PATIENT INFORMATION

Date ____________________

SS/HIC/Patient ID # ____________________

Patient Name ____________________
Last Name

____
First Name Middle Initial

Address ____________________

E-mail ____________________

City ____________________

State ____________ Zip ____________

Sex ☐ M ☐ F Age ____________

Birthdate ____________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ____________________

Occupation ____________________

Employer/School Address ____________________

____

Employer/School Phone (_____) ____________________

Spouse's Name ____________________

Birthdate ____________________

SS# ____________________

Spouse's Employer ____________________

Whom may we thank for referring you? ____________________

INSURANCE INFORMATION

Who is responsible for this account? ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ____________________

Birthdate ____________ SS# ____________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to
Name of Insurance Company(ies)

Dr. ____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________ ____________
Date Relationship to Patient

PHONE NUMBERS

Cell Phone (______) ____________ Home Phone (______) ____________

Best time and place to reach you ____________________

IN CASE OF EMERGENCY, CONTACT

Name ____________ Relationship ____________

Home Phone (______) ____________ Work Phone (______) ____________

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date ____________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) ____________________

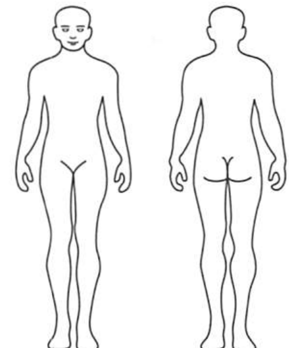
PATIENT CONDITION

Reason for Visit ____________________

When did your symptoms appear? ____________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ____________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ____________________

Is it constant or does it come and go? ____________________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other ______

Name and address of other doctor(s) who have treated you for your condition ______

Date of Last: Physical Exam ______ Spinal X-Ray ______ Blood Test ______

Spinal Exam ______ Chest X-Ray ______ Urine Test ______

Dental X-Ray ______ MRI, CT-Scan, Bone Scan ______

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

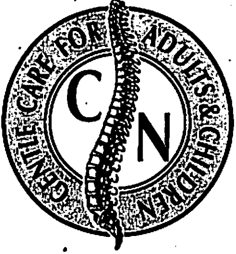
Condition			Condition			Condition			Condition		
AIDS/HIV	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other ______		
Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	______		
Cataracts	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No			

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day ______
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week ______
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day ______
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason ______

Are you pregnant? ☐ Yes ☐ No Due Date ______

Injuries/Surgeries you have had	Description	Date
Falls	______	______
Head Injuries	______	______
Broken Bones	______	______
Dislocations	______	______
Surgeries	______	______

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
______	______	______
______	______	______
______	______	______
Pharmacy Name ______	______	______
Pharmacy Phone (_____) ______	______	______



CHIROPRACTIC
NORTHWEST & Massage
www.chiropracticnw.com

Bus: 253-845-5358
Fax: 253-845-5753

PATIENT CONSENT TO X-RAY

I authorize the performance of diagnostic x-ray examination of myself which Chiropractic Northwest may consider necessary or advisable in the course of my examination and treatment.

Signed ______________________________ Date ________________

CONSENT TO X-RAY A MINOR

I am the parent or legal representative of ________________________, who is a minor, _____ years of age. I authorize the performance of diagnostic x-ray examination of this child or ward which Chiropractic Northwest may consider necessary or advisable in the course of examination or treatment.

Signed ______________________________ Date ________________

FEMALES: REGARDING POSSIBILITY OF PREGNANCY

This is to certify that, to the best of my knowledge, I am not pregnant, and Chiropractic Northwest has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examination, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed ______________________________ Date ________________

FEMALES: CONSENT TO X-RAY DURING PREGNANCY

This is to certify that I am or may be pregnant and that Chiropractic Northwest has my permission to perform diagnostic x-ray examination involving my cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be utilized over the trunk of my body. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed ______________________________ Date ________________

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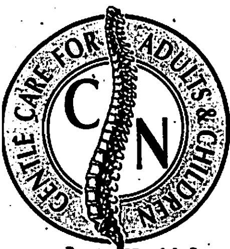

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Fax: 253-845-5753

Notice of Privacy Practices of Chiropractic Northwest

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Chiropractic NW must take steps to protect the privacy of your protected health information (PHI). PHI includes information that we have created or received regarding your health or payments for your health. It includes both your medical records and personal information such as your name, social security number, address, and phone number.

