The Chiropractic Office
Jackson Highley, MA, DC • Stephen Kongs, DC • Sean Marcella, DC
1420 King St, STE D, Bellingham, WA 98229

WELCOME

PERSONAL INFORMATION

First Name:_____ **M.I.**____ **Last Name**:_____ **Preferred Name**:_____

Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Birthdate:_____/_____/_____ **Age**_____ **Gender**: □ Male □ Female □ Unspecified **SSN**:_____/_____/_____

Primary Phone:_____ **Cell Phone**:_____ **Work Phone**:_____

Home Email:_____ **Work Email**:_____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email would you like us to use to communicate with you? (check one) □ Home □ Work

Contact Method: (check one) □ Primary Phone □ Cell Phone □ Work Phone □ Home Email □ Work Email

Status: (check one) □ Single □ Married □ Divorced □ Widowed □ Separated **Children?**: □ Yes □ No How Many:_____

Occupation:_____ **Employer**:_____

Emergency Contact: (Name, Relationship, Phone #)_____

Family Physician Name:_____ **City**:_____

How were you referred to our office? □ Patient_____ □ Physician_____

□ Yellow Pages □ Internet □ Insurance □ Sign □ Other_____

Please provide insurance card(s) to receptionist.

Type of Insurance: □ Private Ins. □ Medicare □ Auto Ins. □ Worker's Comp □ Other_____

INSURANCE OR PRIVATE PAY INFORMATION

Primary Insurance Carrier:_____ **Member ID#**_____

Claim# (if applicable)_____ **Name of Policy Holder**:_____ **Relationship to Patient**:_____

Employer:_____ **Is patient covered by another insurance**? □ Yes □ No

Secondary Insurance Carrier:_____ **Member ID #:**_____

□ **Private Pay/Cash**: By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account:_____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Jackson Highley, MA, DC, Stephen W. Kongs, DC, and/or Sean Marcella, DC all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

X_____ DATE:_____

Signature of Patient, Parent or Legal Guardian (if minor)

HIPAA

I acknowledge that a copy of the patient "Notice of Privacy Practices" is available to me upon request.
In addition to the allowable disclosures described in the "Notice of Privacy Practices", I hereby specifically authorize Disclosure of my protected health care information to the Persons indicated below.

Any member of my immediate family: ❍ Yes ❍ No
Other: (please specify) ❍ Yes ❍ No _____

X_____ _____

Responsible Party Signature Today's Date

REASON FOR VISIT

What is the reason for your visit today? □ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other_____

_____

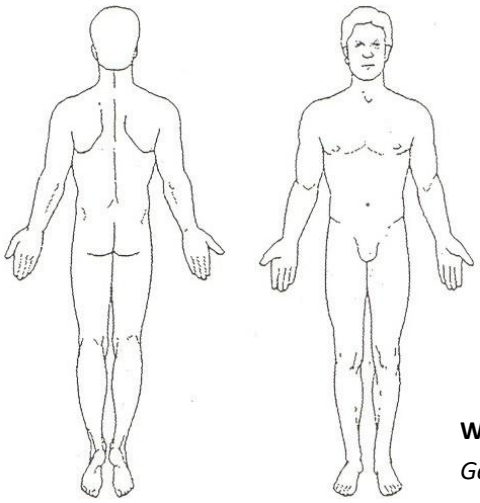
What caused this complaint(s)? _____

Is this complaint a result of a motor vehicle accident or an injury sustained at work? □ Yes □ No

Have you had any recent X-ray's or MRI's? □ Yes □ No **Describe:** _____

When did this complaint begin?_____/_____/_____**Is it getting worse?** □ Yes □ No □ **Constant** or □ **Come and go?**

What does your complaint (s) feel like? Circle all that apply*: Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*_____



←Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

On the scale below, please circle the severity of your main complaint right now:

No Pain *Moderate Pain* *Worst Possible Pain*

0	1	2	3	4	5	6	7	8	9	10

What area(s) does the pain radiate, shoot, or travel to? (if applicable)?_____

_____

What aggravates this complaint? Circle all that apply: *Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:*_____

What relieves this complaint? Circle all that apply: *Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other:*_____

How often do you experience your symptoms? □ 25% of the day □ 50% of the day □ 75% of the day □ 100% of the day

Timing of complaint: Check appropriate box: □ Morning □ As day progresses □ Afternoon □ Evening □ While sleeping

□ During activities □ After activities □ Symptoms are constant and do not change □ Other:_____

