____

Confidential Health History

Name ____ SSN: _____-____-______ Age: ___________

Male / Female Date of Birth: _______________ Marital status: _________________

Address _________________________________ City _________________ State ______ Zip _______

Home/ Cell: _________________ Work: _________________

Email: ________________________________Would you like email/ text reminders? Yes/ No Carrier________

How did you hear about us? ________________ Would you like the Clear Chiropractic Newsletter? Yes/ No

Occupation: ____________________________ Employer's Name:_____________________

Emergency contact: ____ Home Phone: ________________

List authorized person(s) for medical information release: ____

Primary reason for seeking care? ____

Problem started on: ____

Most Aggravation: ____

What makes it worse? ____

What makes it better? ____

Quality of symptoms:

☐ Aching ☐ Burning ☐ Numbness/Tingling ☐Stabbing ☐ Dull

☐ Deep ☐ Superficial

If Symptoms radiate to other areas, Where___________________________________

Mark Symptoms

☐ No Pain Rate your symptom: 1 2 3 4 5 6 7 8 9 10 ☐ Incapacitating Pain

How Frequent is it?

☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

How long does it last?

☐ 24hrs/day (wakes you at night) ☐ 16hrs/day (does not wake you)

☐ Other: ______hrs/day

HT: _____ in. WT: _____lbs. Hobbies/Sports: ______________________________

List of Current Medication: ____

Other Doctors used for healthcare: ____

Previous Chiropractors(s): ____

All Surgeries and dates: ____

____

Doctor's Notes Only

Daily :______
4xs :______
3xs :______
2xs :______
1x :______
E-O :______
Mth :______
Initial :______
Cerv :______
Thor :______
Lum :______
Adj :______
Fup :______
FupXr :______
Traxn :______
Exer :______
Extrm :______

AUTO INSURANCE INFORMATION (not personal medical insurance)

Your Ins. Co. ______________________PIP Claim? Y/N (Circle one) Claim # ___

______________________________ Agent's/ Adjustors Name ______________________________ Contact phone #____________________________________

Responsible Party's Name ____

Address ____ City ______________________ State ________ Zip __________

Responsible Ins Co _____________________________________Policy# ______________________________

ATTORNEY

Name ____ Phone (   ) __________________________

Paralegal Name____ Phone (   )______________________Ext:____

Were there any witnesses? ☐ Yes ☐ No Name(s) ____

NATURE OF ACCIDENT:

Date of Accident ___________________ Time of Day ______________________

Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

Number of people in your vehicle? ___________ Were you wearing seat belts? Yes /No

What direction were you headed? ☐ North ☐ East ☐ South ☐ West Name of street _____________________________

What direction was other vehicle headed? ☐ North ☐ East ☐ South ☐ West Name of street ______________________

Were you struck from: ☐ Behind ☐ Front ☐ Left side ☐ Right side

Approximate speed of your car: _______ mph Other car ____________mph

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? __________________________________

Were police notified? ☐ Yes ☐ No Was there a police report? _____________________________

Please describe accident: ____

____

Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No If yes, please describe in detail:

____

____

Please describe how you felt:

a. DURING the accident: ____

b. IMMEDIATELY AFTER the accident: ____

c. LATER THAT DAY: ____

d. THE NEXT DAY: ____

What are your **PRESENT** complaints and symptoms? ____

____

____

Medication taken SINCE the accident: ____

Do you have any congenital (from birth) factors, which relate to your symptoms? ☐ Yes ☐ No If yes, please describe:

____

Do you have any previous illnesses which relate to this case?, ☐ Yes ☐ No If yes, please describe: ________________

____

Have you ever been involved in an accident before? ☐ Yes ☐ No If yes, please describe, including date(s) and type(s) of accidents, and treatment(s) received. ____

____

____

Where were you taken after the current accident? ____

Have you been treated by another doctor since the current accident? ☐ Yes ☐ No If yes, please list doctor's name, specialty and phone:

____

What type of treatment did you receive? ____

____

CHECK SYMPTONS YOU HAVE NOTICED SINCE ACCIDENT:

General

☐ Unexplained Weight Loss or Gain ☐ Fevers/Chills ☐ Recent Trauma ☐ Fatigue
☐ Past Trauma ☐ Trouble Sleeping/ Sleep Disorder ☐ Irritability ☐ Nervousness

Skin

☐ Rashes ☐ Itching ☐ Color Change ☐ New/Change in Mole ☐ Lumps
☐ Dryness ☐ Hair/ Nail Changes

Head/ Eyes/ Ears/ Nose/ throat

☐ Visual Changes ☐ Sinus Problems ☐ Hearing Loss ☐ Difficulty Swallowing/ Chewing
☐ Double Vision ☐ Head Injury/Trauma ☐ Ringing in Ears ☐ TMJ/ TMD ☐ Headaches ☐ Concussion

Cardiovascular

☐ Chest Pain ☐ Shortness of Breath ☐ High/Low Blood Pressure ☐ Blood Clots
☐ Palpitations ☐ Fainting ☐ Heart Disease ☐ Cold Hands/Feet ☐ Poor Clotting

Respiratory

☐ Cough ☐ Coughing up Blood ☐ TB ☐ Sputum ☐ Asthma/ Wheezing
☐ COPD/Emphysema ☐ Face Flushed

Gastrointestinal

☐ Abdominal Pain ☐ Vomiting ☐ Diarrhea ☐ Nausea ☐ Constipation
☐ Indigestion ☐ Upset Stomach

Musculoskeletal

☐ Neck/Back Pain ☐ Stiff Neck ☐ Joint Pain/ Stiffness ☐ Hip/Knee/Ankle Pain ☐ Plantar Fasciitis
☐ Scoliosis ☐ Joint Swelling ☐ Shoulder/Elbow/Wrist Pain ☐ Tension

Neurologic

☐ Dizziness ☐ Seizures ☐ Weakness ☐ Numbness/Tingling ☐ Migraine/Cluster Headaches
☐ Loss of Memory ☐ Loss of Taste ☐ Loss of Smell ☐ Pins & Needles ☐ Cold Sweats

Other

☐ Diabetes ☐ Cancer ☐ Fibromyalgia ☐ Nervous/Anxiety ☐ Depression ☐ AS
☐ Arthritis ☐ Osteoporosis ☐ Varicose veins ☐ Head Seems Heavy ☐ Anaphylaxis ☐ MS

Female Only

☐ Painful Menstruation ☐ Irregular Cycle ☐ Breast Problems ☐ Menopause

Are You Pregnant?

☐ Yes ☐ No ☐ Maybe

Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐Same

Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, please complete the question.

a. Last Day Worked: ______________________________

b. Type of Employment: ______________________________

c. Present Salary: ______________________________

d. Are you being compensated for time lost from work? ☐ Yes ☐ No If yes, please state type of compensation you are receiving: ______________________________

Do you notice any daily activity restrictions as a result of this injury? ☐ Yes ☐ No If yes, please describe, in detail:

____

____

Other pertinent Information : ______________________________

____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and form to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to may account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand than agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be check if CLEAR Chiropractic extend credit to me and I understand that if I suspend or terminate my care and treatment, and fee for professional services rendered to me will be immediately due and paid unless other arrangement are made. I hereby authorize the doctors at CLEAR Chiropractic and whomever they may designate as their assistants, to administer treatments as they so deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

______________________________ ______________

Print Name **DATE**

______________________________ ______________

Patient Signature **DATE**

______________________________ ______________

Guardian Signature **DATE**

CLEAR Chiropractic
Notices of Privacy Practices

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

CLEAR Chiropractic is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations (example),

"On occasion, it may be necessary to seek consultation regarding your treatment from other health care providers associated with CLEAR Chiropractic"

"It is our policy to provide a substitute health care provider, authorized by CLEAR Chiropractic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness or other emergency situation."

Due to the nature of CLEAR Chiropractic's open adjustment areas, others may overhear conversations between the doctor and patient although every effort will be made to avoid loss of confidentially. At any time you may request a private consultation with the doctor.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (Example)

"As a courtesy to our patients, we will submit an itemized statement to your insurance center for the purpose of payment to CLEAR Chiropractic for health care services rendered. If you pay for your health care services personally we will, as a courtesy to you, provide and itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information including diagnosis, date of injury or condition, and codes which may describe the health care services received."

