
- ...the nervous system controls all bodily functions?
- ...if Chiropractic care starts at birth, you can achieve a higher level of health throughout life?

Yes  No

Yes  No

Yes  No

# Health Conditions

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Heart Defect / Murmur   | <input type="checkbox"/> Shingles                       |
| <input type="checkbox"/> Heart Surgery/ Pacemaker | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Heart Attack/Stroke            |
| <input type="checkbox"/> Sinus Problems           | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Ulcers                         |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Venereal Disease               |
| <input type="checkbox"/> Loss of Sleep            | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Chemotherapy                   |
| <input type="checkbox"/> Digestive Problems       | <input type="checkbox"/> Anemia                  | <input type="checkbox"/> HIV/Aids                       |
| <input type="checkbox"/> Difficulty Breathing     | <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Tuberculosis                   |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Psychiatric Problems    | <input type="checkbox"/> Diabetes                       |
| <input type="checkbox"/> Numbness in Limbs        | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Thyroid Problems               |
| <input type="checkbox"/> Alcohol/Drug Abuse       | <input type="checkbox"/> Chronic Fatigue         | <input type="checkbox"/> Drop Attacks (Fainting spells) |
| <input type="checkbox"/> Visual Disturbances      | <input type="checkbox"/> Difficulty Urinating    |   |

## For Women

- |                                    |                              |                             |
|------------------------------------|------------------------------|-----------------------------|
| Are You Pregnant?                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are You Nursing?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are You Taking Birth Control?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do You Experience Painful Periods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do You Have Irregular Cycles?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do You Have Breast Implants?       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## Medications

- Anti Inflammatories
- Pain Killers
- Muscle Relaxers
- Blood Pressure Medicine
- Insulin
- Blood Thinners
- Anxiety / Depression Meds
- Other

## Goals For My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain and some to correct the cause of pain along with whatever may be malfunctioning in their bodies as a result of these problems. The Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care - Symptomatic relief of pain or discomfort.
- Corrective Care - Correcting and relieving the cause of the problem as well as the symptoms.
- I want the Doctor to select the type of care appropriate for my condition.

Name \_\_\_\_\_ Date \_\_\_\_\_

# Primary Complaints

If you are currently experiencing symptoms or have experienced any of these symptoms in the last 8 weeks please circle all that apply

Neck Pain : Mid-Back Pain : Low Back Pain : Headache : Shoulder Pain

Arm(s): Tingling / Pain / Numbness (Circle) Right or Left (Circle)

Leg(s): Tingling / Pain / Numbness (Circle) Right or Left (Circle)

Other: (Please Include All Other Health Concerns) \_\_\_\_\_

2) When Did You First Experience This/These Problems? \_\_\_\_\_

3) Due To A Particular Incident? (Explain) \_\_\_\_\_

4) Is The Problem(s) Getting (Please Circle)      Worse      Same      Better

5) What Relieves The Problem? (What Have You Tried For Relief?) \_\_\_\_\_

6) Is The Problem(s) Worse In The (Please Circle)

Morning : Afternoon : Evening : Same All Day : Varies

7) Does The Pain Radiate To Any Part Of Your Body? (Please Circle)

Arms : Legs : Buttocks : Chest : Shoulders : Head : Fingers : Toes

8) How Often Do You Experience This Pain/Problem? (Please Circle)

1 X/Day : 5X/Day : 10 X/Day : Constant : Varies

Other \_\_\_\_\_

9) Have You Had Other Treatment For This Condition?    Y    N

Dr.'s Name(s) \_\_\_\_\_

Type Of Treatment \_\_\_\_\_ Results (please Circle) Positive : Negative : No Change

10) Have You Had Any Previous Injuries To The Areas You Mentioned Above?    Y    N

When Did This Occur? \_\_\_\_\_

Were You Treated For The Injury? \_\_\_\_\_

If So, Where? \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature:

