SNOHOMISH
Natural Health

Confidential Patient History

Date _____

Last _____ First _____ MI _____ Birthdate _____ Age _____

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ May we send you our email appointment reminders? ☐ Yes ☐ No

Occupation _____ Employer _____

Spouse's Name _____ Birthdate _____ Phone _____ Employer _____

Children's Names & Ages _____

Have you had previous Chiropractic care? ☐ Yes ☐ No Provider? _____

Who may we thank for referring you to our office? _____ ☐ Walk-in ☐ Facebook ☐ Website ☐ Insurance

Who is your primary care physician? _____ Address _____

Phone _____ Date of last physical/exam? _____ Provider? _____

When doctors work together, it benefits you. May we update your medical doctor regarding your treatment in our office? ☐ Yes ☐ No

Insurance

☐ Self Pay ☐ Primary Insurance _____ Responsible party? _____

Card ID# _____ Group # _____

Deductible _____ Copay _____ Coinsurance _____

What brings you to our office? Please provide as much detail as possible

Primary Complaint _____

Date symptoms first appeared? _____ How did it begin _____

Frequency of symptoms? ☐ Constant 100% ☐ Frequent 75% ☐ Intermittent 50% ☐ Occasional 25% ☐ Rare 10%

Have you ever experienced similar symptoms? ☐ Yes ☐ No When? _____

Have you been treated for this before? ☐ Yes ☐ No Who/Where? _____

Type of Pain? ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Tingling If so, where? _____

Does the pain radiate into ☐ Arm ☐ Hand ☐ Leg ☐ Foot ☐ Other ☐ Does not radiate

What makes symptoms increase? _____ What relieves symptoms? _____

Secondary Complaint

Date symptoms first appeared? _____ How did it begin _____

Frequency of symptoms? ☐ Constant 100% ☐ Frequent 75% ☐ Intermittent 50% ☐ Occasional 25% ☐ Rare 10%

Have you ever experienced similar symptoms? ☐ Yes ☐ No When? _____

Have you been treated for this before? ☐ Yes ☐ No Who/Where? _____

Type of Pain? ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Tingling If so, where? _____

Does the pain radiate into ☐ Arm ☐ Hand ☐ Leg ☐ Foot ☐ Other ☐ Does not radiate

What makes symptoms increase? _____ What relieves symptoms? _____

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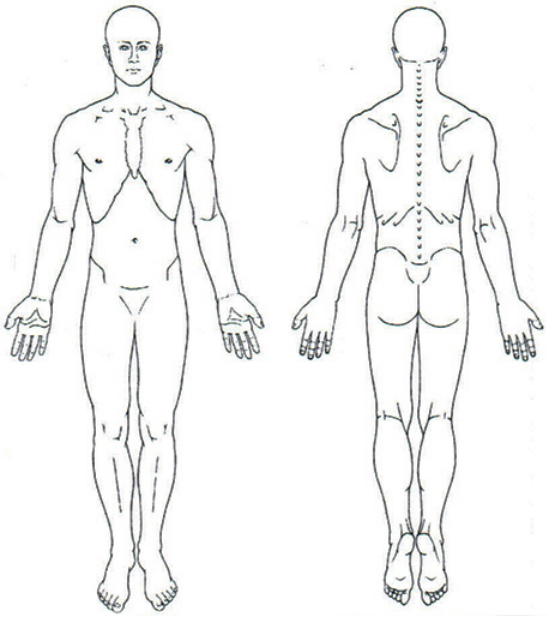
Please mark off all areas of complaint on the diagrams with the following indicators:

AAA = ache
DDD = dull
NNN = tingling
BBB = burning
SSS = sharp/stabbing
XXX = other

1-10 Severity



Please list any medications or vitamins you are currently taking (including dosage).

_____

_____

_____

_____

_____

_____

_____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

0 ○○○ 1 ○○○ 2 ○○○ 3 ○○○ 4 ○○○ 5 ○○○ 6 ○○○ 7 ○○○ 8 ○○○ 9 ○○○ 10

Do you smoke? ☐ Yes ☐ No Packs per week? _____ Have you ever smoked in the past? ☐ Yes ☐ No When did you quit? _____

Do you consume alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you consume caffeine? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you exercise? ☐ Yes ☐ No If yes, how many times per week and what type? _____

Do you have a high stress level? ☐ Yes ☐ No If yes, list reasons: _____

Is there a possibility you may be pregnant? ☐ Yes ☐ No

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Arthritis	☐ Disc Degeneration	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Fibromyalgia	☐ Asthma	☐ Numbness/Tingling
☐ Allergies	☐ High Cholesterol	☐ Digestive Problems	☐ Join Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Glaucoma	☐ Diabetes	☐ High Blood Pressure
☐ Cancer	☐ Nervousness	☐ AIDS/HIV	☐ Osteoporosis	☐ Heart Disease/Problems
☐ Paralysis	☐ Parkinson's Disease	☐ Kidney Disease	☐ PMS/Cramps	☐ Prostate Problems
☐ Rheumatoid Arthritis	☐ Sciatica	☐ Sinus Pain	☐ Pacemaker	☐ Stroke
☐ Thyroid Problems	☐ Tumors/Growths	☐ Urinary Problems	☐ Vascular Disease	☐ Vision Problems

☐ Other_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Snohomish Natural Health Chiropractic, PS will prepare any necessary reports and forms to assist me in making collection from the insurance compa ny. I authorize payment of insurance benefits directly to Snohomish Natural Health Chiropractic, PS. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage.

Patient's Signature _____ Date _____

Guardian's Signature _____ Date _____

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Notice Of Privacy Practices - Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and/or copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number.

Our Notice of Privacy Practices describes in more detail how your health information may be used, disclosed, and how you can access your information.

By my signature below I acknowledge the receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature | Date

Printed name if signed on behalf of the patient (parent, legal guardian, personal representative.) | Relationship

Staff Notes:

This from will be retained in your medical record.

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PATIENT COPY —— FOR YOUR RECORDS

Date _____

Notice Of Patient Privacy

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As out patient, you have important rights relating to inspecting and coping your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosers of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and out obligations under law. We may revise out Notice from time to time. The effective date at the top right hand side of this page indicated the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact our office at 360-568-3319.

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Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of manual therapy and referral for diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure with the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I will have an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature of the purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritations, burns, mild to severe bruising or minor complications.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read, or have had read to me, the above consent. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek
treatment.

I, _____ being the parent or legal guardian of _____
have read and full understand the above terms of acceptance and herby grant permission for my child to receive chiropractic care.

Patient/Parent/Guardian Signature Date