Worker's Compensation

We may disclose your health information as necessary to comply with State Workers compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or your death.

Public Health

As required by law, we may disclose your health information to public health authorities for the purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infectious exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order of subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by the Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lesson a serious and imminent threat to the health or safety of a particular person or to the general public

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

"It is our practice to participate in charitable events to raise awareness, food donations, etc. During these times, we may need to send you a letter, post card or call your home to invite you to participate in the charitable activity.We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of CLEAR Chiropractic sponsored fund- raising events."

Change of Ownership

In the event that CLEAR Chiropractic is sold or merged with another organization, your health information will become the property of the new owner.

Your Health Information Rights

- *You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that CLEAR Chiropractic is not required to agree to the restriction you requested.*
- *You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.*
- *You have the right to inspect and receive a copy of your health information.*
- *You have the right to request that CLEAR Chiropractic amend your protected health information. Please be advised, however, that CLEAR Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.*
- *You have the right to receive an accounting of disclosures of your protected health information made by CLEAR Chiropractic*
- *You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.*

Changes to this Notice of Privacy Practices

CLEAR Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all the information that it maintains. Until such an amendment is made, CLEAR Chiropractic is required by law to comply with this Notice. (Continued)

(cont'd) CLEAR Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Angela Ritson by calling 425-820-8837. If she is not available you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or how CLEAR Chiropractic has handled your health information should be directed to Angela Ritson by calling 425-820-8837. If she is not available you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, SW Room 509F HHH Building Washington, D.C. 20201

This notice is effective as of (01/14/2010)

I have read the Privacy Notice and understand my rights contained in the notice

By way of my signature, I provide CLEAR Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of the treatment, payment and health care operations as described in the Privacy Notice.

Patient Name (please print) ______________________________

______________________________ ______________________________

Patient Signature **Date** **Guardian Signature** **Date**

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is be specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________________, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient Name (please print) ______________________________

____

Patient Signature **Date**

General Pain Index Questionnaire

We would like to know how much your pain presently ***prevents*** you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **Family/at -home responsibilities** such as yard work, chores around the house or driving the kids to school -

completely able to function	0	1	2	3	4	5	6	7	8	9	10	totally unable to function

2. **Recreation** including hobbies, sports or other leisure activities –

completely able to function	0	1	2	3	4	5	6	7	8	9	10	totally unable to function

3. **Social activities** including parties, theater, concerts, dining –out and attending other social functions with friends -

