Intro to the Office

Let me extend a warm and personal welcome to you on behalf of the staff and myself. We want to provide you with the finest health care and we'll offer you many informative and entertaining educational opportunities.

WHY?

First, you'll want to make informed decisions regarding your health. During the course of your care you'll be presented with several choices that affect your ability to reach your individual health objectives.

Secondly, this information will be useful in making decisions about your health for the rest of your life.

To begin this process, here are a few important terms and procedures as you begin care:

FIRST VISIT

On your first visit we will gather information about you through our examinations and consultations. There will be someone here to assist you in each step along the way. If you're not sure about what we need, just ask. Nothing will be done without your consent and full understanding.

PATIENT EDUCATION

We will be giving you information and clinical data in the form of literature, personal and media presentations. These are designed to help you understand your own case and the procedures you'll experience in this office. Everything is brief and to the point. It is recommended that you read the material and keep it together for reference during the course of your care.

CHIROPRACTIC EDUCATION

Just as we need to know about you, you should know about us. Chiropractic education currently consists of four years of pre-Chiropractic college education in the biological sciences, followed by another four

years of Chiropractic education and clinical internship. Then we are required to attend many hours of post-graduate education each year for license renewal. On top of this, our office is frequently involved in various seminars to keep abreast of the latest information.

PAPERWORK & FORMS

We have minimized paperwork in our office. However, there are clinical forms that must be filled out accurately for your health, legal and professional reasons. We ask that you read a form through before completing it so you understand its intent. If you have questions, please ask.

HEALTH ATTITUDES

Your attitude about your health is as important to us as the specific reason you've consulted our office. Below are four prevalent health attitudes. **Please mark** the one that most closely reflects your personal values.

- **Treatment Only**. I only consult a doctor when I have an ache or pain and discontinue care as soon as it has cleared up.
- **Prevention.** In addition to symptom treatment, I consult specialists occasionally to prevent problems from recurring.
- **Maintaining Health.** I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.
- **Family Health**. I take an active part in assisting, informing, and maintaining health with my family. I'm concerned with the long-term affects of good health for them.

Thank you. And again, we look forward to a healthy relationship with you.

Personal Information **Date** _____

Name_____ **SS#:**_____ **Address** _____

City _____ **State** _____ **Zip** _____ **Date of Birth** _____

Phone: (Home)_____ (Work)_____ **Occupation and Employer** _____

Referred by_____ **Marital Status: S M D W**

Spouses Name _____ **Spouses Occupation**_____

Location of Collision_____ **Date of Onset/Collision**_____

Responsible Insurance Company

Name_____ **Address**_____

City_____ **State**_____ **Zip**_____ **Phone #**_____

Adjuster_____ **Claim #**_____ **Fax #**_____

Please mark areas of pain resulting from this collision on figures below. Use shapes from the legend to describe what type of pain you are experiencing.

Pain Legend

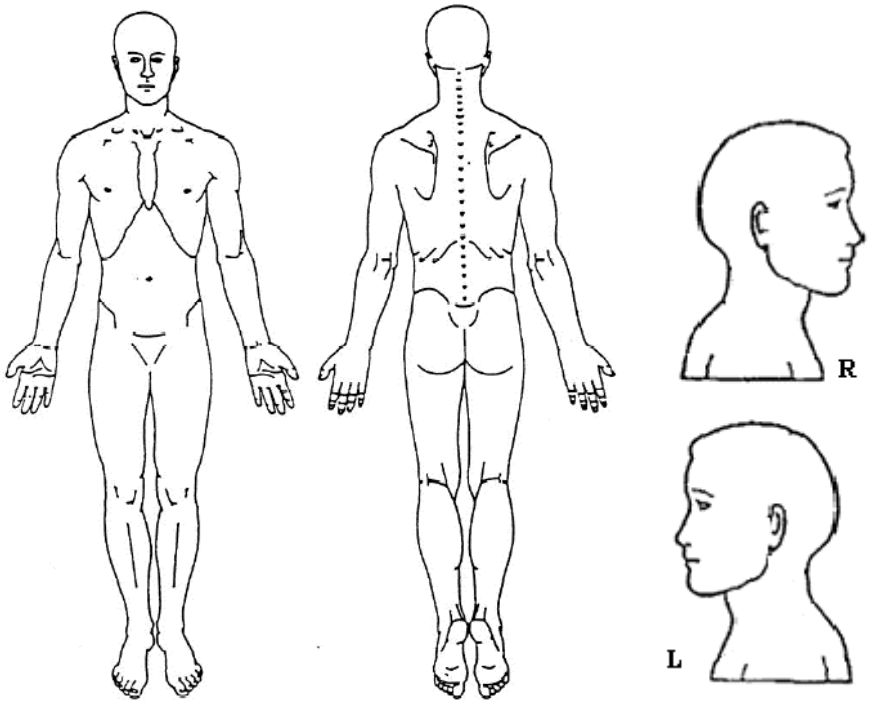
X = sharp

○ = dull/achy

□ = throbbing

Δ = burning

SS = muscle spasm



Is the pain getting worse_____ staying the same_____ or improving_____?

