

CONFIDENTIAL PATIENT INFORMATION

NAME: _____ DATE: _____

HOME PHONE: _____ WORK PHONE: _____

STREET ADDRESS: _____

CITY/STATE: _____ ZIP: _____ PO BOX # _____

AGE: _____ BIRTHDAY: _____ # OF CHILDREN: _____

MARITAL STATUS: S M W D SOCIAL SECURITY#: _____

E-MAIL ADDRESS: _____ GENDER: M F

NAME OF EMPLOYER: _____

OCCUPATION: _____ REFERRED BY: _____

NAME OF SPOUSE: _____ OCCUPATION: _____

NEAREST RELATIVE: _____ PHONE: _____

ADDRESS: _____

CITY/STATE: _____ ZIPCODE: _____

WERE YOU INJURED ON THE JOB? YES NO

WERE YOU INJURED IN AN AUTO ACCIDENT YES NO

PURPOSE OF THIS APPOINTMENT/MAJOR COMPLAINT (please describe):

WHEN DID IT START? _____

SYMPTOM

SEVERITY (0=no pain, 10= emergency)

1. _____

2. _____

3. _____

4. _____

HAVE YOU LOST ANY DAYS FROM SCHOOL/WORK? YES NO

DATES: _____

HAVE YOU EVER HAD THIS PROBLEM BEFORE? YES NO

IF SO, WHEN? _____ IS THIS CONDITION: WORSENING STAYING THE SAME
IMPROVING

WHAT MAKES YOUR SYMPTOMS WORSE? _____

DID YOU CONSULT OTHER DOCTORS FOR THIS CONDITION? YES NO

NAMES AND DATES: _____

THEIR DIAGNOSIS: _____ RESULTS: _____

ARE YOU TAKING MEDICATION? YES NO

IF SO WHAT KIND? _____

HAVE YOU HAD ANY BROKEN BONES? YES NO PLEASE LIST:

PLEASE LIST ANY PAST ACCIDENTS OF FALLS: _____

DATE OF LAST PHYSICAL EXAM: _____ CHIROPRACTIC EXAM: _____

HEIGHT: _____ WEIGHT: _____ DATE OF LAST MENSUS: _____

ARE YOU PREGNANT? YES NO PLEASE INITIAL HERE: _____

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? YES NO

WHEN? _____ WHAT TYPE? _____

ANY HISTORY OF CANCER IN YOUR FAMILY? YES NO

HAS A PHYSICIAN TREATED YOU FOR ANY HEALTH CONDITIONS IN THE LAST YEAR?

YES NO IF YES, PLEASE DESCRIBE: _____

REMARKS AND ADDITIONAL INFORMATION: _____

PLEASE CHECK THE FOLLOWING HABITS:

TOBACCO _____ ALCOHOL _____ COFFEE _____ DRUGS _____ OVEREATING _____

PLEASE CHECK THE CONDITIONS YOU NOW HAVE, OR HAVE HAD IN THE PAST:

Current/Past		Current/Past		Current/Past				
		NECK PAIN			ANEMIA			POLIO
		HEADACHES			NERVOUSNESS			ULCERS
		DIZZINESS			BED WETTING			ARTHRITIS
		ARM PAIN			HEMORRHOIDS			CANCER
		ARM NUMBNESS			HOT FLASHES			CHEST PAIN
		HAND NUMBNESS			CONSTIPATION			DIABETES
		LOW BACKACHES			NOSE BLEEDS			DIARRHEA
		MID BACKACHES			SINUS TROUBLE			GOUT
		LEG PAIN			LUMPS IN BREAST			GOITER
		LEG NUMBNESS			SLEEPING PROBLEMS			ASTHMA
		SCIATICA			LOW BLOOD PRESSURE			COLITIS
		JOINT SWELLING			HIGH BLOOD PRESSURE			ALLERGIES
		NAUSEA			PAIN BETWEEN SHOULDERS			HEART TROUBLE
		FREQUENT URINATION			DEPRESSION			
		LOSS OF APPETITE			DIFFICULTY SWALLOWING			

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

NAME OF PERSON RESPONSIBLE FOR PAYMENT: _____

ARE YOU INSURED? YES NO COMPANY: _____

GROUP# _____ ID# _____ PHONE _____

ASSIGNMENT AND RELEASE

I UNDERSTAND AND AGREE ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND ANY HEALTH OR ACCIDENT INSURANCE POLICIES ARE BETWEEN THE INSURANCE CARRIER AND MYSELF. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. CHIROPRACTIC CARE CENTER WILL ASSIST IN PREPARING ANY NECESSARY FORMS OR REPORTS AND I AUTHORIZE THE CHIROPRACTOR TO RELEASE ANY INFORMATION REQUIRED.

PATIENT'S SIGNATURE: _____ DATE: _____

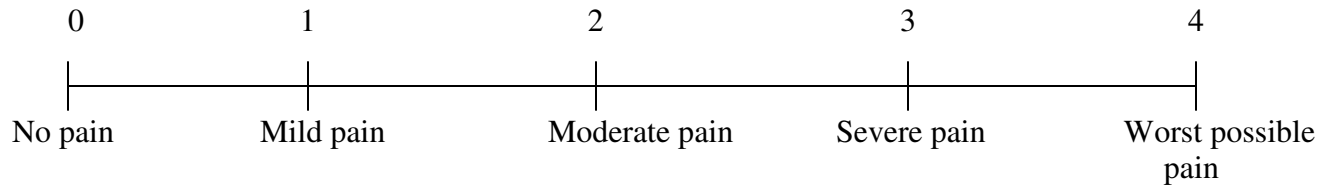
GUARDIAN'S SIGNATURE: _____ DATE: _____

FUNCTIONAL RATING INDEX

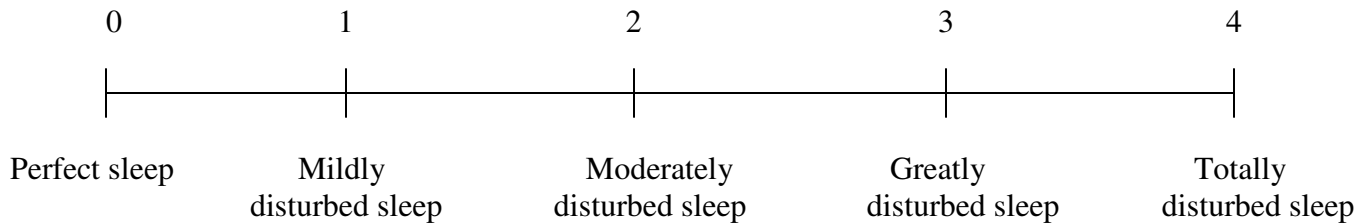
(FOR USE WITH NECK AND/OR BACK PROBLEMS ONLY)

In order to properly assess your condition we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below please circle the number that most closely describes your condition right now.

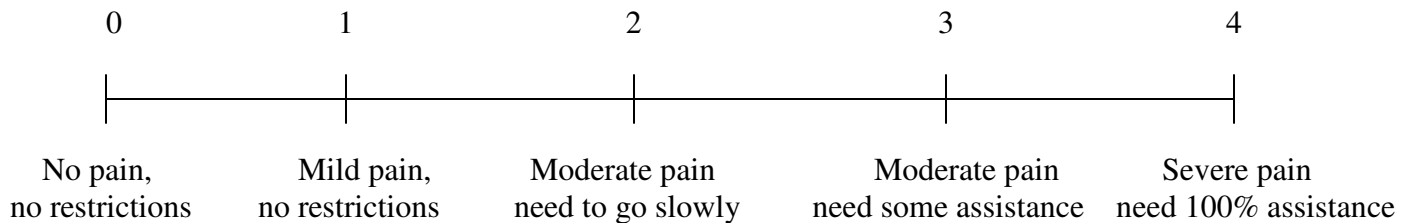
1. PAIN INTENSITY



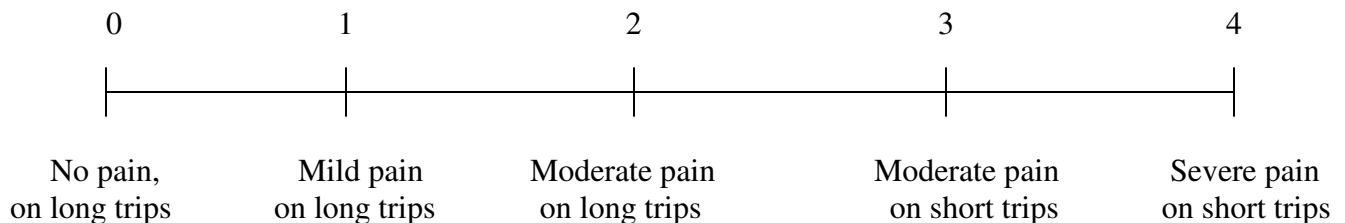
2. SLEEPING



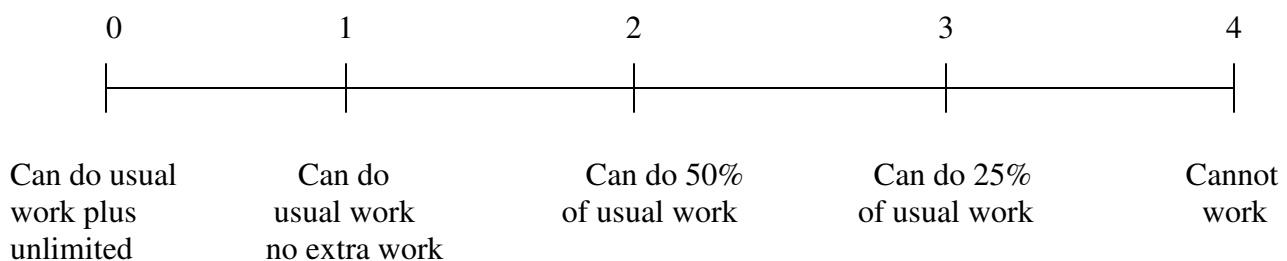
3. PERSONAL CARE (washing, dressing, etc.)



