#_____ Confidential Health History

CLEAR CHIROPRACTIC Upper Cervical Care

Name _____ SSN: _____-____-_____ Age: _____

Martial Status: _____ Spouse' Name_____ Date of Birth:_____ Gender: _____

Address _____ City _____ State _____ Zip _____

Home/ Cell: _____ Work: _____

Email: _____ I would like email text reminders Carrier:
Eg: Verizon, AT&T

How did you hear about us? _____

Occupation: _____ Employer's Name: _____

Emergency contact: _____ Home Phone: _____

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

Primary reason for seeking care? _____

Problem started on: _____

Most 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 Rate your symptom: 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 of Current Medication: _____

Other Doctors used for healthcare: _____

Previous Chiropractors(s): _____

All Surgeries and dates: _____

_____

Doctor's Notes Only

Daily :_____
4xs :_____
3xs :_____
2xs :_____
1x :_____
E-O :_____
Mth :_____
Initial :_____
Cerv :_____
Thor :_____
Lum :_____
Adj :_____
Extr :_____
F/U :_____
Trxn :_____
Exer :_____
CBCT :_____

AUTO INSURANCE INFORMATION (not personal medical insurance)

Your Ins. Co. _____PIP Claim? ☐ yes ☐ no Claim # ___

Adjuster's Name _____ Adjuster's Phone #_____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Responsible Ins Co _____Policy# _____

ATTORNEY

Name _____ Phone ( ) _____

Paralegal Name_____ Phone ( )_____Ext:____

Were there any witnesses? ☐ Yes ☐ No Name(s) _____

NATURE OF ACCIDENT:

Date of Accident _____ Time of Day_____ City, State_____

Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

Number of people in your vehicle? _____ Were you wearing seat belts? yes no

What direction were you headed? ☐ North ☐ East ☐ South ☐ West Name of street _____

What direction was other vehicle headed? ☐ North ☐ East ☐ South ☐ West Name of street _____

Were you struck from: ☐ Behind ☐ Front ☐ Left side ☐ Right side

Approximate speed of your car: _____ mph Other car _____mph

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____

Were police notified? ☐ Yes ☐ No Was there a police report? _____

Please describe accident: _____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No If yes, please describe in detail:

_____

_____

Please describe how you felt:

a. DURING the accident: _____
b. IMMEDIATELY AFTER the accident: _____
c. LATER THAT DAY: _____
d. THE NEXT DAY: _____

What are your **PRESENT** complaints and symptoms? _____

_____

_____

Medication taken SINCE the accident: _____

Do you have any congenital (from birth) factors, which relate to your symptoms? ☐ Yes ☐ No If yes, please describe:

_____

Do you have any previous illnesses which relate to this case?, ☐ Yes ☐ No If yes, please describe: _____

_____

Have you ever been involved in an accident before? ☐ Yes ☐ No If yes, please describe, including date(s) and type(s) of accidents, and treatment(s) received. _____

_____

_____

Where were you taken after the current accident? _____

Have you been treated by another doctor since the current accident? ☐ Yes ☐ No If yes, please list doctor's name, specialty and phone:

_____

What type of treatment did you receive? _____

_____

CHECK SYMPTONS YOU HAVE NOTICED SINCE ACCIDENT:

General

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

☐ Past Trauma ☐ Trouble Sleeping/ Sleep Disorder ☐ Irritability ☐ Nervousness

Skin

☐ Rashes ☐ Itching ☐ Color Change ☐ New/Change in Mole ☐ Lumps

☐ Dryness ☐ Hair/ Nail Changes

Head/ Eyes/ Ears/ Nose/ throat

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

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

Cardiovascular

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

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

Respiratory

☐ Cough ☐ Coughing up Blood ☐ TB ☐ Sputum ☐ Asthma/ Wheezing

☐ COPD/Emphysema ☐ Face Flushed

Gastrointestinal

☐ Abdominal Pain ☐ Vomiting ☐ Diarrhea ☐ Nausea ☐ Constipation

☐ Indigestion ☐ Upset Stomach

Musculoskeletal

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

☐ Scoliosis ☐ Joint Swelling ☐ Shoulder/Elbow/Wrist Pain ☐ Tension

Neurologic

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

☐ Loss of Memory ☐ Loss of Taste ☐ Loss of Smell ☐ Pins & Needles ☐ Cold Sweats

Other

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

☐ Arthritis ☐ Osteoporosis ☐ Varicose veins ☐ Head Seems Heavy ☐ Anaphylaxis ☐ MS

Other:_____

Female Only

☐ Painful Menstruation ☐ Irregular Cycle ☐ Breast Problems ☐ Menopause

Are You Pregnant?

☐ Yes ☐ No ☐ Maybe

Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐Same

Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, please complete the question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? ☐ Yes ☐ No If yes, please state type of compensation you are receiving: _____

Do you notice any daily activity restrictions as a result of this injury? ☐ Yes ☐ No If yes, please describe, in detail:

_____

_____

Other pertinent Information : _____

_____

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 form 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 may account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand than agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be check if CLEAR Chiropractic extend credit to me and I understand that if I suspend or terminate my care and treatment, and fee for professional services rendered to me will be immediately due and paid unless other arrangement are made. I hereby authorize the doctors at 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.

