Jackson Highley, MA, DC, Dr. Lisa M. Nelsen, PLLC or Stephen W. Kongs, D.C.

PATIENT INFORMATION

Date ______________________________

Patient Name (Last, First, Initial) ______________________________

Address ______________________________

____
City State Zip

Sex: ❍ M ❍ F Birth Date ______________

Height: ______________ Weight: ______________

❍ Single ❍ Married ❍ Widowed ❍ Separated ❍ Divorced

Ages of children ______________________________

Patient SS# ______________________________

Name of Primary Care Doctor ______________________________

Occupation ______________________________

Employer ______________________________

Spouse's Name ______________________________

Spouse's Employer ______________________________

Email Address ______________________________

Whom may we thank for referring you? ______________

Is it ok to contact you at your address and/or leave you a message at the numbers provided? ❍ Y ❍ N

PHONE NUMBERS

Home ____________ Work ___________ Ext. ____

Cell ______________________________

IN CASE OF EMERGENCY, CONTACT:

Name ________________ Relationship ________

Home Phone ______________________________

Cell Phone ______________________________

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

______________________________________.

______________________________ ______________
Responsible Party Signature Date

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________ and assign directly to Dr. Highley and/or Dr. Nelsen all insurance benefits, if any, otherwise payable to me for services redeemed. I understand I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. As part of our collection practices, we reserve the right to invoke the use of a medical lien.

______________________________ ______________
Responsible Party Signature Date

ACCIDENT INFORMATION

Is condition due to an accident? ❍ Yes ❍ No Date______

Type of accident: ❍ Auto ❍ Work ❍ Home ❍ Other

PATIENT CONDITION

Reason for Visit ______________________________

When did your symptoms appear? ______________________________

Is this condition getting progressively worse? ❍ Yes ❍ No ❍ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 __________

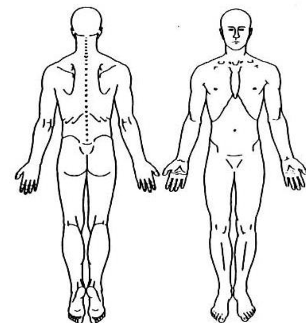
Type of pain: ❍ Sharp ❍ Dull ❍ Throbbing ❍ Numbness ❍ Aching
❍ Shooting ❍ Burning ❍ Tingling ❍ Cramps ❍ Stiffness ❍ Swelling ❍ Other

How often do you have this pain? ________________

Is it constant or intermittent? ________________

Does it interfere with your ❍ Work ❍ Sleep ❍ Daily routine ❍ Recreation

Mark an X on the picture where you continue to have pain, numbness or tingling



Jackson Highley, MA, DC, Dr. Lisa M. Nelsen, PLLC or Stephen W. Kongs, D.C.

Activities or movements that are painful to perform ❍ Sitting ❍ Standing ❍ Walking ❍ Bending ❍ Lying Down

HEALTH HISTORY

What treatment(s) have you already received for your condition? ❍ Medication ❍ Surgery ❍ Physical Therapy

❍ Chiropractic ❍ None ❍ Other ____________________

Name of the above Doctor, Therapist or facility where you treated for your condition ____________________

Date of Last: Physical Exam ____________ X-ray ____________ Blood Test ____________

MRI, CT-Scan or Bone Scan ____________________

Place a mark on "Yes" or "No" to indicate if you have ever had any of the following then circle ones you have had in the last six months:

Musculo Skeletal
- Low Back Pain ❍ Y ❍ N
- Neck Pain ❍ Y ❍ N
- Arm Pain ❍ Y ❍ N
- Joint Pain ❍ Y ❍ N
- Joint Stiffness ❍ Y ❍ N
- Walking Problems ❍ Y ❍ N
- Difficulty Chewing ❍ Y ❍ N
- Clicking Jaw ❍ Y ❍ N
- General Stiffness ❍ Y ❍ N

Cardio-Vascular
- Chest Pain ❍ Y ❍ N
- Short Breath ❍ Y ❍ N
- Blood Pressure Problems ❍ Y ❍ N
- Heart Problems ❍ Y ❍ N
- Lung Problems/ Congestion ❍ Y ❍ N
- Vericose Veins ❍ Y ❍ N

Ear, Nose Throat
- Vision Problems ❍ Y ❍ N
- Ear Aches ❍ Y ❍ N
- Hearing Difficulty ❍ Y ❍ N
- Stuffed Nose ❍ Y ❍ N

