Chiropro Care
6840 Fort Dent Way Ste 120, Tukwila, WA 98188
(206) 466 1880

PATIENT INFORMATION

Patient Name: ____ Nickname: ____________________

Home Address: ____

City: _________________________________ State: ___________________ Zip Code: _________________

Phone Number: *Cell* (_____) ______________ *Home* (_____) ______________ *Work* (_____) ______________

Email Address: _________________________________ Date of Birth (MM/DD/YYYY): _____/_____/_____

Sex: (*circle one*) Male / Female / Other: _______________ Referred by: ____________________________

Emergency Contact Name: ________________________ Contact Phone Number: (_____) _________________

Employment Status: (*circle one*) Employed / Full-Time Student / Part-Time Student / Retired / Other: ____________

Employer: ________________________________ Type of Work: _________________________________

Relationship Status: (*circle one*) Married / Single / Widowed / Divorced / Partner / Other: ____________________

PRIMARY INSURANCE INFORMATION

**If patient is the primary insured, this section does not need to be filled out (if same as above).*

Primary Insured First Name: ___________________________ Last Name: ____________________________

Patient Relationship to Insured: (*circle one*) Spouse / Partner / Child / Other: _____________________________

Home Address: ____

City: _________________________________ State: ___________________ Zip Code: _________________

Date of Birth (MM/DD/YYYY): _____/_____/_____

Employment Status: (*circle one*) Employed / Full-Time Student / Part-Time Student / Retired / Other: ____________

Employer: ________________________________ Type of Work: _________________________________

Relationship Status: (*circle one*) Married / Single / Widowed / Divorced / Partner / Other: ____________________

Secondary Insurance? (*circle one*) Yes / No

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections 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 remittance 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 that I am personally responsible for payment. I also understand that if I suspend or terminate my health care and treatment, any fees for professional services rendered to me will be immediately due and payable.

By my/our signature(s) below, I/we accept full responsibility for payment of services provided by this office. Should my/our account become delinquent, I/we agree to also pay all costs of collection of this account including, but not limited to collection agency fees, legal costs, and attorney fees.

Patient's Signature: ____ Date: ______________________

Spouse's / Guardian's Signature: ______________________________ Date: ______________________

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Date: __________________

Information on Chiropractic Care

To our patients:

The doctors and staff of Chiropro Care welcome and want to provide you with the best possible care. We will conduct a thorough health history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will refer you to another healthcare provider.

Chiropractic examination and therapeutic procedures (including spinal adjustment, ice/heat application, Class IV laser therapy, therapeutic exercise, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of Chiroprio Care to inform patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications are available upon request.

Please initial each item below indicating agreement with the statement:

_______ I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for specific cure or result.

_______ I hereby authorize Chiropro Care Chiropractic to provide chiropractic services for me.

_______ I have read and understand the Chiropro Care Chiropractic Notice of Privacy Practices, and I consent to them.

By signing this application, I affirm under penalty that I have given true and complete information:

______________________________ ______________________________
Patient Signature Signature of Parent/Guardian (if under 18 years of age)

______________________________ ______________________________
Patient Printed Name Printed Name of Parent/Guardian (if under 18 years of age)

____
Date

********Portion Below Used If Additional Information Requested and Received********

I requested and received, in substantial detail, further explanation of the procedure or treatment. I was also given information about material risks of the procedure or treatment, and other alternative procedures or methods. I give my permission and consent to the procedure or treatment.

______________________________ ______________________________
Patient Signature Signature of Parent/Guardian (if under 18 years of age)

______________________________ ______________________________
Patient Printed Name Printed Name of Parent/Guardian (if under 18 years of age)

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Date: ___________________

Patient: ___________________________________

Subjective Complaint

Describe your complaint: ____

____

Is the complaint: [ ] Improving [ ] Worsening [ ] Same over time

Is the complaint a result of a(n): [ ] Injury [ ] Auto Accident [ ] Work-related Accident
[ ] Other: ____

When did it first happen? ____

Did you miss work? [ ] No [ ] Yes (If Yes, from ______/______/______ to ______/______/______)

What activities, if any, worsen the complaint? ____

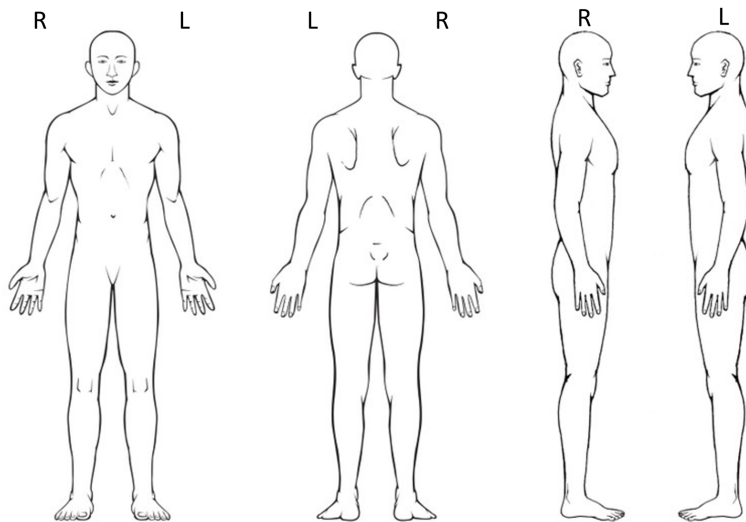
What activities, if any, can't you do because of the complaint? _____________________________

Do any treatments help? (i.e. heat, ice, supplements, over-the counter medications, prescriptions, stretches, etc.)