completely able to function	0	1	2	3	4	5	6	7	8	9	10	totally unable to function

4. **Employment** including volunteer work and homemaking tasks -

completely able to function	0	1	2	3	4	5	6	7	8	9	10	totally unable to function

5. **Self -care** such as taking a shower, driving or getting dressed -

completely able to function	0	1	2	3	4	5	6	7	8	9	10	totally unable to function

6. **Life -support activities** such as eating and sleeping -

completely able to function	0	1	2	3	4	5	6	7	8	9	10	totally unable to function

PATIENT NAME ______________________________ DATE ____________________

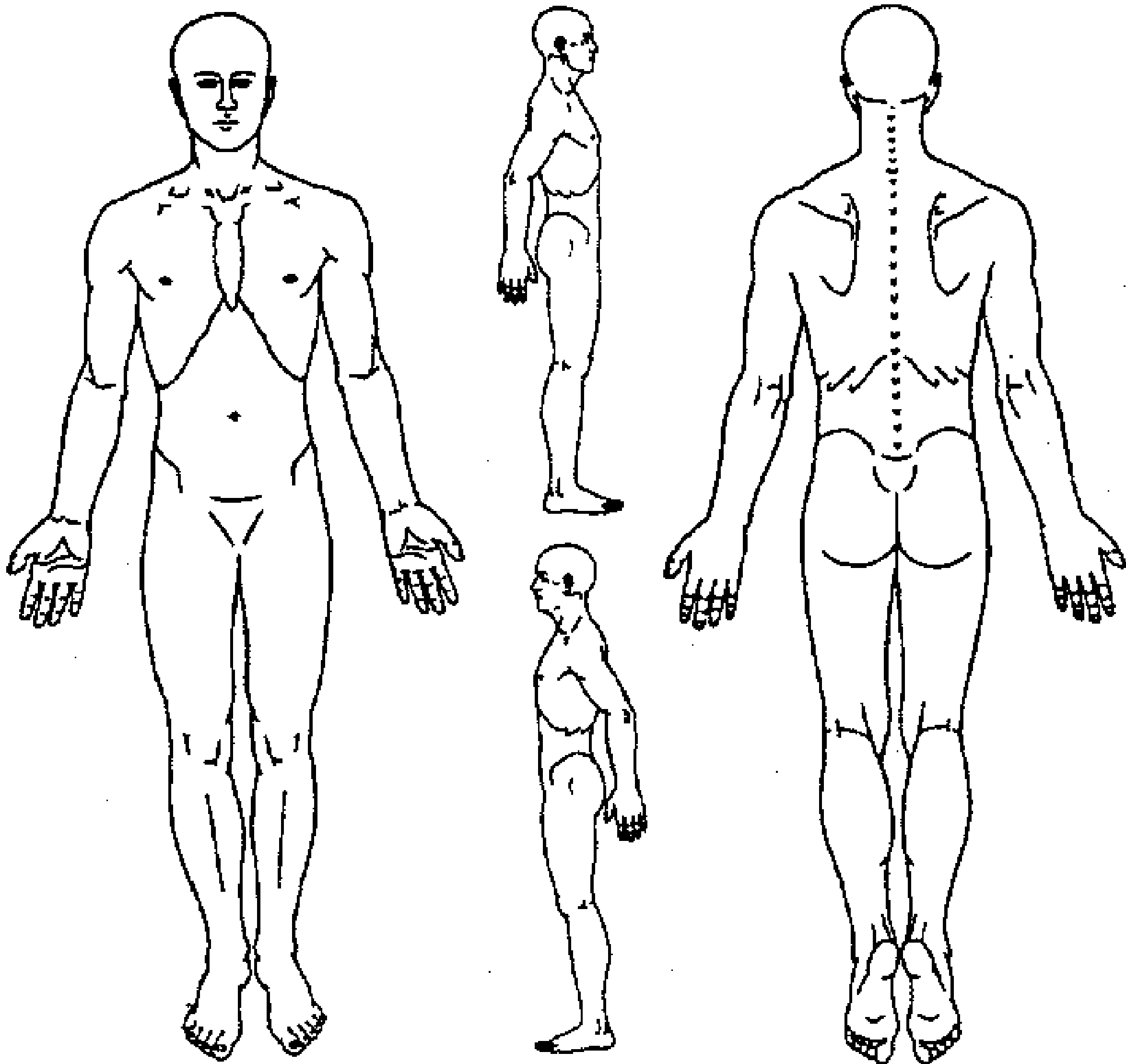
Score __________ [60] Benchmark -5 = __________

Pain Diagram

Name: ____

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗⊗⊗⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗⊗⊗⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗⊗⊗⊗



Date: ________________ Signature: ______________________________________

Clear Chiropractic

Patient Payment Plan

Patient name: ________________________________Date__________

The Personal injury Case

We recognize that some patients are under great physical and financial stress following their accident and are unable to pay for their chiropractic care as it is rendered after their personal injury. Accordingly, Clear Chiropractic will not require that you make “out of Pocket” payments as you receive your care related to your personal injury case, provided you agree to the following:

Personal Injury Payment Agreement

I, _____________________________, give Clear Chiropractic the permission and authority to bill any and all insurance plans available to me for the payment of chiropractic care and other services received by myself or others I am responsible for, including the taking and/or reading of x-rays, until all charges billed by Clear Chiropractic for such care is paid in full.

In the event that health insurance available to me does not cover all charges of my care at Clear Chiropractic, I authorize any and all responsible parties to pay, from the proceeds of settlement I may receive, any outstanding balance.

In the event that all health insurance and settlement I may receive does not cover the cost of my care at Clear Chiropractic, I agree to pay the full balance for services rendered over no more than ninety (90) days.

____

Patient’s Signature Date Account Representative