#	Confider	ntial Health History	CLEAR	CHIROPRACTIC Upper Cervical Care
Today's Date:				- <del> </del>
Name:		SSN:		Age:
Email:		I would like appointment remind Cell phone provider (eg. Verizor		t 🔲 email
Address:			te of Birth:	
City:	State: Zip:	Occupation:		
Home Phone:	Cell Phone:	Employer:		
Work Phone:	How did you ho	ear about us?	Marital :	Status:
Emergency Contact Name:		Home	e Phone:	
Is your visit due to an auto or work	related injury?	☐ Yes ☐ No ☐ If yes, stop here a	nd see front des	sk!
List authorized person(s) for medi	cal information re	lease:		
Primary reason for seeking care?			<u>Doctor's N</u>	otes Only Initial:
Problem started on:	Most recen	t aggravation:	Daily:	Cerv
What makes it worse?			3xs :	Lum:
What makes it better?			2xs :	Extr: F/U:
Quality of symptoms: Aching Burning Numbness	E-O :	Consul Traction:		
If symptoms radiate to other area	Mth :	Exer:		
Mark Symptoms  No Pain 1 2 3 4 [	 5	8 9 10 Incapacitating Pain		
How frequent is it?				
☐ Constant(100%) ☐ Frequent(7	75%) 🗌 Intermit	tent(50%)   Occasional(25%)		
How long does it last?				
24hrs/day (wakes you at night)	16hrs/day (does no	ot wake you) Other: hrs/day		
HT: in. WT: lbs Ho	obbies/Sports:			
List medications:				
Other providers used for healthcare	:			

Previous chiropractor(s):

All surgeries and dates:

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

Please Check accompanying Box If Relevant To Your Health History General **Doctor's Notes** ☐ Unexplained Weight/Loss Gain Fevers/Chills Recent Trauma ☐ Trouble Sleeping/Sleep Disorder ☐ Past Trauma ☐ Fatigue 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 Heart Disease Cold Hands/Feet Poor Clotting Fainting Respiratory Cough Cough Up Blood ☐ TB Sputum ☐ Asthma/Wheezing COPD/Emphysema **Gastrointestinal**  ☐ Abdominal Pain □ Vomiting Diarrhea Constipation Indigestion ☐ Nausea Musculoskeletal Women Only □ Neck/Back Pain ☐ Stiff Neck ☐ Joint Pain/Stiffness ☐ Hip/Knee/Ankle Pain Painful Menstruation Shoulder/Elbow/Wrist Pain ☐ Plantar Fasciitis ☐ Scoliosis ☐ Joint Swelling Irregular Cycle **Neurologic** Breast Problems Seizures Weakness Numbness/Tingling Migraine/Cluster Headaches Dizziness Menopause Other Are You Pregnant? ☐ Diabetes ☐ Cancer ☐ Fibromyalgia ☐ Nervous/Anxiety ☐ Depression ☐ Stroke ☐ Yes ☐ No ☐ Maybe ☐ Arthritis ☐ Osteoporosis □ Varicose Veins Anaphylaxis Other: 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.

## acquired in the course of examination or treatment. I certify that the above information is true and correct Signed By (please print) Signature Date

Page 2 of 5

## **Pain Index Questionnaire**

In the las				vork o	r school	l) due to	o (this he	ealth prob	olem)?			
How many	days dic	you <i>i</i>	reduce	your i	normal a	activities	due to	(this hea	Ith proble	em)?		
How many	days dic	d you s	stay in	bed n	nore tha	n half a	<i>day</i> due	to (this I	health pr	oblem)?	·	
How many	days ha	ve you	u felt ve	ery he	althy an	nd full of	energy?	·				
							Being S					
	ease thin low, mak											
WOR	ST YOU	ı	I								BEST Y	OU
CC	ULD	.								4	COUL	D
POSSIE	BLY FEE	L								I PO	SSIBLY	FEEL
					Nume	eric Ra	ting Sc	ale				
On	a scale	of 0 t	to 10, v	where					ne worst	pain		
	aginable					•				•	٧.	
												_ WORST
NO PAIN	<b>0</b>	<b>1</b>	<b>2</b> 2	· 🗖	3 🗆	14 🗆	5 🗖	6 🗆 7	7 🗆 8	<b>□</b> 9	<b>1</b> 0	PAIN
					Sno	ocific A	ctivitie	c				
			(us	se act				or each	one.)			
Are there			an't do	or ha	ve trouk	ole doin	g due to	this hea	Ith conce			
(examples	: breastfe	eeding	j, sleep	ing, e	ating, c	rawling,	walking	, playing,	, going to	school	, etc.)	
												-
					Act	ivitv Li	mitatio	n				
How muc	<b>h</b> did this	healt	h conc	ern lir					st week?			
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ties are limited	0 🗖 1		12	<b>3</b>	<b>4</b>	<b>5</b>	<b>□</b> 6	<b>7</b>	□ 8	<b>9</b>	<b>1</b> 0	Can't do activities
IIIIIILEU												activities
ent Name	(please	print)							Date	e		
		- <b>,</b>										
ant or Gua	rdian Si	ignati	ure									



## 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 <b>Notices of Privacy Practices</b> 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 <b>Terms of Acceptance</b> . 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 <b>Office Policies</b> . 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. <b>NOTICE</b> : Any appointments missed without proper notification, will be subject to a <b>(\$25/Chiropractic)</b> 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!