
Confidential Health History



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

Marital 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: _____

<p>Primary reason for seeking care? _____</p> <p>Problem started on: _____</p> <p>Most Aggravation: _____</p> <p>What makes it worse? _____</p> <p>What makes it better? _____</p> <p><u>Quality of symptoms:</u></p> <p><input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Stabbing <input type="checkbox"/> Dull</p> <p><input type="checkbox"/> Deep <input type="checkbox"/> Superficial</p> <p>If Symptoms radiate to other areas, Where _____</p> <p><u>Mark Symptoms</u></p> <p><input type="checkbox"/> No Pain Rate your symptom: 1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/> Incapacitating Pain</p> <p><u>How Frequent is it?</u></p> <p><input type="checkbox"/> Constant (100%) <input type="checkbox"/> Frequent (75%) <input type="checkbox"/> Intermittent (50%) <input type="checkbox"/> Occasional (25%)</p> <p><u>How long does it last?</u></p> <p><input type="checkbox"/> 24hrs/day (wakes you at night) <input type="checkbox"/> 16hrs/day (does not wake you)</p> <p><input type="checkbox"/> Other: _____ hrs/day</p> <p>HT: _____ in. WT: _____ lbs. Hobbies/Sports: _____</p> <p>List of Current Medication: _____</p> <p>Other Doctors used for healthcare: _____</p> <p>Previous Chiropractors(s): _____</p> <p>All Surgeries and dates: _____</p> <p>_____</p>	<p><u>Doctor's Notes Only</u></p> <p>Daily : _____</p> <p>4xs : _____</p> <p>3xs : _____</p> <p>2xs : _____</p> <p>1x : _____</p> <p>E-O : _____</p> <p>Mth : _____</p> <p>Initial : _____</p> <p>Cerv : _____</p> <p>Thor : _____</p> <p>Lum : _____</p> <p>Adj : _____</p> <p>Extr : _____</p> <p>F/U : _____</p> <p>Trxn : _____</p> <p>Exer : _____</p> <p>CBCT : _____</p>
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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 SYMPTOMS 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 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 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 _____

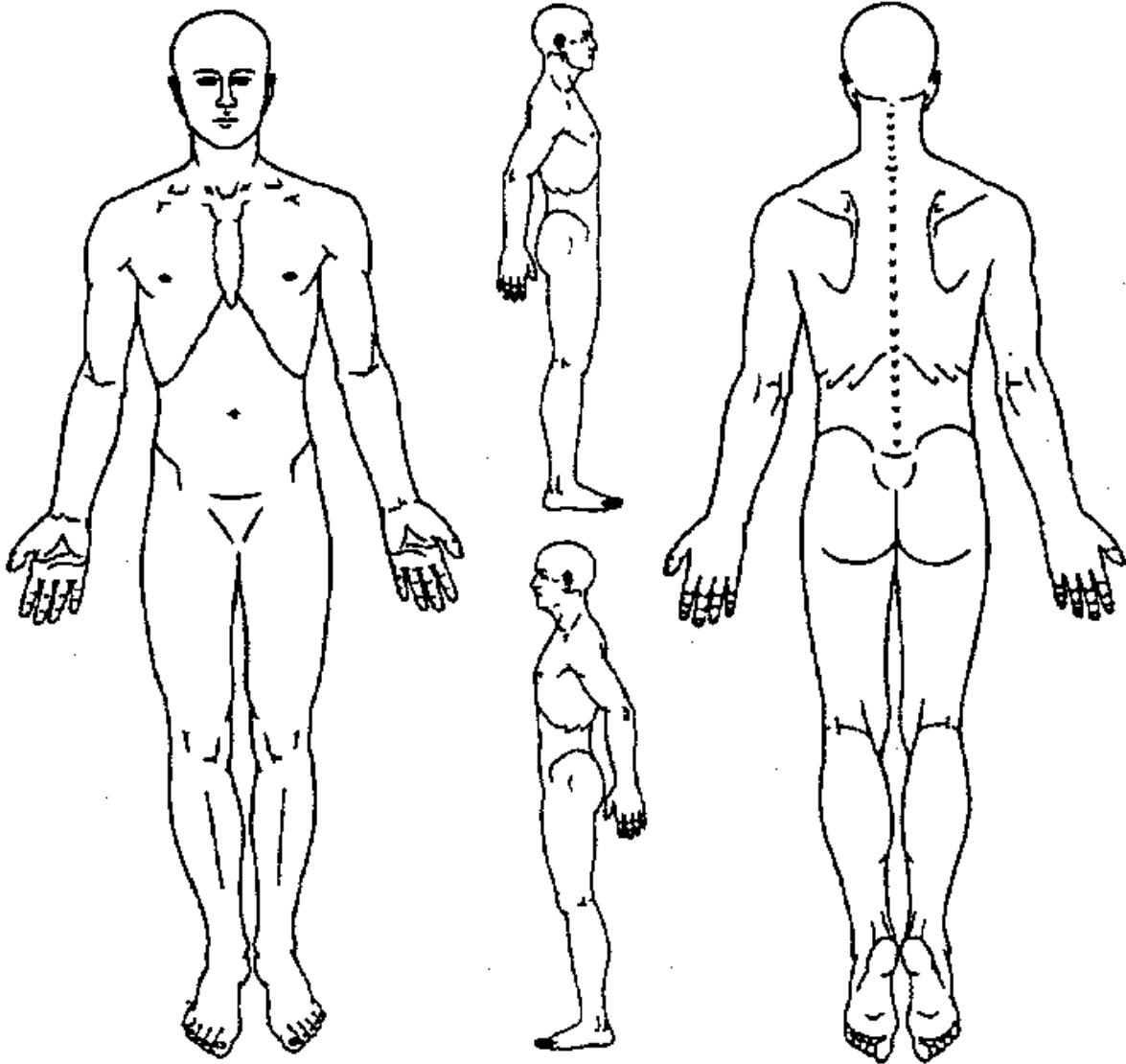
Pain Diagram

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
-----	○ ○ ○ ○ ○	^ ^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
-----	○ ○ ○ ○ ○	^ ^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
-----	○ ○ ○ ○ ○	^ ^ ^ ^ ^	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!