# 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 effects of good health for them.

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

# Case History

Name ______________________________________________________________ Date ______________________
Address _____________________________________ City __________________ State _____ Zip ______________
H. Phone (____) _________________ W. Phone (____) _________________ Date of Birth ______________ Age ________
Referred By ____________________________________ Social Security # __________________________________
Occupation ____________________________________ Employer _______________________________________
Marital Status S M D W Spouses Name _______________________________________
Spouses Occupation ______________________________ Number of Children & Ages __________________________
Have you ever received Chiropractic Care? Yes No If yes, when was your last adjustment? ______________

## About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that result in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

## Loss of Health

Throughout life spinal injuries can accumulate which weaken the support system and decrease the strength of your spine.

| Yes | No | | Patient Comment If answer is Yes. | Chiropractor's Comments |
|---|---|---|---|---|
| | | 1. Birth Process | | |
| ☐ | ☐ | Was the delivery long? | ____________________ | ____________________ |
| ☐ | ☐ | Was the delivery difficult? | ____________________ | ____________________ |
| ☐ | ☐ | Forceps? | ____________________ | ____________________ |
| ☐ | ☐ | Caesarean? | ____________________ | ____________________ |
| ☐ | ☐ | Breach/cephalic? | ____________________ | ____________________ |
| ☐ | ☐ | Home birth? | ____________________ | ____________________ |
| ☐ | ☐ | Hospital birth? | ____________________ | ____________________ |
| ☐ | ☐ | Mother given drugs? | ____________________ | ____________________ |
| ☐ | ☐ | Was labor induced? | ____________________ | ____________________ |
| | | 2. Growth and Development | | |
| ☐ | ☐ | Were you taught how to care for your spine? | ________________ | ____________________ |
| ☐ | ☐ | Did you fall out of bed? | ____________________ | ____________________ |
| ☐ | ☐ | Were you a headbanger or rocker? | ____________________ | ____________________ |
| ☐ | ☐ | Childhood sicknesses? | ____________________ | ____________________ |
| ☐ | ☐ | Accidents? | ____________________ | ____________________ |
| ☐ | ☐ | Surgery? | ____________________ | ____________________ |
| ☐ | ☐ | Drugs? | ____________________ | ____________________ |
| ☐ | ☐ | Did you fall while learning to walk? | ____________________ | ____________________ |
| ☐ | ☐ | Were you picked on by siblings? | ____________________ | ____________________ |
| ☐ | ☐ | Child Abuse | ____________________ | ____________________ |
| ☐ | ☐ | Spanking (how)? | ____________________ | ____________________ |
| ☐ | ☐ | Pulled ear/chin | ____________________ | ____________________ |
| ☐ | ☐ | Other | ____________________ | ____________________ |
| ☐ | ☐ | Chair pulled out when sat down? | ____________________ | ____________________ |
| ☐ | ☐ | Did you fall down stairs? | ____________________ | ____________________ |
| ☐ | ☐ | Were you yanked by your arm? | ____________________ | ____________________ |
| ☐ | ☐ | Did you have other traumas? | ____________________ | ____________________ |
| | | What? When? | ____________________ | ____________________ |

| Yes | No | 3. Current Health Habits | | |
|---|---|---|---|---|
| ☐ | ☐ | Did/do you smoke? | ____________ | ____________ |
| ☐ | ☐ | Did/do you drink any alcohol? | ____________ | ____________ |
| ☐ | ☐ | Diet (Do you eat healthy foods)? | ____________ | ____________ |
| ☐ | ☐ | Any accidents? When? | ____________ | ____________ |
| ☐ | ☐ | Have you had surgery? When? | ____________ | ____________ |
| ☐ | ☐ | Any organs removed or replaced? | ____________ | ____________ |
| ☐ | ☐ | Drugs (prescriptive or non)? | ____________ | ____________ |
| ☐ | ☐ | Teeth problems? | ____________ | ____________ |
| ☐ | ☐ | Eye problems? | ____________ | ____________ |
| ☐ | ☐ | Hearing problems? | ____________ | ____________ |
| ☐ | ☐ | Exercise regularly? | ____________ | ____________ |
| ☐ | ☐ | Sleeping habits (nightmares?) | ____________ | ____________ |
| ☐ | ☐ | Did/do you have occupational stress? | ____________ | ____________ |
| ☐ | ☐ | Physical stress? | ____________ | ____________ |
| ☐ | ☐ | Mental stress? | ____________ | ____________ |
| ☐ | ☐ | Hobbies/Sports injuries? | ____________ | ____________ |
| ☐ | ☐ | Sleeping posture ☐ side ☐ stomach ☐ back | ____________ | ____________ |

