DATE:	I.D. NO.

Confidential Patient Health Record

PERSONAL HISTORY

Name: ______________________ Phone: ______________________

Address: ______________________ City: ______________________

State: ________ Zip: ________ Email: ______________________

Birthdate: ________ Age: ______ Sex: □ M □ F Marital Status: Sing □ Mar □ Wid □ Div □ Sep □

Business/Employer: ____________ Type of Work: ______________________

Business Phone: __________ Name of Spouse: ____________ No. of Children: ___

Spouse's Employer: ________________Type of Work: ________________

Name and Number of Emergency Contact: ____________ Relationship: ____________

Referred To This Office By: ______________________________

How Will You Be Paying For Today's Visit: □ Cash □ Check □ Credit Card □ Insurance

CURRENT HEALTH CONDITION

Purpose of This Appointment: ______________________________

Other Doctors Seen For This Condition: □ Yes □ No Who? ______________________

Did You Have X-Rays Or Other Imaging □ Yes □ No Where: ______________________

Type of Treatment: ______________ Results: ______________

When Did This Condition Begin? ______________ Has This Condition Occurred Before? □ Yes □ No

Is Condition: □ Job Related □ Auto Related □ Home Injury □ Fall □ Other ____________

Date of Accident: ______________ Time of Accident: ______________

Have You Made A Report Of Your Accident To Your Employer:□ Yes □ No

Drugs You Now Take: □ Nerve Pills □ Pain Killers/Muscle Relaxers □ Blood Pressure Medicine

□ Insulin □ Other: ______________________________

List Other Medical Conditions Other Than That Which You Are Now Consulting Us? ____________

____

PAST HISTORY

Please Check or Describe:

Major Surgery/Operations: □ ______________________________

□ Broken Bones □ Joint Replacement □ Other: ______________________

Major Accidents Or Falls: ______________________________

____

Health Related Issues: ______________________________

Hospitalization (Other Than Above): ______________________________

____

Previous Chiropractic Care: □ No □ Yes: Approximate Date of Last Visit: ______________

Doctor's Name :______________________________

1. Patient Health Questionnaire - PHQ

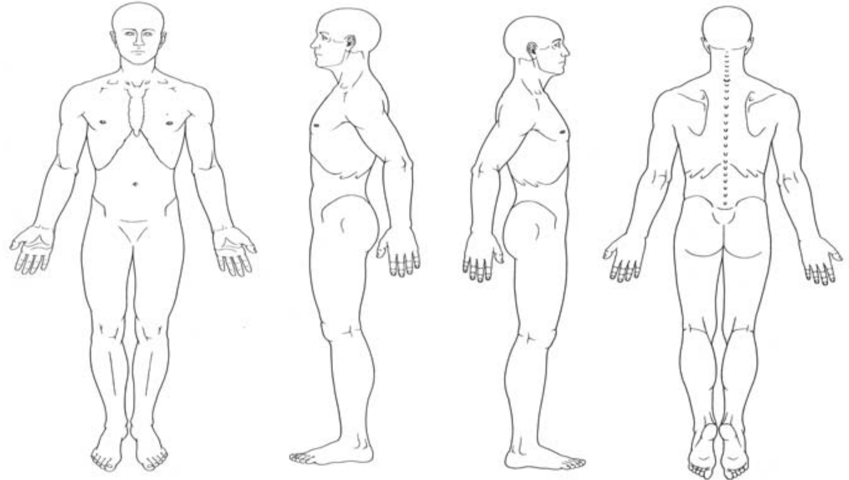
1. Describe your symptoms ____

____

a. When did your symptoms start? ____

b. How did your symptoms begin? ____

Draw where you have pain or other symptoms



2. How often do you experience your symptoms?
① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?
① Sharp
② Dull ache
③ Numb
④ Shooting
⑤ Burning
⑥ Tingling

4. How are your symptoms changing?
① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

None ... *Unbearable*

a. Indicate the average intensity of your symptoms ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

b. How much has pain interfered with your normal work (including both work outside the home, and housework)
① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)
① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...
① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms? ① No One ① Medical Doctor ① Other
① Other Chiropractor ① Physical Therapist

a. What treatment did you receive and when? ______________________________

b. What tests have you had for your symptoms and when were they performed? X-rays *date:* ______________ CT Scan *date:* ____________
MRI *date:* ________________ Other *date:* ______________

