Spinal & Sports Care Clinic, PS

12905 E Sprague Ave., Spokane Valley, WA 99216

First Name (Legal): _____ (MI): _____ Last Name: _____

Social Security Number: ___/___/___ Birth Date: ___/___/___ Married ❑ Single ❑ Other ❑

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____ Work Number: _____

May we leave a message if we need to? ❑ Yes ❑ No E-mail address: _____

Occupation: _____ Patient Employer/School: _____

Military: ❑ Active ❑ Veteran ❑ N/A Who may we thank for referring you? _____

In Case of Emergency Contact

Name: _____ Relationship to patient: _____

Phone Number: _____ Work Number: _____

Insurance Information

Who is responsible for this account?: _____ Relationship to patient: _____

Primary Insurance Company: _____ Phone Number: _____

Subscriber Name: _____ Subscriber Date of Birth: ___/___/___

Insurance ID: _____ Group Number: _____

Employer: _____ Work Number: _____

Secondary Insurance Company: _____ Phone Number: _____

Subscriber Name: _____ Subscriber Date of Birth: ___/___/___

Insurance ID: _____ Group Number: _____

Employer: _____ Work Number: _____

I understand it is my responsibility to provide Spinal & Sports Care Clinic with accurate information concerning my insurance coverage and personal information. I understand that all quotes are an estimate and all balances are subject to the information Spinal and Sports Care Clinic received from my insurance carrier. I understand there are no guarantees of benefits and I am financially responsible for all charges rendered whether or not paid by my insurance. I authorize Spinal & Sports Care Clinic the use of my signature on all insurance submissions. I also authorize Spinal & Sports Care Clinic to provide information to my insurance carrier(s) and their agents for the purpose of obtaining payment for services rendered and assign directly to Spinal & Sports Care Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand Spinal & Sports Care Clinic will not become involved in any dispute between me and my insurance company. It will be my responsibility to settle any such dispute.

_____

Print Patient Name Date

_____

Signature of patient/parent/guardian/personal representative Relationship to Patient

Chiropractic Headache Questionnaire

Patient's Name: _____ **Date:** _____

1. Did your headaches start after an accident, illness or infection? YES NO

2. When did your headaches first start?

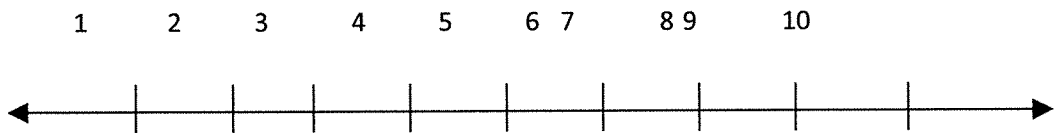
3. Do you have more than one type of headache? YES NO

   If Yes, please explain

4. How many regular headaches do you have per month?

5. How many migraine headaches do you experience per month?

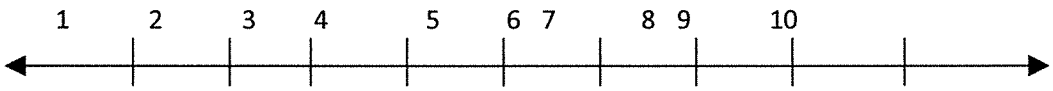
6. How painful are your regular headaches? (Circle one number)



7. How painful are your migraine headaches? (Circle one number)

Steven Shirley, D.C. W. Jack Choate, D.C. Brittany Rush, D.C. Sylvia Tripp, D.C.

12905 E. Sprague Ave., Spokane Valley, WA 99216 (509) 922-0303



8. Are your headaches: constant come and go

9. Where are your headaches usually located? (Check all that apply)

Behind right eye	behind left eye	behind both eyes
Right temple	left temple	both temples
Top of head	neck	above both eyebrows
Back of head on right	back of head on left	back of head on both sides

10. What does the pain feel like?

_____Throbbing or pounding _____Exploding _____Sharp

_____Tightness (like a rubber band wrapped around the head)

_____Dull _____Aching _____Pressure

Please describe the pain in your own words:

11. Is your current headache today the worst you have ever experienced? YES NO

12. What % of your waking time do you have some degree of headache?

13. How often do the headaches occur? (daily, weekly, monthly, etc.)

14. Do the headaches occur at a certain time of the day?

morning afternoon night anytime all the time

15. Are the headaches becoming stronger, lasting longer or occurring more frequently?

YES NO

16. Do the headaches wake you up from sleeping? Never Occasionally Often

17. Does rest or sleep relieve the headache? YES NO

18. Do the headaches stop you from doing things (like playing, watching TV, going outside) ?

YES NO

Which activities are restricted?

19. Have you missed school or work because of a headache? Yes No

20. Do any of the following occur before or during your migraine headaches?

(Circle all that apply)

☐ Nausea	☐ Vomiting	☐ Increased appetite
☐ Bothered by light/noise	☐ Blurred/double vision	☐ Sparkling, flashing, or colored lights
☐ Tired or sleepy	☐ Eyelid droops	☐ Loss of vision
☐ Feeling lightheaded	☐ Numbness / tingling	☐ Weakness of arm or leg
☐ Difficulty concentrating	☐ Speech difficulty	☐ Loss of consciousness
☐ Runny nose	☐ Stomachache	☐ Other_____

21. Do any of the following bring on your migraine headaches or make them worse?

(Check all that apply)

☐ Stress (worry,anger)	☐ Bright lights	☐ Weather Change
☐ "Letdown" after stress	☐ Loud noise	☐ Heavy lifting
☐ Air travel	☐ Fatigue	☐ Certain smells, odors
☐ Missed meals	☐ Sexual activity	☐ Coughing, straining, bending over
☐ Certain foods (chocolate, cheese, MSG, milk)	☐ Medications:	☐ Alcohol
☐ Exercise	☐ Allergies	☐ Other:_____

22. Do any of the following make your headaches better? (Check all that apply)

☐ Rest	☐ Exercise	☐ Quiet and darkness
☐ Hot or cold compress	☐ Massage	☐ Warm shower
☐ Pressure over migraine area	☐ Other: _____	

Medications: _____

23. If you are female, do your headaches change with the following?

(Check all that apply)

☐ Menstrual Periods ☐ Birth Control Pills ☐ Pregnancy ☐ Other Hormonal Drugs

24. Do any of your family members have headaches?

☐ Yes ☐ No If "yes", explain (who): _____

25. Have you ever had a head or a neck injury requiring medical treatment?

☐ Yes ☐ No If "yes", describe: _____

26. Have you ever been diagnosed to have any health disorder (e.g. high blood pressure, asthma, heart disease, gastric ulcers, others)?

☐ Yes ☐ No If "yes", please list: _____

27. Have you had your headaches evaluated by a neurologist?

☐ Yes ☐ No If "yes", when, where and by whom? _____

What was the diagnosis? (Check all that apply.)

☐ Migraine ☐ Tension Type ☐ Cluster

28. What tests were done?

☐ CT scan ☐ Eye Exam ☐ Sinus X-rays

☐ MRI ☐ Dental Exam ☐ Allergy Tests

☐ Spinal Tap ☐ Blood tests (etc)

Any other tests?_____

29. What prescription medications are you taking for your headaches?

30. What over the counter medications are you currently taking regularly for your headaches?

31. Please list all other medications that you are taking for any health problem.

32. What other forms of treatment have you tried for your headaches?

(Circle all that apply):

Chiropractic Massage Herbs Acupuncture Meditation/Yoga Other:_____

33. On a scale of 1-10, rate your stress level over the last 6 months _____

Describe any major stresses in the last year

34. On average, how many 8 ounce servings daily do you have of the following:

_____ Water _____Coffee _____Tea

_____ Other Caffeinated Beverages _____Soda _____Diet Soda

_____ Beer or Wine _____ Other Alcoholic Drinks

35. Do you regularly eat breakfast? ☐ Yes ☐ No

36. How often do you eat during the day? _____

37. How many hours of sleep do you get a night? _____hours

38. Do you: (mark all that apply)

_____ usually sleep through the night without waking

_____ wake up frequently through the night

_____ wake up and can't go back to sleep

_____ wake feeling rested

_____ wake feeling tired

39. Please describe what you regularly do for exercise, how frequently and for how long.

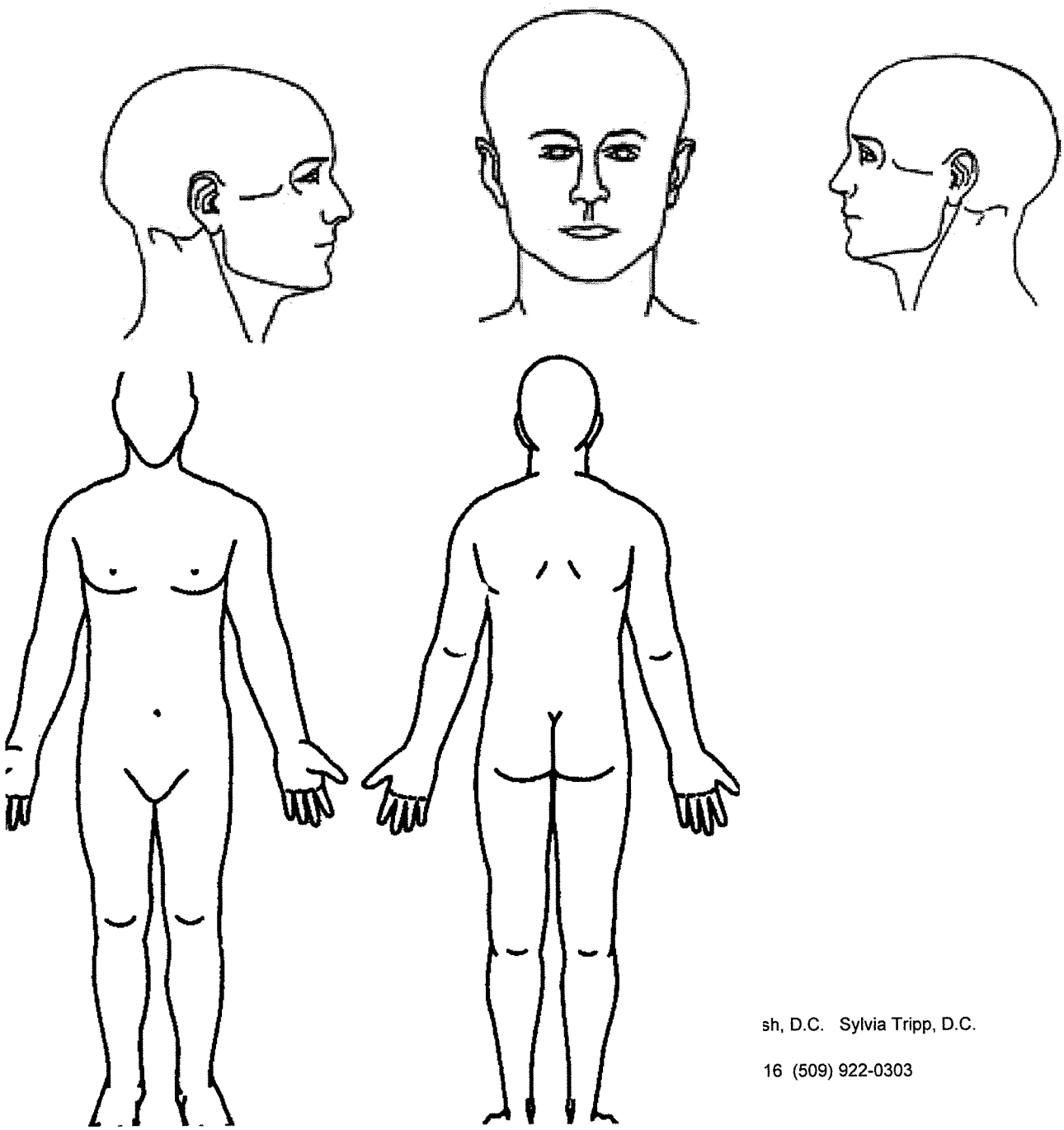
40. What questions do you have about your headaches? What worries you most?

How are you feeling currently?

Please complete this drawing carefully. Mark on the drawing the areas where you feel the described sensation. Use the appropriate symbols and include all involved areas of your body.

NUMBNESS **===** PINS & NEEDLES **OOO** ACHING PAIN **!!!**

BURNING PAIN **xxx** STABBING PAIN **|||**



sh, D.C. Sylvia Tripp, D.C.

16 (509) 922-0303

Informed Consent

Before beginning treatment, it is our office policy to inform you of what to expect, possible complications of chiropractic, as well as complications of other forms of treatment. Remember that all forms of treatment (including non-treatment!) have associated risks. **If you have any questions, please be sure to ask the doctor.**

What to expect

The treatment at our office will consist of manipulation of the joints and soft tissues, using the hands and/or a mechanical instrument. You may feel movement, and you may hear joint clicks or other noises. Physical therapy methods, including therapeutic exercise, massage and heat or ice may also be used.

Chiropractic risks

Chiropractic treatment is one of the safest methods of treating spinal problems. Still, unexpected problems can occur. Minor, temporary problems, such as soreness and stiffness can occur, especially in the beginning of a treatment plan. More significant problems, such as fracture of a weakened bone or sprain/disc injuries are rare. A stroke following neck manipulation is an extremely rare complication, occurring less than 1 per million treatments. Stroke has also been the result of ordinary activities, such as head turning or stargazing.

Other treatments and risks

There are other treatments used by medical doctors. Their risks include:

Medications: Many commonly used medications, such as NSAIDs (e.g., Advil, Aleve or Tylenol), carry risks of tissue damage, including stomach ulcers or kidney damage. This damage can occur quickly, and may irreversible. There is a significantly higher risk of developing a serious complication with NSAIDs as opposed to chiropractic. Other medications are habit forming, and may mask pain to allow further tissue damage.

Surgery: Surgery is the treatment of choice in less than 1% of back pain patients. Your doctor has screened for surgical "red flags", and will refer you for a surgical opinion if indicated. Clinical results of surgery for mechanical back pain have been disappointing, and exposes you to unnecessary hospital and medication risk.

Rest/non-treatment: Bedrest has been shown to increase the likelihood of re-occurrence of back episodes, and make chronic pain more likely. Likewise, non-treatment may cause a permanent mechanical problem to develop, causing future back problems.

I have read the above, and give my consent to begin chiropractic treatment.

Printed Name:_____ Date:_____

Signature:_____

Steve Shirley, D.C. W. Jack Choate, D.C. Brittany Rush, D.C. Sylvia Tripp, D.C.
Spinal & Sports Care Clinic, P.S. 12905 E. Sprague Ave., Spokane Valley, WA 99216 (509) 922-0303 Fax (509)922-0657

Spinal & Sports Care Clinic, PS, 12095 E. Sprague Ave, Spokane Valley, WA 99216

Financial Policy

_____ **Payment Methods**
We accept cash, checks, Visa, Master Card, American Express, Discover and debit cards.

_____ **Self Pay**
If you have no insurance or insurance that has no chiropractic benefits, payment at the time of service will be expected, unless prior arrangements have been made. We offer at time of service discount for payment in full on the day of service.

