CHIROPRO Care

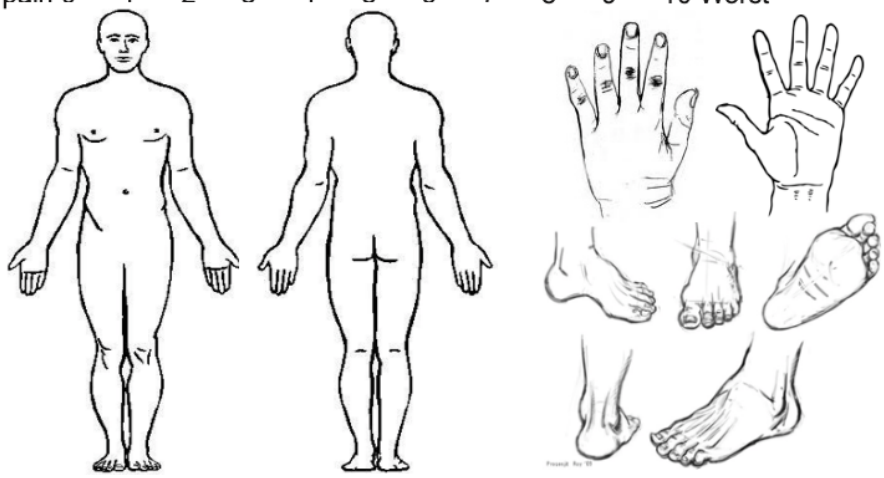
6840 Fort Dent Way Ste 120
Tukwila, WA 98188
T: 206.466.1880 F:844.376.0427
www.ChiroproCare.com

Welcome to Chiropro Care

Name_____ Date of Birth _____/_____/_____ Phone # _____
Gender ☐ Male ☐ Female Email _____
Social Security Number _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Other
Address _____ City, State & Zip _____
Emergency Contact _____ Phone # _____ Relation _____
How did you hear about us? ☐ Family/ Friend _____ ☐ Online ☐ Insurance Website
☐ Attorney _____ ☐ Physician's Referral _____
☐ Other _____

1. Reason for today's visit _____
2. What's your current pain level now? No pain 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst
3. Indicate the area(s) showing the type of discomfort you have using the provided markings.

Aching ○
Dull Pain ////
Stabbing X
Tingling ✱
Numbness ◇
Pins & Needles △
Burning ☐



4. Is this visit related to an auto accident or work related injury? ☐ No ☐ Yes *Incident Date* _____
5. How long have you had the symptom? _____ 6. If you've had the issue before, *When* _____
7. What caused the symptom/injury to occur? _____ ☐ Don't know
8. What makes it ***better***? _____
9. What makes it ***worse***? _____
10. List any other doctors and type of treatment received for above conditions _____
_____ *When* _____
11. Have you had Xray, MRI, CT, etc. for the condition? *When & Where* _____
12. List all medications you are currently taking (OTC, Prescriptions, Vitamins, Herbs...) _____
_____
13. Have you had previous chiropractic care? ☐ More than 30 times ☐ 10 to 30 times ☐ Less than 10 times ☐ Never
14. Can you perform daily home activities? ☐ All ☐ Some ☐ None
15. Rate your stress level over the last 30 days? Low 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 High
16. ***FEMALE ONLY*** » Is there any chance that you are pregnant? ☐ No ☐ Yes / Maybe

Lifestyle

1. Do you smoke? ☐ No if yes, how much, often & long have you been smoking? _____
2. Do you consume alcohol? ☐ No if yes, how much & often? _____
3. Activity level ☐ Light ☐ Moderate ☐ Sedentary ☐ Vigorous

Medical History

Hospitalizations	
Surgeries	
Prior Accident/ Injuries	
Ongoing illness	
Allergies	
Current Medications	
Family History	
Social History	
Sexual History	
Previous Tests	
Medical Procedures	
Dietary Habits	
Nutritional Supplements	
Prior Chiropractic Care	

VITAL (OFFICE USE ONLY)

Height	**Inches**
Weight	**Lbs**
Pulse	**bpm**
Respiration	**bpm**
Temperature	**F**
Blood Pressure	**/ mmHg**
Additional Note	

Review of Systems: Do you have any of the following? (Check all that apply)