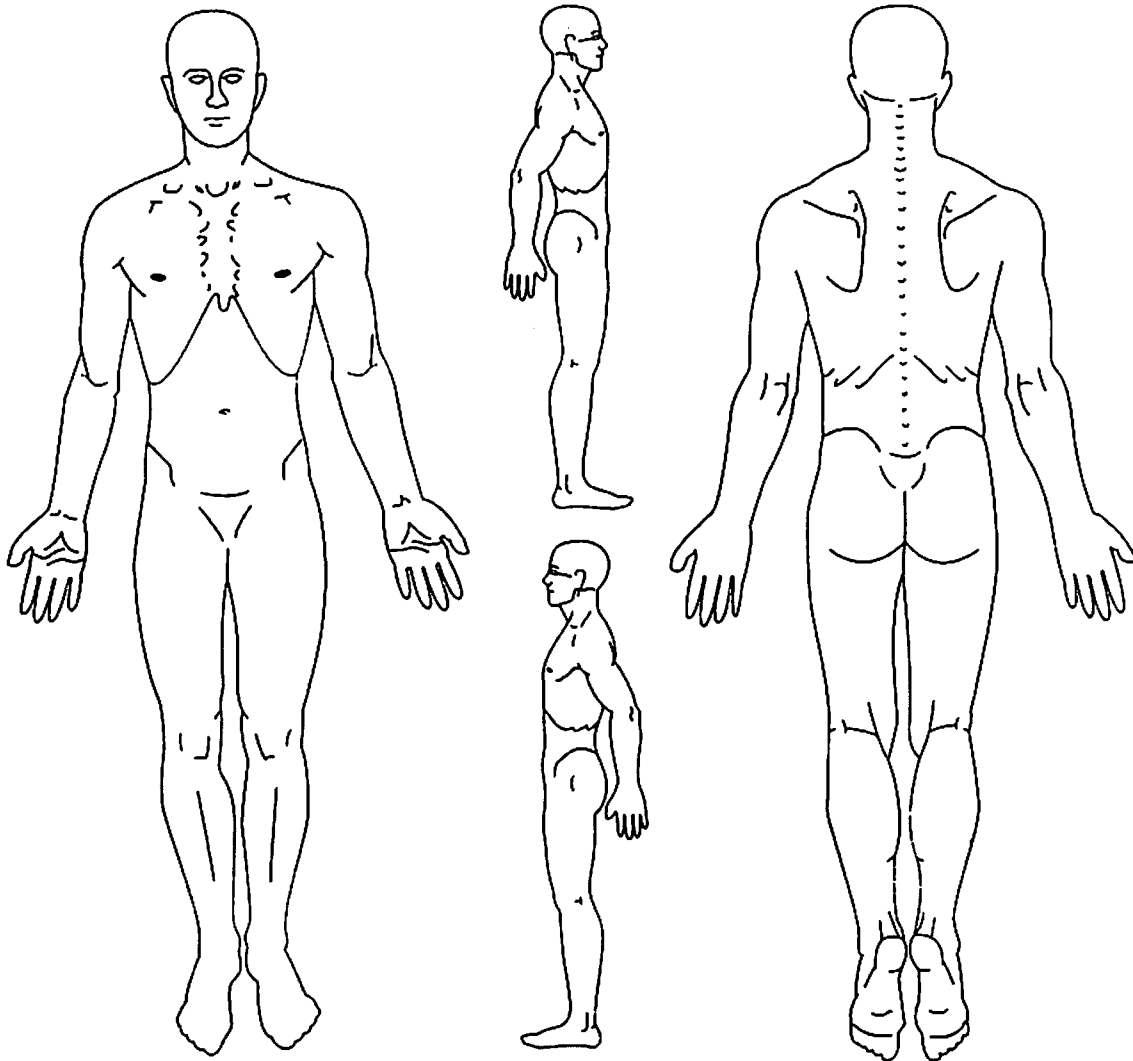
\_\_\_\_\_  
Date:

Patient Name(Print) \_\_\_\_\_ Date \_\_\_\_\_

Patient ID # \_\_\_\_\_

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

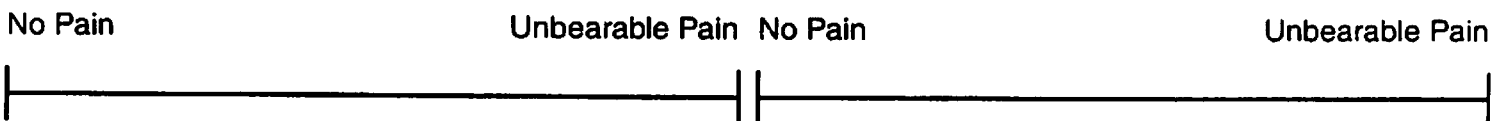
- D = Dull
- B = Burning
- N = Numb
- S = Stabbing/Cutting
- T = Tingling (Pins & Needles)
- C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

