

Welcome to
WALK-IN CHIROPRACTIC

710 GEORGE WASHINGTON WAY #N, RICHLAND WA 99352 (509) 943-2333 PH (509) 588-1669 FX

Patient Information

Last Name: _____ First: _____ MI: _____

Date of Birth: ___/___/___ Age: _____ Social Security #: _____ - _____ - _____

Cell Phone #: _____ Home Phone #: _____

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

Gender: Male Female Height: _____ Weight: _____

e-mail: _____ Referred by: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Phone #: _____

Primary Care Physician _____ Have you seen him/her for this condition? No Yes

Address/Location: _____ Phone #: _____

Reason for visit: Musculo-Skeletal Evaluation Laser Treatment Allergy Evaluation
Nutritional Consult Hormone Balancing

Are you most interested in: Symptomatic Relief Corrective Care Wellness

Health Insurance

Insurance Company: _____ Phone #: _____

Primary Insured Last Name: _____ First: _____ MI: _____

Relation to Insured: Self Spouse Child Other: _____

Subscriber ID #: _____ Group #: _____

History of Present Complaint

Patient Name:	Date:	Claim/ID#:
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Is this visit related to a: Motor Vehicle Accident Work Injury Neither

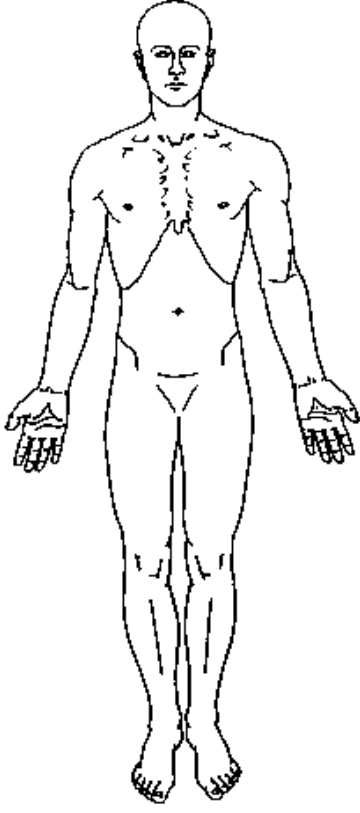
Reason for this visit:

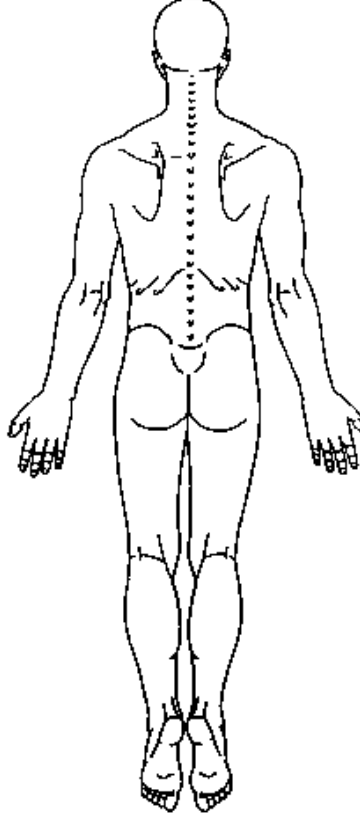
Date of injury:	When did your symptom(s) start:
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How did your injury(s) occur:

Please describe your injury(s) / symptom(s):

On the picture below circle or mark area(s) of injury or complaint. Use letters to label areas of complaint.





A – Aching
B – Burning
D – Dull Pain
N – Numbness
P – Pins & Needles
S – Sharp Pain
T – Throbbing
W - Weakness

Circle the number(s) that best represent your pain or symptom level. If more than one please label.

GOOD ← 0 1 2 3 4 5 6 7 8 9 10 → **BAD**

How often do you experience the above symptoms? Constantly Daily Weekly Monthly

Describe activities that are affected by your injury(s) or symptom(s), such as: sitting, standing, walking, sleeping, driving, work, etc...

List all other health profesionalis you have seen for this condition:

Health History

Patient: _____ Date: ____/____/____ Claim/ID#: _____

Have you ever had Chiropractic treatment? No Yes; when was your last treatment? _____

In the past 24 months have you had: X-ray MRI CT where/when: _____

Cervical Spine (Neck) - check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Pain into Arms/Hands | <input type="checkbox"/> TMJ/Jaw Pain/Clicking |
| <input type="checkbox"/> Numbness/Tingling in Arms/Hands | <input type="checkbox"/> Low Energy/Fatigue |
| <input type="checkbox"/> Muscle Weakness in Arms/Hands | <input type="checkbox"/> Thyroid Conditions |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Dizziness/Lightheaded | <input type="checkbox"/> Sinusitis |

Thoracic Spine (Upper/Mid Back) - check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Upper/Mid Back Pain | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pain with Deep Inhale/Exhale |
| <input type="checkbox"/> Angina/Heart Pain | <input type="checkbox"/> Recurrent Bronchitis/Lung Infection |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Recurrent Acid Reflux/Heart Burn |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Tired/Irritable before/after meals |

Lumbar Spine (Low Back) - check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Frequent/Difficult Urination |
| <input type="checkbox"/> Pain into Legs/Feet | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Numbness/Tingling in Legs/Feet | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Muscle Weakness in Legs | <input type="checkbox"/> Recurrent Bladder Infections |
| <input type="checkbox"/> Constipation/Diarrhea | |

Health Conditions - check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Psychological Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Spinal Disc Injury/Hernia/Bulge | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Insomnia; Average hrs of sleep per night: _____ |
| <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> Pregnant: date of last menstrual period: _____ |
| <input type="checkbox"/> Unexplained Weight Loss/Gain | <input type="checkbox"/> Bone Fractures: |

List any health condition(s) not mentioned: _____

Do you have a Family History of: Heart Disease Diabetes Stroke Cancer

List date & type of all **Surgeries:** _____

List all **Medications** presently taking: _____

1. Informed Consent

Welcome to our integrated wellness practice, offering chiropractic, physical therapy, nutritional & massage therapy. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & I believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of medicine, chiropractic, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprain/strains, drug interactions & reactions and/or injuries or side effects which cannot be pre-determined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. Therefore, I give my full consent to the doctor/provider to render treatment on me or the minor whom I am legally responsible by a health care provider of this Facility.

2. Patient Privacy

I acknowledge that I have received, read, & understand the "Notice of Patient Privacy" stating that; The Health Insurance Portability Act (HIPAA) ensures a patient's right to privacy regarding personal health information. (It is our office's policy to maintain confidentiality to the highest degree.)

3. Insurance & Payment Policy

I understand that payment for all services or co-pays are due at time of service.

I acknowledge that I am responsible for all fees for services rendered on my behalf, regardless of insurance benefits. Insurance coverage whether accident, work related, or general health coverage is an arrangement between me and my insurance carrier. Our office will estimate and bill as a courtesy, however billing an insurance company does not guaranty they will pay, and does not release me from payment for unpaid services.

4. Medical Records Release

I authorize this office to release any medical &/or legal information necessary to collect on services. This is a permanent authorization that I may revoke at any time by written notice.

Patient Signature: _____ **Date:** ____/____/____

If assistance required; print assistants name: _____
Relationship to patient: Spouse Parent Guardian Interpreter Other: