Chiropractic Health & Wellness Center
127 Avenue C, Suite A
Snohomish, WA 98290
360-568-4185 / 360-568-2377fax
Chirohealthandwellness.net

Patient Introduction

Date: _____

Name: _____
First Middle Last

Financially Responsible Party: _____
(if someone other than patient)

Mailing Address: _____

City _____ State _____ Zip _____

Telephone: Cell: _____ Home: _____

Work: _____ Other: _____

Email Address: _____

Birth Date: Month: _____ Day: _____ Year: _____ Sex: M / F

Social Security Number: _____ Marital Status: _____
(for billing purposes)

Occupation: _____ Employer: _____

Insurance: _____
(Please bring health card to front desk)

Previous Chiropractor: _____ Last Visit: _____

Reason for leaving: _____

Present PCP: _____

Referred to us by: _____

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Initial Child & Adolescent Questionnaire

Your Name: _____ Your Mom: _____
Your Dad: _____

Mainly for Moms:

1. Tell us about your pregnancy;
Did you carry to full term? _____
Describe any complications and when they occurred:_____
_____
_____

2. Tell us about your delivery and birth of this child:
Did you use a midwife? _____ Hospital? _____ Obstetrician? _____
Did you have a C-Section? _____ Were forceps used? _____
Vacuum Extraction? _____ Were you induced? _____
Did you have an Epidural? _____ Was it a difficult birth? _____
What was the baby's **APGAR** Score? _____ at 5 minutes? _____

3. Tell us more:
Did you breastfeed? _____ How long? _____ What formula after? _____
Did you consume alcohol during your pregnancy? _____ How much? _____
Did you smoke? _____ How much? _____ How long? _____
Did you take any medication during your pregnancy?
For what? _____ What type? _____
Any exposures to ultrasound?_____, How many?_____

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

___ Fall from a change table
___ Tumble down stairs
___ Fall out of crib
___ Involved in car accident
___ Fall off playground equipment
___ Play in "Jolly Jumper"
___ Frequent ear infections
___ Tonsillitis
___ Reaction to vaccination
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Other_____

Please explain the above: _____
_____
_____

5. As a young child, (5-12 years), did any of the following occur?

___ Fall from a tree
___ Fall of a bicycle
___ Fall of playground equipment
___ Sports accident
___ Car accident
___ Stomach pains
___ Scoliosis
___ Bed wetting
___ Hyperactivity/Autism
___ Learning difficulties
___ Asthma
___ Allergies
___ Leg/knee pains
___ Other_____

Please explain the above: _____
_____

6. **Tell us about any vaccinations your child has had:** _____

_____

_____

Any reactions to any of these? _____

_____

Were you told that you had a choice in vaccinating your child? ___**YES,** ___**NO**
Would you like information on the Aother side@ of this issue? ___**YES** ___**NO**

7. **As a child or adolescent, has your child experienced any of the following:**

___ Headaches
___ Dizziness
___ Ringing in ears
___ Sleeping problems
___ Allergies
___ Asthma
___ Hyperactivity
___ Fatigue
___ Stomach problems

_____ Numbness in arms/hands
_____ Foot/ankle/knee pains
_____ Arm/wrist pains
_____ Tingling in arms/legs
_____ Neck/back pains
_____ Shoulder pains
_____ "Growing Pains"
___ Weight gain/loss
___ Other :_____

Please explain any of the above: _____

_____

_____

8. **Which of the problems you have checked off is the worst?** _____

_____

Is this problem: Constant __, Intermittent __, Occasional __, Cyclic ___

9. **How long has it persisted?** _____
10. **When it is at its worst, how does it make your child feel?** _____
11. **What have you done about it that has NOT worked?** _____

_____

12. **What makes it worse?** _____
13. **What effect does this problem have of your child's body functions**?

_____

_____

On his/her participation in daily activities? _____
14. **Describe any hospital stays:** _____

_____

15. **Approximately how many times have antibiotics been prescribed and for what conditions?** _____

_____

16. **List any medications your child is currently taking:** _____

_____

17. **To summarize, what is your purpose for this appointment?** _____

_____

_____

18. **Is there anything else you feel we should know?** _____

_____

_____

_____

Signature of parent or guardian: _____**Date:** _____

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Your Informed Consent

Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that it is responsible to let you know:

a. Risk of stroke is reported to be 1 in 5-8 million or so... and the cause has yet to be determined.
b. While extremely rare, there have been reports of ligament sprains, and even rib fractures reported.
c. There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause.

Chiropractic care has been proven to be both, clinically and very cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world.
Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in North America, Chiropractic is your safest health care system.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor.
I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Chiropractic Health& Wellness Center. This consent applies to all present and future care for me and my family.

Your Name: _____, Date: _____
Your Signature: _____
Witness: _____

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Terms of Acceptance

I have been informed and fully understand that Chiropractic care is not the treatment of any disease or condition.

I understand that the body is a self-healing organism, that the nervous system is the master controller of the body and that any interference to the function of the nervous system creates a malfunction within the body.
I understand that vertebral Subluxation interfere with the function of my nervous system and produce poor health expression.

I also understand that my care is aimed at correction of my vertebral Subluxations thereby restoring or optimizing my health potential.

Name of Patient: _____

Signature:_____ **Date:** _____

Thank You

STATEMENT OF PRIVACY PRACTICES

CHIROPRACTIC HEALTH & WELLNESS CENTER

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Chiropractic Health & Wellness Center. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Chiropractic Health & Wellness Center reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	**☐ YES**	**☐ NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	**☐ YES**	**☐ NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other:	**☐ YES**	**☐ NO**
Name of patient (please print):		
Patient signature:		
Patient's personal representative: (Please Print):		
Personal Rep's signature:		
Representative's Phone Number:	**Date:**	

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided: _____**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	