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

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Chiropractic Headache Questionnaire

Name: ______________________________ **Date:** ______________

1. Did your headaches start after an accident, illness or infection?
   YES / NO
2. When did your headaches first start?

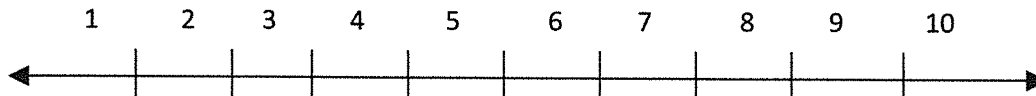
3. Do you have more than one type of headache?
   YES / NO
   If Yes, please explain:

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

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

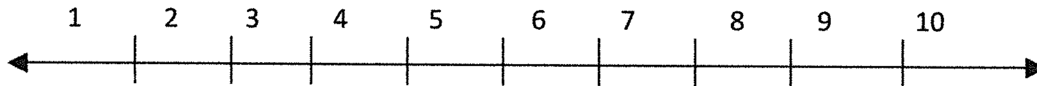
6. How painful are your regular headaches? (Circle one number)

1 2 3 4 5 6 7 8 9 10



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

1 2 3 4 5 6 7 8 9 10



8. Are your headaches:
   CONSTANT / COME & GO
9. Where are your headaches usually located? (Check all that apply)
   - O behind right eye
   - O behind left eye
   - O behind both eyes
   - O above both eyebrows
   - O right temple
   - O left temple
   - O both temples
   - O neck
   - O top of head
   - O back of head on right
   - O back of head on left
   - O back of head on both sides
10. What does the pain feel like?
    - O exploding
    - O sharp
    - O dull
    - O pressure
    - O aching
    - O tightness (like a rubber band wrapped around the head)
    - O throbbing or pounding

    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?
    O morning O afternoon O night O anytime O 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?
    O never O occasionally O often
17. Does rest or sleep relieve the headache?
    YES / NO
18. Do the headaches stop you from doing activities (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? (check all that apply)
    O nausea O vomiting O increased appetite
    O bothered by light/noise O blurred/double vision O sparkling, flashing, or colored lights
    O tired or sleepy O eyelid droops O loss of vision
    O feeling lightheaded O numbness/tingling O weakness of arm or leg
    O difficulty concentrating O speech difficulty O loss of consciousness
    O runny nose O stomach ache O other ____________________

21. Do any of the following bring on your migraine headaches or make them worse? (Check all that apply)
    O stress (worry, anger) O bright lights O weather change
    O "letdown" after stress O loud noise O heavy lifting
    O air travel O fatigue O certain smells, odors
    O missed meals O sexual activity O coughing, straining, bending over
    O alcohol O exercise O allergies
    O certain foods (chocolate, cheese, MSG, milk) O medications: ____________________
    O other: ____________________

22. Do any of the following make your headaches better? (Check all that apply)
    O rest O exercise O quiet and darkness O pressure over migraine area
    O hot or cold compress O massage O warm shower O other: ____________
    O medications: ____________________

23. If you are female, do your headaches change with the following? (Check all that apply)
    O menstrual periods O birth control pills O pregnancy O other hormonal drugs