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see? ① This Office ② Medical Doctor ③ Other
④ Other Chiropractor ⑤ Physical Therapist

10. What is your occupation? ① Professional/Executive ② Laborer ③ Retired
④ White Collar/Secretarial ⑤ Homemaker ⑥ Other
⑦ Tradesperson ⑧ Full Time Student

a. *If you are not retired, a homemaker, or a Student, what is your current work status?* ① Full-time ② Self-employed ③ Off work
④ Part-time ⑤ Unemployed ⑥ Other

List all Medications, Vitamins & Supplements you are currently taking: ______________________________

____

____

Patient Signature: ____ ***Date:*** ______________________

TUKWILA FAMILY CHIROPRACTIC
15125 62nd Ave S Tukwila, WA 98188

Posted Fee Schedule

A 30% discount is provided from our Posted Fee Schedule for all services paid for *at the time of service*.

Service	Fee
Consultation with Doctor	No Charge
Examination w/Review of History/ With Injury Evaluation:	$128/$178
Medical Evaluation Management/ Re-examination:	$28/$69
Chiropractic Adjustment 1-2 regions/Full Spine:	$48/$68
Chiropractic Adjustment of Extremity Primary Service/Combined:	$48/$24
Myofascial Release by hand or instrument:	$33/unit
Extended Office Visit:	$45/15 min.
After Hours Office Visit:	$55

Our experience has shown that it is wise to have an understanding with our clients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your Chiropractic care at our office and if you are accepted for care, you may choose the plan that you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being and we will do our best to help you.

IMPORTANT: ALL PATIENTS, WITH OR WITHOUT INSURANCE, ARE RESPONSIBLE FOR FULL PAYMENT OF THE FIRST VISIT (UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE).

INSURANCE: Please let the office know if you have insurance or have been in some type of accident or if you have been hurt on the job. This will enable them to give you any and all information necessary for us to serve you completely and accurately. Some insurance companies require pre-authorization for care and if insurance is not verified in advance the office may be unaware of such policies. If you do not provide insurance information before evaluation or care you may be responsible for any balance your insurance denies.

AGREEMENT: My signature below signifies my agreement to payment in full on a cash basis if I have no insurance, or if I have not provided TUKWILA FAMILY CHIROPRACTIC with all necessary documents and information prior to my visit.

I have read and agree to the above fee statement.

______________________________ ______________________________
Patient's Signature Witness

____
Date

Consent to use Personal Health Information for Purposes of Treatment Payment & Healthcare Procedures (per HIPPA)

I consent to the use or disclosure of my protected health information by Tukwila Family Chiropractic for the purpose of analyzing and providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis and treatment of me by Tukwila Family Chiropractic may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. If Tukwila Family Chiropractic agrees to a restriction that I request, the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that Tukwila Family Chiropractic has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the ***Notice of Privacy Practices*** of Tukwila Family Chiropractic and understand that I have a right to read the ***Notice of Privacy Practices*** prior to signing this document. The ***Notice of Privacy Practices*** describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Tukwila Family Chiropractic. The Notice of Privacy Practices for Tukwila Family Chiropractic is also posted in the office. This Notice of Privacy Practices also describes my rights and duties and those of Tukwila Family Chiropractic with respect to my protected health information.

Tukwila Family Chiropractic reserves the right to change the privacy practices that are described in the ***Notice of Privacy Practices*** at any time. I may obtain a revised ***Notice of Privacy Practices*** by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

______
Initial

Terms of Acceptance

When a person seeks chiropractic care and when a chiropractor accepts a person for care, it is essential that they both be seeking the same goals. It is not the goal or intention of this office to treat or cure any physical, mental or emotional medical condition or to medically diagnose or give advise about any medical ailments. We will report symptoms and diagnosis codes to insurance companies to communicate your condition as is required by insurance carriers to document need for care. We maintain up-to-date records of any illness, surgeries, accidents or other injuries for safety reasons only, not for diagnosis or treatment of any injury or sickness. It is the responsibility of the individual to continuously supply the necessary information to keep these records current. Our only goal and intention is to keep the body as free from vertebral subluxations as we can. We do this because of our absolute conviction that every human being functions better, including self healing and self regulation, on all levels when no subluxations or interference is present. We do not do it as a treatment for any ailments. We do it for the promotion of health.

______________________________	______________________________	__________
Signature of Patient or Representative	Printed Name of Patient	Date