PERSONAL INFORMATION

Patient Name:_________________________________ Home Phone:____________
Address:_____________________________________ Work Phone:____________
City / State / Zip:_______________________________ Cell Phone:_____________
Birth Date:______ Age:_____ Height:_____ Weight:_____ SSN:__________________
E-Mail_________________________________@______________________
Occupation:___________________________________ Employer:_____________
Spouse's Name:________________________________ Phone:________________
Emergency Contact:_____________________________ Phone:________________
Who is your Primary Care Physician?_______________________________________
May we send him / her a report concerning this appointment? ____Yes ____No
Who referred you to our office?____
Race: ____Caucasian ____American Indian / Alaska Native ____African American
____Asian ____Pacific Islander ____Other ____I Decline to Answer
Ethnicity: ____Hispanic / Latino ____Not Hispanic / Latino ____I Decline to Answer
Preferred Language:_________________
Smoking Status: ___Every Day ___Occasional Smoker ___Former Smoker ___Never

HEALTH HISTORY

Purpose of this appointment:____
Symptoms are worse in the: ___AM ___Afternoon ___PM ___Do not change with time of day
Major Surgery: ___Back Surgery ___Hernia ___Gall Bladder ___Heart ___Other:_____
Major Accidents / Falls:____
Previous Chiropractic Care? ___No ___Yes Approx. Date of Last Treatment:________

Current Medication Name	Dosage and Frequency (i.e. 5mg once a day)

Medication Allergies	Reaction	Onset Date

Would you like clinical summaries e-mailed after every visit? ___Yes ___No
(These summaries are often blank as a result of the nature and frequency of chiropractic care).

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Polio
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid Disorders
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Pleurisy

Have you been tested HIV positive? ____Yes ____No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain / Stiffness
- ☐ Walking Problems
- ☐ Jaw Pain / TMJ

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Fainting
- ☐ Cold / Tingling Extremities

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful Urination
- ☐ Excessive Urination
- ☐ Discolored Urine

EENT

- ☐ Recent Vision Changes
- ☐ Recent Dental Changes
- ☐ Hearing Difficulty

GASTRO-INTESTINAL

- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Abdominal Cramps
- ☐ Colitis
- ☐ Black / Bloody Stool
- ☐ Heartburn
- ☐ Gas / Bloating

CARDIO-VASCULAR

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

MALE / FEMALE

- ☐ Menstrual Irregularity
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

GENERAL

- ☐ Fatigue
- ☐ Allergies
- ☐ Headaches
- ☐ Other:____________________

____

____

FEMALES ONLY:

Are you pregnant? ____Yes ____No ____Not Sure

Date of your last menstrual cycle:________________

PAIN SCALE:

Using the scale of 0 - 10, with 0 = no pain and 10 = worst pain possible, please write the number indicating your present pain level in the box below:

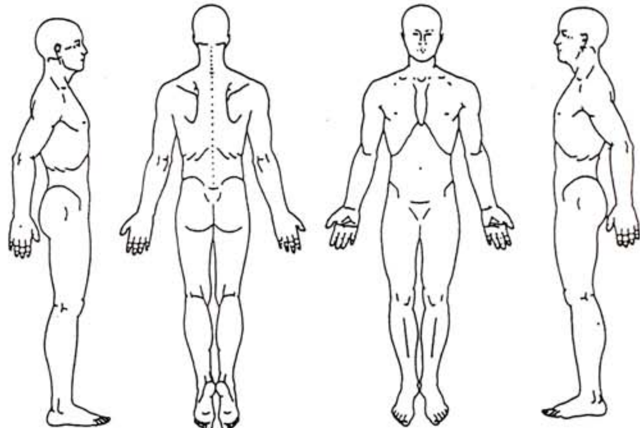
☐

PAIN BODY DIAGRAM:

Please use the following indicators to accurately mark the areas of your complaints on the diagram below:

Dull Pain: X X Numbness: = =

Stabbing Pain: /// /// Tingling (Pins & Needles): ::: :::



FINANCIAL POLICY

It is our office policy that all services rendered are charged directly to you the patient, and that you are ultimately responsible for all payments, regardless of whether or not this office accepts insurance assignments.

1. Deductibles and co-payments are expected at the time of service. Patient balances may not exceed $200.00 at any time, or professional care may be terminated unless other arrangements have been made.
2. This office does not guarantee that an insurance company will pay for the usual and customary charges of this office, nor will this office enter into any dispute with an insurance company over reimbursement. Ultimately the patient is responsible for his or her bill.
3. Should you discontinue care for any reason other than discharge by the doctor, any and all balances will become immediately due and payable in full by you, regardless of any insurance claims submitted.
4. Delinquent accounts will be subject to a 15% annual interest rate. A $25.00 service charge and a $10.00 collection fee will be added to any and all accounts placed in collections.

INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND TREATMENT

I herby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by Kevin Marsh, D.C.

I understand the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and strains / sprains. I do not expect the doctor to be able to anticipate and explain all of the risks and complications, and wish to rely on the doctor to exercise judgement during the course of the procedures which the doctor feels at the time, based upon the facts known, is in my best interest.

I have read, or have had read to me, the above financial policy and consent. I have also had the opportunity to ask questions about their content. By signing below, I agree to the above named policies and procedures. I intend this form to cover the entire course of treatment for my present condition, as well as for future conditions for which I seek treatment.

HEALTH INFORMATION PRIVACY

I understand that upon my request, Hayden Lake Chiropractic, P.A. must give me a notice that tells me how they may use and share my health information, and how I can exercise my health privacy rights.

____________________	____________________
Print Patient's Name	Print Name of Guardian
____________________	____________________
Signature of Patient	Signature of Guardian
____________________	____________________
Date Signed	Relationship