Confidential Health History

CLEAR CHIROPRACTIC Upper Cervical Care

#_____

Today's Date: _____

Name: _____ SSN: _____ Age: ____

Email: _____ I would like appointment reminders by: ☐ text ☐ email

Cell phone provider (eg. Verizon, ATT): _____

Address: _____ ☐ M ☐ F Date of Birth: _____

City: _____ State: ____ Zip: _____ Occupation: _____

Home Phone: _____ Cell Phone: _____ Employer: _____

Work Phone: _____ How did you hear about us? _____ Marital Status: _____

Emergency Contact Name: _____ Home Phone: _____

Is your visit due to an auto or work related injury? ☐ Yes ☐ No *If yes, please fill out Auto Accident Forms*

List authorized person(s) for medical information release: _____

Primary reason for seeking care? _____

Problem started on: _____ Most recent aggravation: _____

What makes it worse? _____

What makes it better? _____

Quality of symptoms:

☐ Aching ☐ Burning ☐ Numbness/Tingling ☐ Stabbing ☐ Dull ☐ Deep ☐ Superficial

If symptoms radiate to other areas, where? _____

Mark Symptoms

☐ No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Incapacitating Pain

How frequent is it?

☐ Constant(100%) ☐ Frequent(75%) ☐ Intermittent(50%) ☐ Occasional(25%)

How long does it last?

☐ 24hrs/day (wakes you at night) ☐ 16hrs/day (does not wake you) Other: ____ hrs/day

HT: ____ in. WT: ____ lbs Hobbies/Sports: _____

List medications: _____

Other providers used for healthcare: _____

Previous chiropractor(s): _____

All surgeries and dates: _____

Do you have insurance? ☐ Yes ☐ No ***If yes, please give your card to the front desk***

Doctor's Notes Only

Daily: _____ Initial: ____

4xs : _____ Cerv ____

3xs : _____ Thor: ____

2xs : _____ Lum: ____

1x : _____ Adj: ____

E-O : _____ Extr: ____

Mth : _____ F/U: ____

Trxn: ____

Exer: ____

Please Check accompanying Box If Relevant To Your Health History

General

☐ Unexplained Weight/Loss Gain ☐ Fevers/Chills ☐ Recent Trauma

☐ Fatigue ☐ Trouble Sleeping/Sleep Disorder ☐ Past Trauma

Skin

☐ Rashes ☐ Itching ☐ Color Change ☐ New/Change in mole

☐ Lumps ☐ Dryness ☐ Hair/Nail Changes

Head/Eyes/Ears/Ears/Nose/Throat

☐ Visual Changes ☐ Sinus Problems ☐ Hearing Loss ☐ Difficulty Swallowing/Chewing

☐ Double Vision ☐ Head Injury/Trauma ☐ Ringing in Ears ☐ TMJ/TMD ☐ Headaches

Cardiovascular

☐ Chest Pain ☐ Shortness of Breath ☐ High/Low Blood Pressure ☐ Blood Clots

☐ Palpitations ☐ Fainting ☐ Heart Disease ☐ Cold Hands/Feet ☐ Poor Clotting

Respiratory

☐ Cough ☐ Cough Up Blood ☐ TB

☐ Sputum ☐ Asthma/Wheezing ☐ COPD/Emphysema

Gastrointestinal

☐ Abdominal Pain ☐ Vomiting ☐ Diarrhea

☐ Nausea ☐ Constipation ☐ Indigestion

Musculoskeletal

☐ Neck/Back Pain ☐ Stiff Neck ☐ Joint Pain/Stiffness ☐ Hip/Knee/Ankle Pain

☐ Plantar Fasciitis ☐ Scoliosis ☐ Joint Swelling ☐ Shoulder/Elbow/Wrist Pain

Neurologic

☐ Dizziness ☐ Seizures ☐ Weakness ☐ Numbness/Tingling ☐ Migraine/Cluster Headaches

Other

☐ Diabetes ☐ Cancer ☐ Fibromyalgia ☐ Nervous/Anxiety ☐ Depression ☐ Stroke

☐ Arthritis ☐ Osteoporosis ☐ Varicose Veins ☐ Anaphylaxis Other: _____

Doctor's Notes

Women Only

☐ Painful Menstruation

☐ Irregular Cycle

☐ Breast Problems

☐ Menopause

Are You Pregnant?

☐ Yes ☐ No ☐ Maybe

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if CLEAR Chiropractic extends credit to me and I understand that if I suspend or terminate my care, fees for professional services rendered to me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors of CLEAR Chiropractic and whomever they may designate as their assistants to administer treatments as they so deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Signed By (please print)

Signature **Date**

Pain Index Questionnaire

In the last (week/month),

How many days did you *miss (work or school)* due to (this health problem)? ..... __

How many days did you *reduce your normal activities* due to (this health problem)? ..... __

How many days did you *stay in bed more than half a day* due to (this health problem)? ..... __

How many days have you felt very healthy and full of energy? ..... __

Global Well Being Scale

Please think about your general sense of health and well-being. On the line below, make a straight line (up-and-down) to show how you feel right now.

WORST YOU COULD POSSIBLY FEEL |——————————————————| **BEST YOU COULD POSSIBLY FEEL**

Numeric Rating Scale

On a scale of 0 to 10, where "0" is "no pain" and "10" is the worst pain imaginable, please check the number that represents your pain right now.

NO PAIN ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 **WORST PAIN**

Specific Activities

(use activity limitation scale for each one.)

Are there activities you can't do or have trouble doing due to this health concern? Please list. (examples: breastfeeding, sleeping, eating, crawling, walking, playing, going to school, etc.)

_____ _____

Activity Limitation

How much did this health concern **limit** your daily activities **in the last week**?

Activities are not limited ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 Can't do daily activities at all

Client Name (please print) _____ **Date** _____

Client or Guardian Signature _____

Notice of Privacy Practices, Terms of Acceptance and Office Policies

I, _____ have read and agree with the associated pages in regards to my care with Clear Chiropractic Spokane and have read the attached pages. (Pages present in office and copies are available upon request.)

_____ (initial) I have read and agree with the **Notices of Privacy Practices** and understand that it is required by law to maintain the privacy and confidentiality of your protected information. You have the right to a paper copy of this Notice of Privacy practices upon request.

_____(initial) I have also read and agree with the **Terms of Acceptance**. I understand that the only practice objective at Clear Chiropractic is to eliminate a major interference to the expression of the body's innate wisdom. This method is specific adjusting to correct vertebral subluxations.

_____ (initial) I have read and agree with the Clear Chiropractic **Office Policies**. Our office requires at least 24 hours of notice so that the provider may see others in need. It is recommended that all missed appointments be made up later in the same day or within 7 days to help you stay on track with your health care goals. **NOTICE:** Any appointments missed without proper notification, will be subject to a **($25/Chiropractic)** fee due at your next visit. You are always able to call and leave a message outside of office hours to reschedule.

I have read and fully understand the above statements.

Print Name: _____ Date: _____

Signature: _____

Print Name: _____ Date: _____

(Guardian name if under 18)

Your health is of the utmost importance to us, and we want you to get the most out of your chiropractic care. If you have any questions, about office policies or appointments, DO NOT hesitate to ask. We are here for you!