## Symptoms and Ill Health (Present State of Ill Health)

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present Complaint (be brief)

Major ____________________________________________

Pain or Problem started on ____________________________________________

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

What activities aggravate your condition/pain? ____________________________________________

What activities lessen your condition/pain? ____________________________________________

Is condition worse during certain times of the day? ____________________________________________

Is this condition interfering with work? ____________ Sleep? _______ Routine? _______ Other? _________

Is condition getting progressively worse? ____________________________________________

Other Doctors seen for this condition ____________________________________________

Any home remedies? ____________________________________________

Other Symptoms:

| | | |
|---|---|---|
| ☐ Headaches | ☐ Pins & Needles in Legs | ☐ Fainting |
| ☐ Neck Pain | ☐ Pins & Needles in Arms | ☐ Loss of Smell |
| ☐ Sleeping Problems | ☐ Numbness in Fingers | ☐ Loss of Taste |
| ☐ Back Pain | ☐ Numbness in Toes | ☐ Diarrhea |
| ☐ Nervousness | ☐ Shortness of Breath | ☐ Constipation |
| ☐ Tension | ☐ Fatigue | ☐ Change in Urination |
| ☐ Irritability | ☐ Depression | ☐ Cold Hands |
| ☐ Chest Pains | ☐ Lights Bother Eyes | ☐ Cold Feet |
| ☐ Dizziness | ☐ Loss of Memory | ☐ Stomach Upset |
| ☐ Face Flushed | ☐ Ears Ring or Buzz | ☐ Cold Sweats |
| ☐ Neck Stiff | ☐ Fever | ☐ Loss of Balance |

Have you been under drug and medical care? ____________________________________________

What medications are you taking? ____________________________________________

How Long? ________________ Have you had surgery? __________ What? ______________ When? _________

What side effects have you experienced from the drugs and surgery? ______________________________

____________________________________________________________________________

| Is there a family history of: | Heart Disease | Arthritis | Cancer | Diabetes | Other |
|---|---|---|---|---|---|
| Father's side | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mother's side | ☐ | ☐ | ☐ | ☐ | ☐ |

## About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layers of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care.** All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

# Camp Chiropractic Center Informed Consent to Treat

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy / physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic indicated below and/or other licensed Doctors of Chiropractic and support staff who now or in the future treat me while employed by, working or associated with, or serving as backup for the Doctor of Chiropractic named below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand that chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, I understand and am informed that, as is with all healthcare treatments, results are not guaranteed, and there is no promise to cure. In addition, I understand and am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short period of time, aggravating and/or temporary increase in symptoms, lace of improvement of symptoms, burns from heat lamps, ice or heating devices, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs, such as anti-inflammatories, muscle relaxants and pain killers; physical therapy; acupuncture, massage, steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options. I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment. I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the above-named chiropractic and related procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment from this clinic or Chiropractic doctor.

______________________________________________ ____________________________

Patient or Representative or Guardian for Patient Date

# 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.
7. If my case is a personal injury claim, I understand that when I am considered pre-injury status, and/or my case is closed, all further care will be my responsibility.
8. **If we are filing insurance for you today, once your insurance carrier receives your claim, they may determine that you are responsible for a different amount than discussed at your time of service. Exact patient responsibility amounts will be determined by your insurance company**.

__________ 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 your 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 service 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.)*

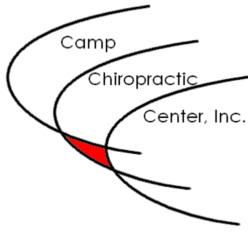
**Camp Chiropractic reserves the right to change its privacy policy. You will be notified prior to a changed disclosure only when it applies to you.**

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 do? 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."*