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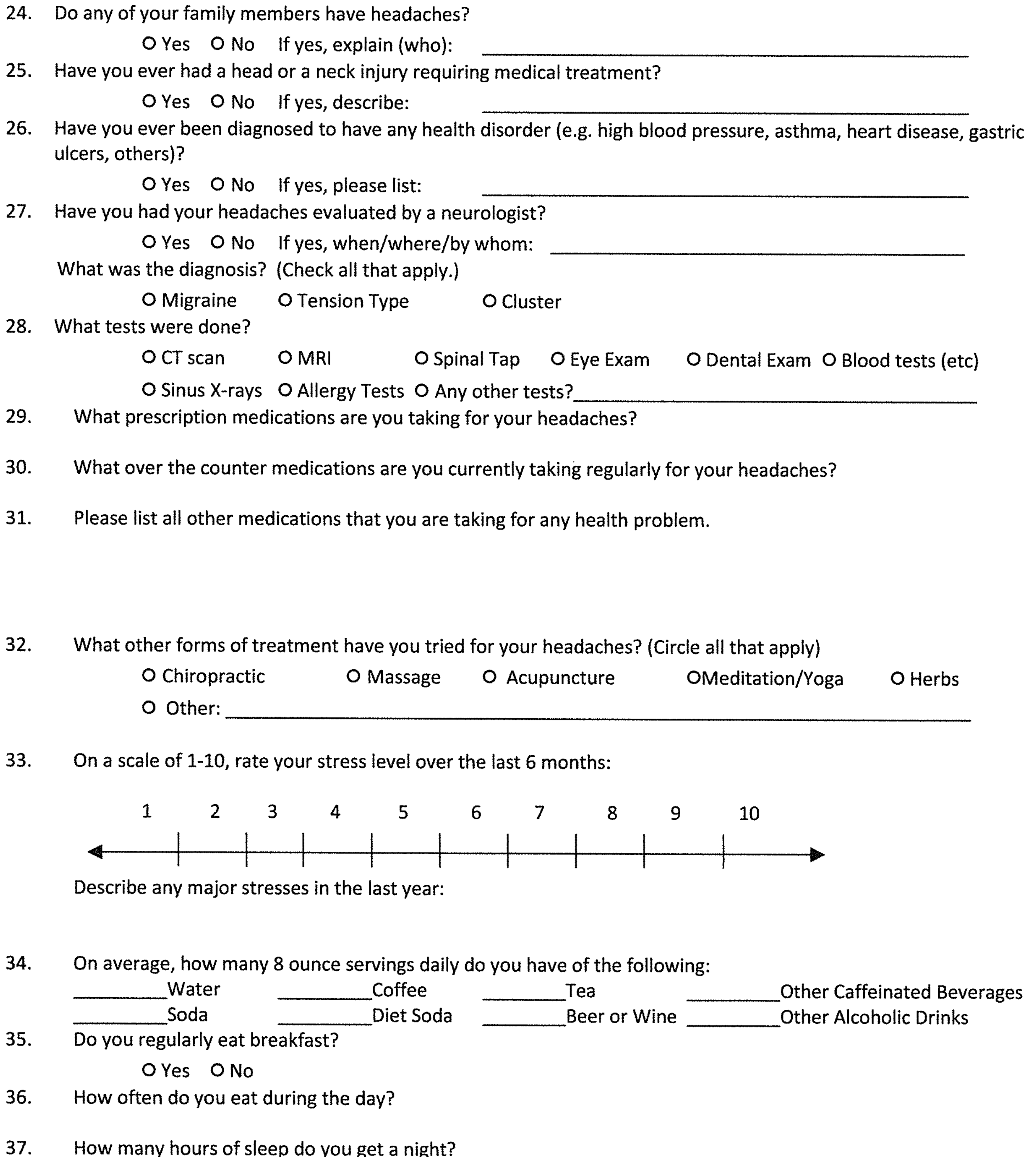

24. Do any of your family members have headaches?

    O Yes O No If yes, explain (who): ______________________

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

    O Yes O 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)?

    O Yes O No If yes, please list: ______________________

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

    O Yes O No If yes, when/where/by whom: ______________________

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

    O Migraine O Tension Type O Cluster

28. What tests were done?

    O CT scan O MRI O Spinal Tap O Eye Exam O Dental Exam O Blood tests (etc)

    O Sinus X-rays O Allergy Tests O 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)

    O Chiropractic O Massage O Acupuncture OMeditation/Yoga O Herbs

    O Other: ______________________

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

    1 2 3 4 5 6 7 8 9 10

    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?

    O Yes O No

36. How often do you eat during the day?

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

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38. Do you: (mark all that apply)

O usually sleep through the night without waking O wake up frequently through the night