Is the pain occasional_____ frequent_____ or constant_____?

What makes the pain better?_____

What makes the pain worse?_____

PAIN SCALE (please mark on the line where you feel your level of pain is at)

No Pain Severe Pain

Name _____ **Date** _____

Describe the Collision/Injury (if auto accident, please include specifics):

_____

_____

Car was hit: [ ] In front [ ] Rear end [ ] On Side

Specifics of Collision/Injury (Mark each that applies):

Job or Work Related injury ( ) Yes ( ) No
Your were the [ ] Driver [ ] Passenger [ ] N/A
Sitting [ ] Front seat [ ] Back seat

Aware of Impact: [ ] Braced [ ] Not braced
Head Did: [ ] Strike Object [ ] Not strike Object
Did you experience: [ ] Shock
[ ] Flash of Light Seen Upon Impact
[ ] Air bag Deployed

Immediately Following the Collision/Injury

[ ] Ambulance – Paramedics Called
[ ] Treated at Scene
[ ] Transported to Hospital by Ambulance
[ ] Went to Hospital on your own
[ ] Diagnostics Performed at Hospital
[ ] Medication Prescribed
[ ] Treatment at Hospital
[ ] Follow-up Recommended

Time Loss

[ ] NO time loss from work due to injury. I am currently working with No limitations.
[ ] NO time loss form work due to injury BUT I do have limitations*.
[ ] I have experienced time loss from work due to injury (Indicate number of days, weeks, etc.).
[ ] N/A

*Describe limitations due to collision/injury:_____

_____

Mechanism of Injury (Skip this section if this incident was not involved in a motor vehicle)

Were you surprised by the impact? __Yes __No

In relation to the back of your head, was your headrest set: __Low __Middle __High __None

Where was your head facing at the time of impact? __Left __Forward __Right __Unknown

Were you leaning forward at the time of impact or out of position? __Yes __No

Were you wearing a seatbelt/harness? __Yes __No

Were you rendered unconscious as a result of the collision? __Yes __No

Did you feel pain immediately after the collision? __Yes __No

Year and type of vehicle were you in? _____

Size of your vehicle? __Small __Mid __Large __Unknown

Year and type of other vehicle involved in the collision? _____

Size of other vehicle? __Small __Mid __Large __Unknown

What was the approximate speed of your vehicle when the collision occurred? _____

What was the approximate speed of the other vehicle when the collision occurred? _____

Did you have any bruises or cuts as a result of the collision (Yes/No)? Where?_____

Was your foot on the brake at impact? Yes / No

Social History

[ ] Single
[ ] Married
[ ] Divorced
Number of Children: _____

[ ] Smoker
[ ] Non-Smoker
[ ] Drink Alcohol
[ ] Do not drink Alcohol
[ ] Take Drugs
[ ] Do not take Drugs

Are any activities limited by pain or have you noticed pain while doing these that you didn't have before the collision?
[ ] Work
[ ] Household chores
[ ] Intimate life
[ ] Exercise

List your Hobbies & Exercise Activities (do these make your pain worse? Yes/No)

_____

Occupational History of (name) _____

Your Employer _____

Job Title _____

What is your current job satisfaction:
[ ] Very Satisfied
[ ] Satisfied
[ ] Dissatisfied
[ ] Very Dissatisfied

Are your Job Duties Physically demanding for you? [ ] Yes [ ] No
Have you had any disability time? [ ] Yes [ ] No
If you are currently working which are you performing?
[ ] Regular Duties
[ ] Limited – Light Duties

Your highest level of education attained? (years) _____

Medical History

I have seen the following physician/practitioners for this condition:
Chiropractor (Name): _____
Massage Therapist: _____
Neurologist: _____
Orthopedist: _____
Physical Therapist: _____
Physician: _____
Psychiatrist/Psychologist: _____
Other: _____
Have you ever received Chiropractic Care? Yes No

List the treatments you have had done for this condition.
[ ] Ice
[ ] Heat/Ultrasound
[ ] Electrical Stimulation
[ ] Exercises
[ ] Gravity Inversion – Traction
[ ] Bed Rest
[ ] Chiropractic
[ ] Osteopathy
[ ] Injections
[ ] Acupuncture
[ ] Naturopathy
[ ] Massage