Nervous System
- Nervousness ❍ Y ❍ N
- Numbness ❍ Y ❍ N
- Dizziness ❍ Y ❍ N
- Forgetfulness ❍ Y ❍ N
- Confusion/ Depression ❍ Y ❍ N
- Fainting ❍ Y ❍ N
- Convulsions ❍ Y ❍ N
- Cold/Tingling Extremities ❍ Y ❍ N

Male/Female
- Menstrual Irreg. ❍ Y ❍ N
- Menstrual Cramps ❍ Y ❍ N

Male/Female Continued
- Vaginal Pain ❍ Y ❍ N
- Breast Pain ❍ Y ❍ N
- Prostate ❍ Y ❍ N
- Other Problems ❍ Y ❍ N

Genito-Urinary
- Bladder Trouble ❍ Y ❍ N
- Painful/Excessive Urination ❍ Y ❍ N

Gastro-intestinal
- Poor/Excessive Appetite ❍ Y ❍ N
- Frequent Nausea ❍ Y ❍ N
- Vomiting ❍ Y ❍ N
- Diarrhea ❍ Y ❍ N
- Constipation ❍ Y ❍ N
- Hemorrhoids ❍ Y ❍ N
- Liver Problems ❍ Y ❍ N
- Gall Bladder Prob ❍ Y ❍ N

Gastro-intestinal Continued
- Weight Trouble ❍ Y ❍ N
- Abdominal Cramps ❍ Y ❍ N
- Gas/Bloating after Meals ❍ Y ❍ N
- Heartburn ❍ Y ❍ N

General
- Fatigue ❍ Y ❍ N
- Allergies ❍ Y ❍ N
- Loss of Sleep ❍ Y ❍ N
- Fever ❍ Y ❍ N
- Headaches ❍ Y ❍ N
- HIV+/Aids ❍ Y ❍ N
- Diabetes ❍ Y ❍ N

Allergies

____

Other ____________________

____

Exercise
- ❍ None
- ❍ Moderate
- ❍ Daily
- ❍ Heavy

Work Activity
- ❍ Sitting
- ❍ Standing
- ❍ Light Labor
- ❍ Heavy Labor

Habits
- ❍ Smoking
- ❍ Alcohol
- ❍ Coffee/Caffeine Drinks
- ❍ High Stress Level

Vitamins
- ❍ Calcium
- ❍ Glucosamine Sulfate
- ❍ ____________________

Are you pregnant? ❍ No ❍ Yes Due Date ____________________

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Cancers		
Surgeries		

Medications *(if you have a list, give to front desk to make copy)*

____________ ____________ ____________

____________ ____________ ____________

JACKSON HIGHLEY, M.A., D.C.
DR. LISA M. NELSEN, P.L.L.C.
STEPHEN W. KONGS, D.C.
2029 James Street, Bellingham, WA 98225
Phone: (360) 676-4488 ♦ Fax: (360) 647-5587

Authorization for Release of Information

X-Rays Records Other ____________________________________

This will authorize you to give to Jackson Highley, M.A., D.C. Lisa M. Nelsen, D.C., Stephen W. Kongs D.C. and/or their representative located at 2029 James Street, Bellingham, WA 98225, (360) 676-4488, all information you may have regarding my condition when under your observation or treatment, including history, findings, x-ray findings and diagnosis, and subsequent or future developments.

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV/AIDS, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested diagnosed, or treated for HIV/AIDS, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

A duplicate of this authorization shall be considered an original. This authorization shall expire in ninety days from date indicated below.

Patient Signature ____ Date ________________________

Patient Printed Name ____ Date of Birth __________________

Witness Signature ____ Date ________________________

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Informed Consent to Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care (occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments) may be a vertebral artery injury that could lead to a stroke.

Prior to receiving chiropractic care, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.
I understand and accept that there are risks associated with Chiropractic care and give my consent to the examinations deemed necessary, and to the Chiropractic care including spinal adjustments, as reported following my assessment. My name and other personal or identifying information will be kept confidential.

______________________________	______________________________
Patient Name or Guardian (printed)	**Relationship to patient**
______________________________	______________________________
Patient Signature or legal Guardian Signature	**Date of Birth**
______________________________	
Date	
______________________________	______________________________
Witness Signature	**Date**