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.

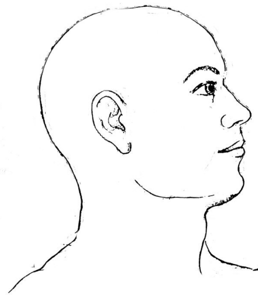
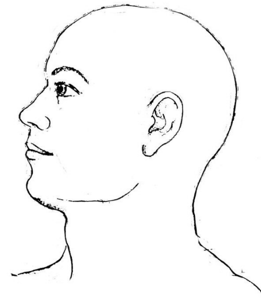
PATIENT'S SIGNATURE:_____________________________________ DATE:____________________________

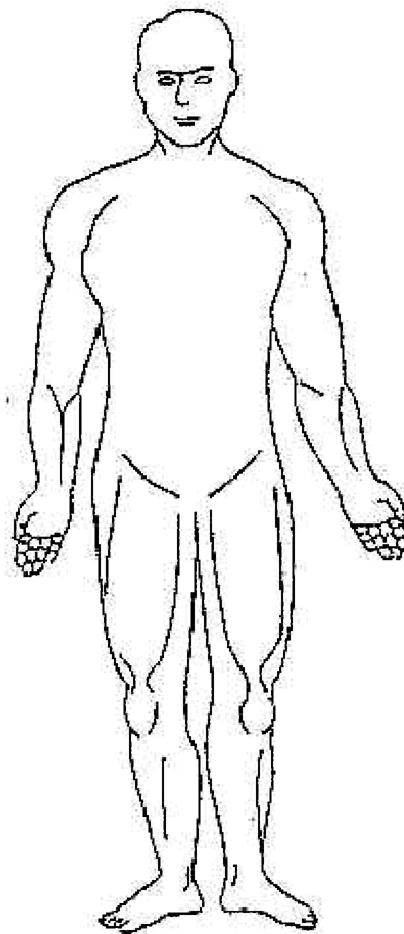
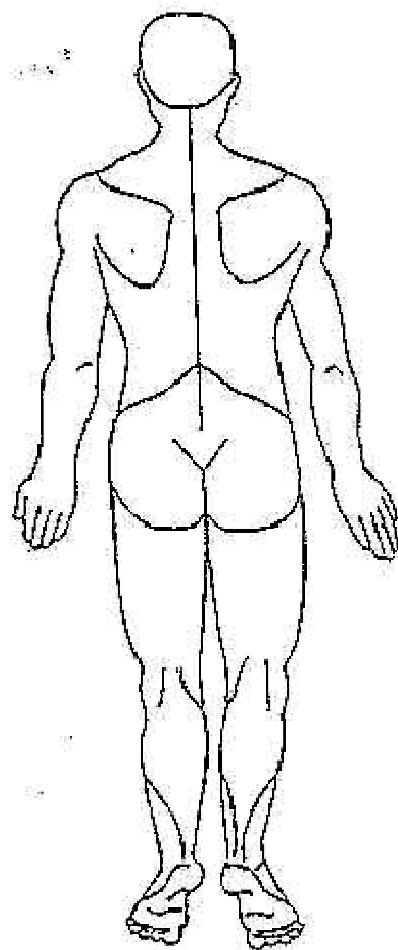
GUARDIAN'S SIGNATURE:___________________________________ DATE:_____________________________

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 it *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:_______________________