List any previous problems with area of complaint (and when)

_____

Were you receiving treatment for these areas at the time of accident? Yes / No

Any new symptoms to these areas since the collision? Yes / No

Since the collision, do you feel you are troubled with:
[ ] Anxiety
[ ] depression
[ ] irritability

Current medications I am taking:
_____
_____

Past Surgeries:
_____
_____
_____
_____

Past Hospitalizations:
_____
_____

Doctors seen prior to accident:
_____
_____
_____

List the types of Diagnostic Testing that has been done for this condition:
[ ] X-rays [ ] Discogram [ ] CT Scan [ ] Bone Scan
[ ] Myelogram [ ] EMG [ ] MRI

Females – Mark if have the following:
[ ] Vaginal bleeding other than period
[ ] Back pain with menstrual periods
[ ] Pap smear within last two years
[ ] Other menstrual problems
[ ] Painful menstrual periods
[ ] Current Pregnancy

Mark if you have had any of the following symptoms in the past 5 years:
[ ] Unexplained fevers
[ ] Stomach pain
[ ] Loss of appetite
[ ] Excessive constipation
[ ] Difficulty sleeping
[ ] Pain-burning when urinating
[ ] Easy bruising
[ ] Need to urinate more at night
[ ] Chest pain or tightness
[ ] Muscle tenderness
[ ] Trouble breathing lying flat
[ ] Coughing up blood
[ ] Swollen ankles
[ ] Weight loss of 10 lbs or more
[ ] Persistent diarrhea
[ ] Problems with depression
[ ] Blood in stools
[ ] Unusual stress at home
[ ] Blood in urine
[ ] Lumps in neck, armpit or groin
[ ] Persistent eye redness
[ ] Trouble breathing with exercise
[ ] Skin rashes
[ ] Joint pain or swelling
[ ] Night sweats
[ ] Change in bowel habits
[ ] Excessive fatigue
[ ] Dark black stools
[ ] Unusual stress at work
[ ] Difficulty urinating – start / stop
[ ] Excessive bleeding
[ ] Morning stiffness
[ ] Persistent or unusual cough
[ ] Dry eyes or mouth

AUTHORIZATION, ASSIGNMENT, & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the names(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorized you to compromise, settle otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect form insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Washington
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization for Assignment will be in continual effect until revoked by both parties.

_____ _____
Date Patient/Insured Signature

RECORDS RELEASE

To _____, I hereby authorize you to release to Camp Chiropractic Center, Inc. any information including the diagnosis and records of treatment or examination rendered to me for all care during the period from _____ to _____.

_____ _____
Date Patient/Insured Signature

_____ _____
Date Staff Signature

Camp Chiropractic Center, Inc.

Privacy Practice Notice

As required by HIPPA, this notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

- Camp Chiropractic Center may be required to share your information with you insurer to obtain payment for services on your behalf. As part of our financial policy you authorize this office to do so when necessary.
- Employees of Camp Chiropractic Center will have access to your records and may need to review them as part of their job duties. They are bound by the same doctor patient relationship and HIPPA regulations.
- Information may be shared with other health care providers that are directly involved with your care upon your written authorization.
- From time to time, Camp Chiropractic Center may utilize your personal information such as mailing address and phone number to contact you regarding your care, such as appointment reminders, to discuss treatment or alternatives or to inform you of a promotional event.

Patient Rights

- You may request restrictions on certain uses and disclosures of the protected information.
- You may revoke any prior written authorization to release records at any time.
- You have the right to receive confidential communication of protected health information.
- You have the right to inspect and copy protected health information from our office, including medical records.
- You have the right to amend protected information.
- You have the right to an accounting of disclosures of protected health information.

(Original information will not be permitted to leave the office for copying purposes. You may bring in a copying serve or Camp Chiropractic Center will provide a copy for a standard fee allowed by law. If you wish to review your file or have it copied, you will need to pre-arrange a convenient time for our staff so to accommodate you.)

Camp Chiropractic reserves the right to change its privacy policy. You will be notified prior to a changed disclosure only when it applies to you.

I, _____, have read and understand the above privacy practice notice.

_____ _____

Signature Date

Notes:

Goals for Care

In our office, we want to know what you expect from your care with us. What kind of things would you like to do that you are currently unable to. Please write out your short term and long term goals you would like to achieve with chiropractic care.

Short Term Health Goals

_____

_____

_____

_____

Long Term Health Goals

_____

_____

_____

_____

"An unmanned sailboat simply drifts about with the wind, but a sailboat with a goal gets to where it's going, although not in a straight line."