GENERAL			HEENT			SKIN/ HAIR			CARDIOVASCULAR		
☐ None of below	past	current	☐ None of below	past	current	☐ None of below	past	current	☐ None of below	past	current
Lethargy/ Weak			Headache			Skin trouble			Chest pain or tight		
Recurring Fever			Vision problem			Rashes			Heart attack		
Weight Loss/Gain			Nose bleeds			Flushing			Shortness of breath		
Dizziness			Eye surgery			Excessive acne			Palpitations		
Fever			Cataracts			Eczema			Swelling/ feet or hand		
Chills			Glaucoma			Psoriasis			High blood pressure		
RESPIRATORY			Sore throat			Skin cancer			Low blood pressure		
☐ None of below	past	current	Hoarseness			Change in hair			High cholesterol		
Persistent cough			Swollen glands			Change in nails			Heart murmur		
Spitting up blood			Sinus trouble			Blood in stool			Blood clots		
Asthma or wheezing			Ear and hearing			Easy bruising			Pacemaker		
Shortness of breath			TMJ problem			Gum bleeding			Mitral valve prolapse		
Exercise intolerance			Postnasal drip			**NEUROLOGICAL**			Congenital heart def.		
Sleep apnea			**GASTROINTESTINAL**			☐ None of below	past	current	Rheumatic fever		
Emphysema			☐ None of below	past	current	Frequent headache			Leg pain upon walk.		
Snoring issues			Loss of appetite			Migraines			Varicose veins		
Tuberculosis			Nausea or vomiting			Dizziness			Dizziness		
Pneumonia			Diarrhea			Fainting			Excessive bruising		
Breathing problem			Constipation			Memory loss			Coronary artery dis.		
Hay fever			Abdominal pain			Poor balance			**MUSCULOSKELETAL**		
BLOOD/ LYMPH			Stomach ulcer			Numbness or tingling			☐ None of below	past	current
☐ None of below	past	current	Bloating/ cramping			Pins and needles			Arthritis		
Anemia			Heartburn			Epilepsy or seizures			Joint pain or swelling		
Bleeding			Hemorrhoids			Stroke			Neck pain		
Bruising			Hepatitis			Tremors			Back pain		
Blood clots			Cirrhosis			Head injury			Trauma		
Past transfusions			Difficulty swallowing			Anxiety/ panic			Osteoporosis		
Leukemia			Jaundice			Depression			Scoliosis		
Lymphoma			Liver disease			Sleeping issues			Cramping		
HIV/ AIDS			Gallbladder problems			Weak muscles			Fractures		
Sickle cell			Pancreatitis			Loss of smell or taste			Implants, plates, pins		
ALLERGIES			Change in bowel stool			Temporary loss of vision			Hip disorder		
☐ None of below	past	current	Colon cancer			Difficulty concentrating			Knee injuries		
Seasonal			Food sensitivities			**ENDOCRINE**			Foot/ ankle pain		
Medication			Irritable bowel syn.			☐ None of below	past	current	Shoulder problems		
Food			Crohn's disease			Diabetes			Elbow/ wrist pain		
PSYCHIATRIC			Gastric reflux			Thyroid problem			Poor posture		
☐ None of below	past	current	Colitis			Sweating			Gout		
Alzheimer's			**URINARY**			Heat intolerant			**FEMALE**		
Insomnia			☐ None of below	past	current	Cold intolerant			☐ None of below	past	current
Difficulty concentrate			Painful urination			Weight loss			Painful sex		
Memory loss			Incontinence			Weight gain			Vaginal discharge		
Depression			Hesitancy			Frequent urination			Breast pain or lumps		
Anxiety			Urgency			Excessive thirst			Hot flashes		
Agitation/ Irritability			Blood in urine			Hyperthyroidism			Menstrual irregularity		
Suicidal thoughts			Kidney stones			Testosterone deficiency			Loss of libido		
Chemical dependency			Urinary infections			Cushing's syndrome			Menopause		
			Genital complaints			Steroid treatments			STD		

Please list other conditions not listed above _____

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PAYMENT POLICES

_____ **Auto Accident, Worker's Comp. or Slip and Fall**: If Chiropro Care agrees to wait for my settlement, I am responsible to (initial) make sure that Chiropro Care receives payment for services when my case is settled.

_____ Cancellation fee is $25 for a missed appointment without letting us know via phone/voicemail/email ***24 hrs before appoint-*** (initial) ***ment***. Appointment reminder service is complimentary but we urge you NOT to rely on it as technical issues can occur.

>>> ☐ Yes or ☐ No for ***Guardian of under 18 yr***: I give permission for my child to be treated when I am not present.

CONSENT TO TREATMENT

I give permission to all providers working for Chiropro Care to initiate care and provide treatment to me. This authorization does not expire and is effective as long as I am a patient.

Though rare, there are risks of complications associated with all health care procedures and treatments. These complications include but are not limited to: bruising, burns, muscle spasm, fractures, disc injuries and dislocations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Strokes have been the subject of tremendous disagreement. The occurrence of a stroke is exceedingly rare and is estimated to occur approximately once per 1 million to 5 million neck adjustments.

The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however it's your responsibility to inform the Doctor if you have a condition that would otherwise not come to the Doctor's attention.

NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of your **protected health information** (PHI). Our **Notice of Privacy Practices** details how we may use and disclose your PHI. You have the right to review our complete Notice which is located in the waiting room, front desk and our website.

By signing below you authorize our **use and disclosure of your PHI to third parties** for purposes related to treatment, payment, health care operations and those required by law. You also acknowledge that:

- **Chiropro Care** has a Notice of Privacy Practices you have had an opportunity to review.
- **Chiropro Care** may modify this Notice as needed at any time. If changes are made, they will be posted at our office.
- Certain situations may require the disclosure of patient PHI without patient authorization.
- Patient PHI may be used to contact patient as needed.
- Patient has the right to restrict the uses of his/her information.
  The Patient may revoke this authorization at any time by submitting a written request to **Chiropro Care.** The request must include name, SS#, date of birth, address, a clear statement of intent to revoke this authorization and signature. This request is not effective until received and reviewed by **Chiropro Care**.

*By signing below, I've completely read the content above and I hereby give **my consent to the treatment** and acknowledge Chiropro Care's **Notice of Privacy Practices**.*

Patient / Guardian's Name _____ Signature _____ Date _____