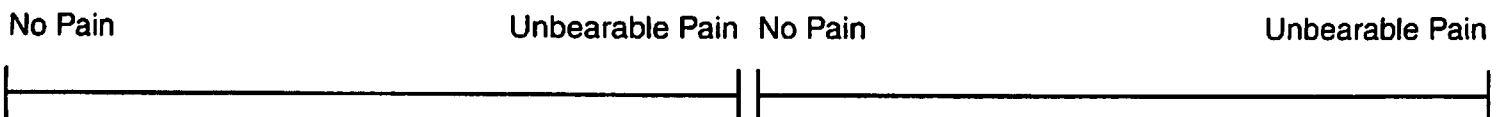
Rate the pain you have right **now**:

Rate your pain at its **best** in the past week:



Rate your **average** pain in the past week:

Rate your **worst** pain in the past week:



## 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 infirmity or disease.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae 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 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 services of a health care provider that 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.  
*(print name)*

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis. \_\_\_\_\_  
*(signature)* *(date)*

### Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

\_\_\_\_\_  
*(signature)*

\_\_\_\_\_  
*(date)*

### Consent to evaluate and adjust a minor child:

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
*(signature)*

\_\_\_\_\_  
*(date)*



## **Professional Fee Schedule**

Consultation.....	No Charge
Chiropractic Examination.....	\$60—\$210
Chiropractic Office Visits (averages)....	\$45—\$110
Chiropractic X-ray Studies (averages)..	\$70—\$280

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. This form has been prepared for your convenience and will enable us to better serve you and avoid misunderstandings in the future. We offer several methods of payment for your Chiropractic Care at our office and you may choose the plan which best fits your needs. If special arrangements are necessary please consult with the Doctor.

**Our main concern is your health and well-being and we will do our best to help you achieve your goals.**

**Plan #1-Insurance**— If you have insurance that covers Chiropractic care, we will bill your insurance directly. *Please bring us your insurance information before your second visit. Until we have the completed necessary insurance information to verify chiropractic coverage, you will be required to pay for your care.* Remember, insurance companies balk at "maintenance" and long-term rehabilitation and usually you will not get much help after your initial corrective care. Most ordinary "health" policies are designed and intended to only take care of acute problems so you should plan to "get off" insurance and be on your own. At this point, refer to our Health and Wellness Plan (ask Doctor for details).

**Plan #2- Cash**— Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

**Plan #3—Weekly/ Monthly Cash Agreement**— For those patients who qualify, we will extend credit through this plan; however, should you become inactive by discontinuing your care, your entire unpaid balance will be due immediately. This plan applies to all cases, except work injury or auto injury claims.

**Plan #4- Labor and Industries**—By law, you need to report your accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by second visit. We will bill labor and industries directly.

**Plan #5—Auto injury** —You need to supply us with the accident report, your car insurance, health insurance, liable parties insurance and (if applicable) attorney information . Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event the check should come to you, you are expected to bring the check to us.

**Plan #6—Medicare**—Per established Medicare guidelines please bring us your Medicare information on or before your second visit. We will bill Medicare directly. In the event the check should come to you, you are expected to bring the check to us.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## NOTICE 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 carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

**Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of the treatment, payment and health care operations.**

**Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example we may need to share information with other health care providers or specialists involved in the continuation of your care.

**Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a chiropractic plan for your chiropractic services.

**Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/ or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/ or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.

The right to request an amendment to your protected health information. We may deny your request in certain situations.

The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations... or based on your previous authorizations.

The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Service, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:	For more information about HIPAA or to file a complaint:
Privacy Officer	Dr. Shaun Reynolds
Office Name	The U.S. Department of Health & Human Services
Address	Office of Civil Rights
City, State, Zip	200 Independence Ave. S.W.
Phone	Washington, D.C. 20201
	(877)696-6775 (toll-free)

**ACKNOWLEDGEMENT  
OF  
PRIVACY PRACTICES**

Ultra Chiropractic  
1100 NE 47th Street Suite 101  
Seattle, WA 98105  
(206)527-0123

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers for my health care services.

Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my chiropractor's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my chiropractor has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**If signing on behalf of the patient:**

Relationship to Patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

\_\_\_\_\_  
\_\_\_\_\_

**For Office Use Only:**

We were unable to obtain patient's written acknowledgement of our Notice of Privacy Practices due to following reason:

The patients refused to sign: \_\_\_\_\_

Communication barriers: \_\_\_\_\_

Emergency situation: \_\_\_\_\_