_____ _____

Print Name **DATE**

_____ _____

Patient Signature **DATE**

_____ _____

Guardian Signature **DATE**

If Patient under 18

As legal parent/guardian of _____, I hereby give my permission to Clear Chiropractic to render Chiropractic services to the above named minor. As minor is defined as any depended under the age of 18 years old.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Date

Pain Index Questionnaire

In the last week,

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: sitting, standing, sleeping, eating, walking, going up or down stairs, 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

Patient Name (please print)_____

_____

Signature Date

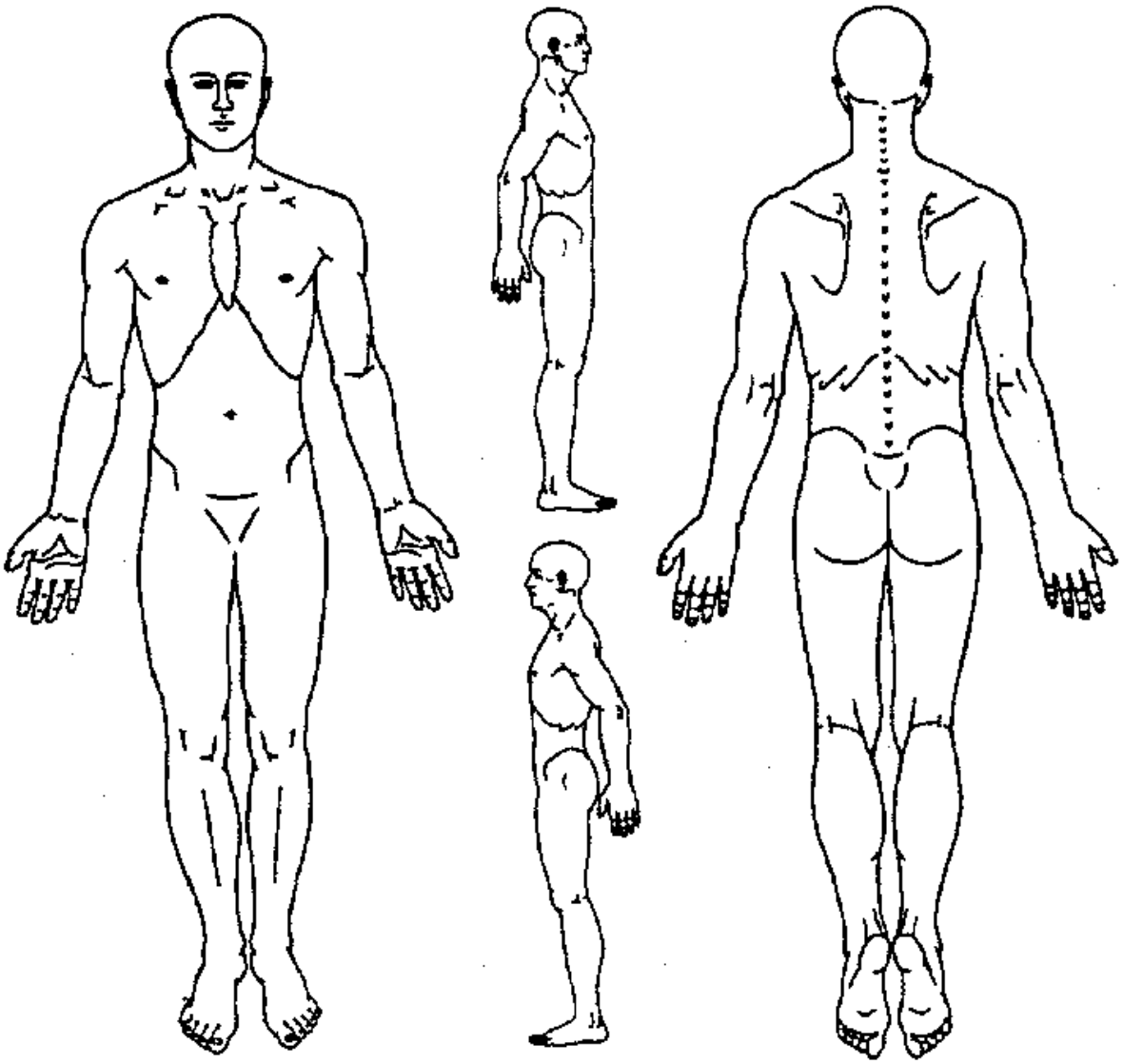
Pain Diagram

Name: _____

(Must be filled out in office by hand)

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗⊗⊗⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗⊗⊗⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗⊗⊗⊗



Date: _____ Signature: _____

Clear Chiropractic

Patient Payment Plan

Patient name: _____Date_____

The Personal injury Case

We recognize that some patients are under great physical and financial stress following their accident and are unable to pay for their chiropractic care as it is rendered after their personal injury. Accordingly, Clear Chiropractic will not require that you make “out of Pocket” payments as you receive your care related to your personal injury case, provided you agree to the following:

Personal Injury Payment Agreement

I, _____, give Clear Chiropractic the permission and authority to bill any and all insurance plans available to me for the payment of chiropractic care and other services received by myself or others I am responsible for, including the taking and/or reading of x-rays, until all charges billed by Clear Chiropractic for such care is paid in full.

In the event that health insurance available to me does not cover all charges of my care at Clear Chiropractic, I authorize any and all responsible parties to pay, from the proceeds of settlement I may receive, any outstanding balance.

In the event that all health insurance and settlement I may receive does not cover the cost of my care at Clear Chiropractic, I agree to pay the full balance for services rendered over no more than ninety (90) days.

Patient’s Signature Date Account Representative

Notice of Office Policies, Privacy Practices and Terms of Acceptance

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 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.

_____ (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.

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!