_____ **Insurance**
We are contracted with most insurance companies. However, some insurance companies arbitrarily select certain services that they will not cover and/or must be medically necessary. It is your responsibility to understand the scope and limitations of your insurance policy and you are financially responsible for all charges rendered whether or not paid by your insurance. ***At the time of service you are responsible for all co-pays, deductibles and any estimated fees for services not covered by your insurance plan.*** As a courtesy we will bill your insurance company; however it is your responsibility to provide us with accurate information.

_____ **Examination & Re-examination**
Should I have a new complaint or if it has been over 1 year since my last visit a new examination will be completed. If my insurance does not pay for this service it is my responsibility to pay in full at time of service unless prior arrangements have been made.

_____ **Motor Vehicle Accident**
You will not be responsible for paying at time of service if you have a personal injury protection coverage plan we can bill for your care. If you've exhausted your personal injury protection coverage you will be financially responsible for all charges rendered whether or not paid by the insurance carrier.

_____ **Workman's Compensation/Self Insured/Federal**
You will not be responsible for paying at time of service if you have an open L&I claim or filing for L&I. If your L&I claim has been denied or closed within the course of treatment you are financially responsible for all charges rendered whether or not paid by L&I.

_____ **NO Show Policy**
You will be considered a no show if you miss an appointment and do not notify us at least four hours in advance. A $25.00 charge will be applied to your account and must be paid prior to being seen by the provider at your next visit. If you miss two appointments in a row, any remaining appointments will be cancelled and you will not be able to schedule with the provider until all fees are paid. If you miss three appointments without canceling you may be discharged from care.

I have read and understand the above terms and I accept full responsibility for the services incurred with Spinal and Sports Care Clinic.

_____
Print Name

_____ _____
Signature Date

Spinal and Sports Care, PS
12905 E Sprague Ave, Spokane Valley, WA 99216
Phone (509) 922-0303 Fax (509) 922-0657

PATIENT AUTHORIZATION FOR RELEASE OF PHI

Patient Name _____ Date of Birth: _____

Address _____

Phone Number _____ Chart Number _____

By signing this form, I authorize Spinal and Sports Care Clinic PS to use and/or disclose my:

- **Protected Health Information (PHI)**: PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services
- **Sensitive Protected Health Information (SPHI)**: SPHI means Protected Health Information that pertains to particularly sensitive information, as defined by state law, such as (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS, or (ii) an individual's substance abuse condition or treatment of an individual for mental illness.

I authorize disclosure of the following information from my medical record:

Note: Include a detailed description of information to be released including dates.

_____

_____

Release medical records to my medical provider or attorney listed below:

Name: _____ Telephone: _____

Address _____

I authorize Spinal & Sports Care Clinic to provide information regarding my personal information such as appointments, bills, or general account information to: (spouse, partner, parent, etc.)

Name: _____ Telephone: _____

Address _____

(Spinal & Sports Care Clinic, by law, cannot speak to anyone regarding personal information unless we are authorized by you to do so!)

I Understand that:

- Treatment will not be conditional on whether I sign this Authorization.
- This Authorization is voluntary and that I have the right to refuse to sign it.
- If I sign this authorization, I may revoke it later by sending a written notice of revocation to the privacy office at the practice.
  Note: The only exception to your right to revoke is if the practice has already acted in reliance upon the authorization.
- Once signed, the Practice will provide me with a copy of this Authorization.
  By signing this form below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
- Conduct, plan and direct my treatment and follow-up among the health care providers who may be

directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

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- Conduct normal health care operations such as quality assessments and accreditation.

Signature(s)

Patient signature _____ Date _____

Sign below if you are a personal representative of the patient.

Representative signature_____ Date _____

Print Name _____

Relationship to Patient _____

For Office Use Only

Verification Method: _____

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____

Staff signature **Date**

Spinal & Sports Care Clinic PS
12905 E Sprague Avenue
Spokane, WA 99216

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____