4. TRAVEL (driving, etc.)

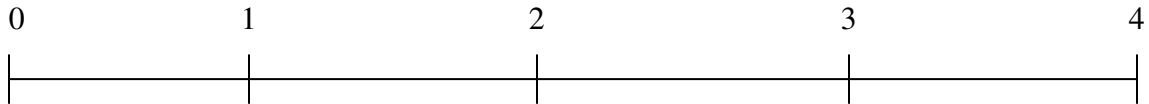


5. WORK



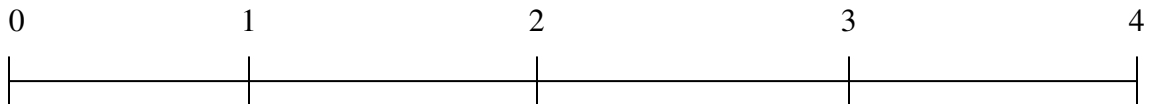
extra work

6. RECREATION



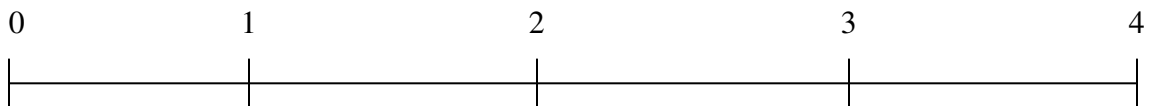
Can do usual all activities Can do most activities Can do some activities Can do a few activities Cannot do any activities

7. FREQUENCY OF PAIN



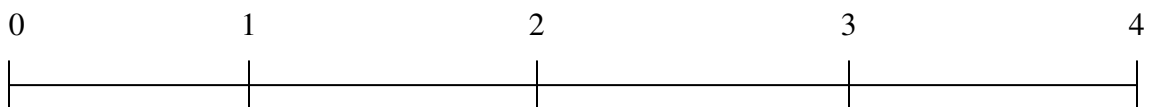
No pain Occasional pain 25% of the day Intermittent pain 50% of the day Frequent pain 75% of the day Constant pain 100% of the day

8. LIFTING



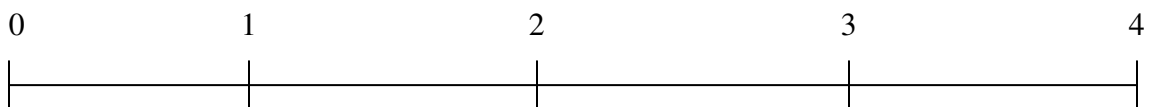
No pain with heavy weight Increased pain with heavy weight Increased pain with moderate weight Increased pain with light weight Increased pain with any weight

9. WALKING



No pain any distance Increased pain after 1 mile Increased pain after 1/2 mile Increased pain after 1/4 mile Increased pain with any walking

10. STANDING



No pain after several hours Increased pain after several hours Increased pain after 1 hour Increased pain after 1/2 hour Increased pain with any standing