O wake feeling rested O wake feeling tired O wake up and can't go back to sleep

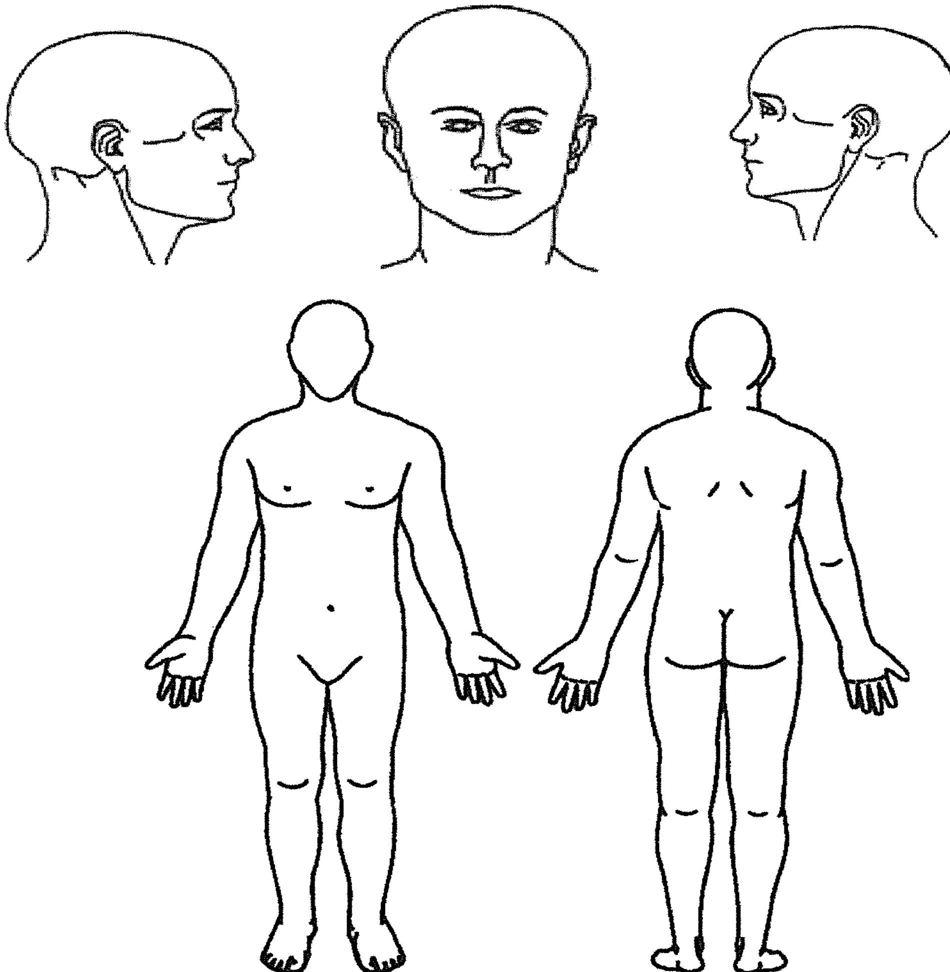
39. Please describe what you regularly do for exercise, how frequently and for how long.

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 |||



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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. These 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 be 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.

Print Name ____

Signature ______________________________________ Date ____________________

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Financial Policy

Please read and initial *all of the following*:

______ Payment Methods
We accept cash, checks, CareCredit, Visa, MasterCard, 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.

______ 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 $40.00 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.

______ 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.

Please read and initial *any that apply*:

______ 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.

______ 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.

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 ________________

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HIPPA Authorization

Patient Name______________________________Date of Birth:______________

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 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.
- 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.

By signing this form below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices:

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

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 prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** ______________________________

Staff signature______________________ **Date**______________

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Authorization for Verbal Communication

Patient Name: ______________________________ **Date of Birth:** ____________________

By signing this form, I authorize Spinal and Sports Care Clinic PS to discuss health information, in person or by telephone, with the following family members or persons directly involved in my medical care.

NAME (please print): **PHONE NUMBER:** **RELATIONSHIP:**

____

NAME (please print): **PHONE NUMBER:** **RELATIONSHIP:**

____

I AUTHORIZE THIS COMMUNICATION TO INCLUDE:

☐ All health care information
☐ Health care information relating to the following treatment/condition: ____________________
☐ Health care information in my medical records for the date(s): ____________________
☐ Other (i.e. x-rays, bills, etc) specify date/item(s): ____________________
☐ Can schedule and reschedule appointments on my behalf

I UNDERSTAND THAT THIS AUTHORIZATION IS:

- **Limited** to verbal and telephone conversations and **does not permit** or authorize the release of any **written health information** to any of the individuals named above.
- **Limited** to the specific timeframe determined by me and that **if I do not specify a specific timeframe,** this authorization will **remain in effect until it is revoked in writing.**

I further understand that if I do not want verbal disucussion to be permitted between my health care provider and the individual(s) named above, I have the right to revoke this authorization in writing at any time. I understand that this written revocation will **not** affect any disclosures of my medical information that the person and/or organization listed on this authorization that have already made, in reliance on this authorization before the time I revoke it.

This document has been explained to me and all my questions have been answered satisfactorily.

____ ______/______/________
(Signature of patient or legal representative) (Date)

____
(Relationship to patient)

This authorization is NOT valid unless it is signed and date by the patient or their representative.

12905 E Sprague Ave Spokane Valley WA 99216-0731 | Phone (509)-922-0303 | Fax (509) 922-0657