With time are your symptoms: □ Improving □ Worsening □ Not changing

Have you seen other doctors for this complaint? □ Yes □ No If "Yes", please provide the following information:

Doctor's name:_____Date consulted:_____Diagnosis_____

Is this condition interfering with your: (Circle all that apply) *Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:*_____

Is your complaint interfering with your daily activities? □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

NAME:_____DATE:_____

HEALTH HISTORY

Please check ALL of the health conditions below that apply to you currently or in the past.				Family History Mark ALL conditions that run in your family (Father,Mother,Sister,Brother)		Relationship:
□	Osteoarthritis/Degenerative Joint Disease	□	Whiplash Injury *Date of injury:*	□	Cancer *Type:*	
□	Asthma	□	Headaches	□	Anemia	
□	Diabetes □ Type I □ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? □ Yes □ No □ Not Sure	□	Joint Pain (circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle, Other:	□	Diabetes (check one) □Type I □ Type II	
□	Anemia	□	Migraines	□	Heart Problems / Stroke	
□	Cancer/Tumor	□	Osteoporosis /Osteopenia	□	High Blood Pressure	
□	Rheumatoid Arthritis	□	Epilepsy / Seizures	□	Genetic Disorders	
□	Depression/ Anxiety	□	Fibromyalgia / Chronic Fatigue	□	Rheumatoid Arthritis	
□	Disc Herniation	□	Genetic Disorders	□	Other (List):	
□	High Blood Pressure /Hypertension	□	Please list any other medical conditions:			
□	Heart Disease / Stroke					

WOMEN ONLY: **Currently Pregnant?** □ Yes □ No **Painful /Abnormal Menstrual Cycle?** □ Yes □ No **Menopause?** □ Yes □ No **Miscarriage?** □ Yes □ No **Do you have children?** □ Yes □ No If "Yes",type of birth? Circle: Vaginal or C-Section

MAJOR TRAUMAS/INJURIES (Broken Bones, Sprains, Strains (List and Date:)

_____

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past year? □ Yes □ No

List current prescription medications. If you have a list, give to front desk to copy. If there are NO current medications, check here □

Name of prescription medication	4.
1.	5.
2.	6.
3.	7.

List any known allergies you have had to prescription medications. If NO medication allergies are known, check here □

1._____ 2._____

SOCIAL HISTORY

Height Ft. In. Weight: Lbs.
Do you exercise? □ Yes □ No **Times per week?** **Intensity?** □ Light □ Moderate □ Strenuous **Type?**:
Do you currently smoke tobacco of any kind? □ Yes □ Former smoker □ Never been a smoker **If "Yes", how often do you smoke:** □ Current every day smoker □ Current sometimes smoker
Do you drink alcohol? □ Yes □ No How many drinks per week? For how many years?
Do you drink caffeine? □ Yes □ No How many drinks per day? What type? □ Coffee □ Tea □ Soft Drinks □ Energy Drinks
Do you take pain killers? □ Yes □ No **How often?** □Daily □ Weekly □ Monthly □ Rarely **What type?** □ Aspirin □ Ibuprofen □ Tylenol □ Other_____
What do your work duties include? □ Sitting □ Standing □ Light Labor □ Heavy Labor □ Other:
Please describe your overall health right now? □ Excellent □ Very Good □ Good □Fair □ Poor
What is your current stress level? □ Mild □ Moderate □ High
Have you been in a motor vehicle accident? □ Yes □ No If so, when?
Have you seen a chiropractor in the past? □ Yes □ No If so, when?

NAME:_____ DATE:_____

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment we use as Chiropractors is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- palpation
- vital signs
- range of motion testing
- orthopedic testing
- basic neurological testing
- muscle strength testing
- postural analysis
- massage therapy
- hot/cold therapy

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

1-Self-administered, over-the-counter analgesics and rest 2-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers 3-Hospitalization 4-Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE "BOX" AND SIGN BELOW:

I have read ☐ **or have had read to me** ☐ the above explanation of the chiropractic adjustment and related treatment. I certify that the information I have provided is correct to the best of my knowledge. I understand and accept that there are risks associated with Chiropractic care and give my consent to the examinations and procedures deemed necessary following my assessment.

Dated:_____ Dated:_____

_____ _____

Patient's Name (Please print) Witness' Name (Please print)

X_____ _____

Signature of Patient, Parent or Legal Guardian (if a minor) Witness' Signature