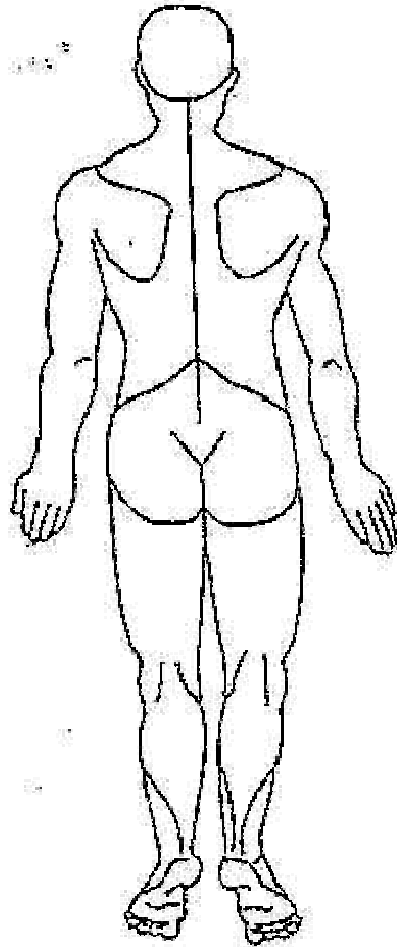
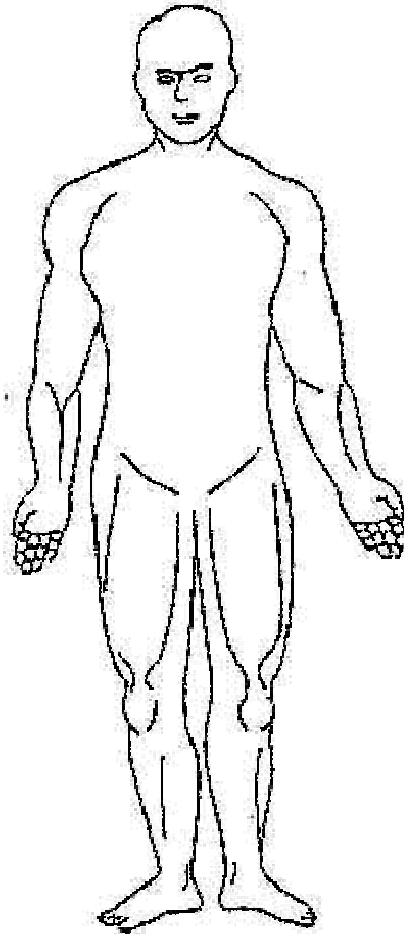
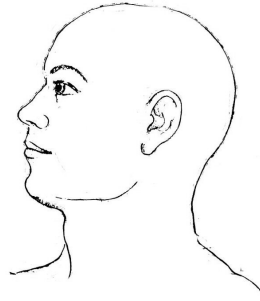
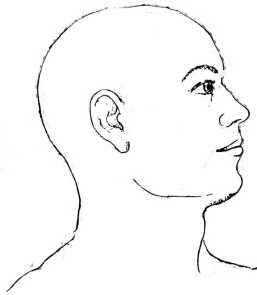
PAIN CHART

Please make the number on the drawing that most closely describes the sensations you feel.
Use arrows to show radiating pain or odd sensations. Fill this out very accurately.

- 1. numbness
- 2. tingling
- 3. burning

- 4. ache
- 5. sharp
- 6. throbbing

- 7. stabbing
- 8. pins and needles



PATIENT SIGNATURE: _____ DATE: _____

PATIENT CONSENT FORM

Chiropractic Care Center

Kenneth W. Trapp, D.C.

Travis Kummer, D.C.

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time 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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to that extent that you have taken action relying on this consent.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

POLICY REGARDING
INSURANCE & FINANCIAL OBLIGATION

Payment is expected at the time of service. If you have insurance that covers chiropractic care, we will bill them as a service to you.

PLEASE CHECK ONE

_____ **NO INSURANCE.** Please be prepared to fully cover the fees for each visit by one the following way: Cash, Check, VISA OR MasterCard.

_____ **PRIVATE OR GROUP INSURANCE.** If your insurance covers chiropractic care you may still have to pay an annual deductible and/or co-pay at the time of service. We will bill your insurance for you and payment for your portion of the fees is due at the time of service and may be taken care of in one of the following ways: Cash, Check, VISA OR MasterCard.

_____ **MEDICARE OR** _____ **DSHS.** You will be required to pay for all services, which Medicare does not cover. Theses include: x-rays, exams and supplies such as ice, supports, etc. Payment for other non-covered services such as Maintenance or Preventative care will be your responsibility. Payment for these services can be taken care of in one of the following ways: Cash, Check, VISA OR MasterCard.

If you are covered under a secondary insurance, or a Medicare supplement we will submit bills to them as well.

_____ **AUTO ACCIDENTS.** If you have PIP (Personal Injury Protection), your care is usually covered at 100%. It is our policy to bill your insurance under PIP regardless of whom was at fault. Any service or supplies not covered will become your personal responsibility. Please supply us with a claim number, billing address, telephone number, claim manager's name, attorney's name and any other information applicable.

If you do not have PIP, or you are waiting for the "at fault" party to reimburse you for medical expenses, as a service to you we will file a lien and wait for financial settlement to receive payment for our services. There is a \$9.00 fee for this service to cover the cost of filing a lien.

_____ **WORKER'S COMPENSATION.** The Washington Department of Labor and Industries will pay for 100% of services and supplies once your claim has been accepted. If Labor and Industries denies your claim you will be responsible for payment of services rendered. Any services provided to you after your claim closes will also be your responsibility.

If you have already opened a claim somewhere else, please provide us with the correct claim number, date of injury, name of your claim's manager, and name of the doctor you were previously seeing for this injury.

I have read and understand the Policy Regarding Insurance and Financial Obligation.

SIGNED: _____ 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 able 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 a chiropractic spinal evaluation, 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.
(Print name)

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.

Signature: _____ Date: _____