____

Other symptoms? (i.e. changes in bowel/bladder habits) [ ] No [ ] Yes ________________________

Please mark on the diagram below areas of discomfort, including abbreviation for type of discomfort:



KEY: Type of Discomfort
N = Numbness
P = Pins & Needles
B = Burning
A = Aching
S = Sharp & Stabbing
_ = ___________________

Are you:
Right-handed?
Left-handed?

Please indicate on the scale below the pain you feel with your current condition.
(0 = no pain, 10 = worst pain)

0 —|—|—|—|—|—|—|—|—|— 10

Current Health Status: [ ] Great [ ] Good [ ] Fair [ ] Poor [ ] Unhappy with Health

Family Health History

Do you have a blood relative with a major disease (i.e. Heart Disease, Stroke, High Blood Pressure, Cancer, Diabetes…)?

Condition:	Relationship to Patient:
______________________	______________________
______________________	______________________
______________________	______________________

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Patient: ___________________________________

Past Health History & Review of Systems

Please check any of the following conditions that you have, had or not had in your past.

Muscloskeletal

[ ] Arthritis
[ ] Joint pain
[ ] Joint swelling
[ ] Neck pain
[ ] Back pain
[ ] Trauma/ Injury
[ ] Osteoporosis
[ ] Scoliosis
[ ] Cramping
[ ] Fractures
[ ] Hip pain
[ ] Knee pain
[ ] Foot/Ankle pain
[ ] Shoulder pain
[ ] Elbow pain
[ ] Wrist pain
[ ] Other:

Cardiovascular

[ ] Chest Pain
[ ] Chest tightness
[ ] Hart attack
[ ] Shortness of breath
[ ] Palpitations
[ ] Edema (swelling) of the Feet
[ ] High blood pressure
[ ] High cholesterol
[ ] High triglycerides
[ ] Pacemaker
[ ] Other:

Neurological

[ ] Frequent Headache
[ ] Migraines
[ ] Dizziness
[ ] Fainting
[ ] Memory loss
[ ] Poor balance
[ ] Numbness
[ ] Tingling
[ ] Pins and needles
[ ] Epilepsy
[ ] Seizures
[ ] Stroke
[ ] Tremors
[ ] Head Injury
[ ] Anxiety
[ ] Panic
[ ] Depression
[ ] Sleeping issue
[ ] Weak muscles
[ ] Loss of smell
[ ] Loss of taste
[ ] Temporary loss of vision
[ ] Difficulty concentrating
[ ] Other:

Skin/ Hair

[ ] Skin trouble
[ ] Rash
[ ] Flushing
[ ] Eczema
[ ] Psoriasis
[ ] Bruise Easily
[ ] Blood in stool
[ ] Other:

Hematologic/Lymphatic

[ ] Anemia
[ ] Abnormal Bleeding
[ ] HIV/AIDs
[ ] Other:

General

[ ] Lethargy/Fatigue
[ ] Recurring Fever
[ ] Recent weight loss
[ ] Recent weight gain
[ ] Fever
[ ] Other:

List any medications currently on and reason for taking the medication:

1. ____________________ ____________________
2. ____________________ ____________________
3. ____________________ ____________________
4. ____________________ ____________________

Check the amount you have of the following:

	Light	Moderate	Heavy	None
Alcohol	[ ]	[ ]	[ ]	[ ]
Tobacco	[ ]	[ ]	[ ]	[ ]
Caffeine / Soda Pop	[ ]	[ ]	[ ]	[ ]
Fast foods / Greasy Foods	[ ]	[ ]	[ ]	[ ]
Exercise	[ ]	[ ]	[ ]	[ ]

Water: _____ glasses / day
Sleep: _____ hours / night
(on average)

Name of Medical Doctor: ______________________________

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Cancellation / No Show Policy and Optional e-Newsletter Opt-In

Patient Name: ____

Email Address: ____

Chiropro Care Cancellation/No Show Policy

I understand that Chiropro Care has a 24-hour cancellation policy. For chiropractic, a $25.00 fee will be charged for no shows or if an appointment is cancelled within 24 hours of the scheduled appointment time.

Dr. Jung's Wellness e-Newsletter

Dr. Jung sends out a Wellness e-Newsletter once or twice a month with useful wellness tips and resources, special sales on supplements, as well as exclusive deals for our patients at local businesses. We respect your privacy and will never give our data to third parties, nor would we ever spam you.

Check one box below.

☐ Yes, I want to receive Dr. Jung's Wellness e-Newsletter!

☐ No, I do not want to receive Dr. Jung's Wellness e-Newsletter.

____
Signature

____
Date