Under federal law we are required to:

- Protect the privacy of your PHI. All of our employees are required to maintain the confidentiality of PHI and receive appropriate privacy training.
- Provide you with this Notice of Privacy Practices explaining our duties and practices regarding your PHI.
- Follow the practices and procedures set forth in this Notice.

Uses and disclosures of your protected health information by Chiropractic NW that do not require your authorization.
Chiropractic NW uses and discloses PHI in a number of ways connected to your treatment, payment for your care and health care operations. Some examples of how we may use or disclose your PHI without your authorization are listed below.

In relation to your health care and treatment:

- To Chiropractic NW employees involved in your care.
- To other health care providers who are not on our staff such as specialists or general practitioners.

In relation to payment:

- To administer your health benefits policy or contract.
- To bill you for health care we provide.
- To pay others who provided care to you. To other organizations and providers for payment activities unless disclosure is prohibited by law.

In relation to health care operations:

- To administer and support our business activities or those of other health care organizations (as allowed by law) including providers and plans. For example, we may use your PHI to review and improve the care you receive, to provide training, and to help decide what rates to charge.
- To other individuals (such as consultants and attorneys) and organizations that help us with our business activities. (Note: If we share your PHI with other organizations for this purpose, they must agree to protect your privacy.)

For legal and/or governmental purposes in the following circumstances:

- Required by law – when we are required to do so by state and federal law, including workers' compensation laws.
- Public health and safety – to an authorized public health authority or individual to:
  - Protect public health and safety.
  - Prevent or control disease, injury or disability.
  - Investigate or track problems with prescription drugs and medical devices.
- Abuse or neglect – to government entities authorized to receive reports regarding abuse, neglect or domestic violence.
- Oversight agencies – to health oversight agencies for certain activities such as audits, examinations, investigations, inspections and licensures.
- Legal proceedings – in the course of any legal proceeding in response to an order of a court or administrative agency and, in certain cases, in response to a subpoena, discovery request, or other lawful process.
- Law enforcement – to law enforcement officials in limited circumstances for law enforcement purposes. (To identify or locate a suspect, witness or missing person; to report a crime; or to provide information concerning victims of crimes.)
- Military activity & national security – to the military and to authorize federal officials for national security and intelligence purposes or in connection with providing protective services to the president of the United States.

Miscellaneous reasons we may disclose your PHI without your authorization:

- To a member of your family or a close friend – or any other person you identify who is directly involved in your health care – when you are either not present or unable to make a health care decision.
- To you, to remind you in writing, by phone or voice mail that you have an appointment with us.
- To communicate with you about treatment services, options, as well as health-related benefits or services that may be of interest to you.

Uses and disclosures of your protected health information that require us to obtain your authorization.
Except in the situations listed above, we will use and disclose your PHI only with your written authorization.

Your rights regarding your protected health information
You have the right to:

- Request restrictions by asking that we limit the way we use or disclose your PHI for treatment, payment or health care operations. All requests must be done in writing.
- Ask that we communicate with you by other means. For example, if you would like for us to communicate with you at a different address or phone number. All requests must be done in writing.
- Requesting a copy of your PHI. This request must be made in writing and we may charge a reasonable fee for the cost of producing and mailing the copies.
- Ask us to amend PHI about you that we use to make decisions about you. Your request for an amendment must be in writing and must provide the reason for your request.

Chiropractic Northwest, Inc. may change the terms of this Notice at any time. The revised Notice would apply to all PHI that we maintain. If we change any of the practices described above, a revised Notice will be posted.

Patient Signature: ______________________________ Date: ____________________

I choose to decline receipt of my clinical summary after every visit.

____
Patient Signature Date