

**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? \_\_\_\_\_

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**In Case of Emergency Contact**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

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**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: \_\_\_\_\_

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*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.*

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Print Patient Name \_\_\_\_\_ Date \_\_\_\_\_

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

### TMJ – Facial Pain Questionnaire

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

REFERRED BY (Doctor): \_\_\_\_\_ REFERRED BY (Location): \_\_\_\_\_

**CHIEF COMPLAINT** (Describe your problem in your own words):

\_\_\_\_\_  
\_\_\_\_\_

#### **SYMPTOMS**

Total length of time some or all TMJ/Facial pain symptoms present: \_\_\_\_\_

- Pain:**             Right             Left             Both Sides
- Location:**       Temporal Region       Cheek Region       TMJ Region (in front of ear)       Lower Jaw  
                          Ear                     Teeth                     Neck                     Shoulders                     Other \_\_\_\_\_
- Duration/Timing: worse in the:**  Morning       Afternoon       Evening  
    Constant       Intermittent       Worse after eating/talking
- Joint Noises:**    *Popping/clicking:*       Right             Left             Bilateral  
   *Grinding:*                     Right             Left             Bilateral
- Limited mouth opening:**       Persistent       Intermittent  
    Difficulty opening mouth       Difficulty closing mouth  
    Sleeping       Chewing       Yawning or laughing
- Jaw locking episodes:**       Locked open       Locked closed      How often? \_\_\_\_\_
- Headaches:**       Right             Left             Bilateral       Frontal (forehead)  
                                  Temporal (side of head)       Occipital (back of head)
- Ringling in Ears:**       Right             Left
- Fullness in Ears:**       Right             Left
- Dizziness             Visual Changes       Change in hearing             Other \_\_\_\_\_

#### **POSSIBLE CONTRIBUTING FACTORS**

- Facial Trauma/Injury \_\_\_\_\_
- Whiplash/Cervical Trauma \_\_\_\_\_
- Bruxism (grinding teeth)             Arthritis             Sleep Disorder \_\_\_\_\_
- Stress      (1 - mild 10 - severe)      1      2      3      4      5      6      7      8      9      10

#### **PREVIOUS DIAGNOSTIC STUDIES/RADIOGRAPHS**

- Panoramic Radiograph or Panorex       TMJ Tomograms       MRI of TMJ region



Name: \_\_\_\_\_ Date: \_\_\_\_\_

## **TMD Disability Index (Steigerwald/Maher)**

**Please circle the number that corresponds with the one statement that best pertains to you (not necessarily exactly) in each of the following categories.**

### **1. Communication (talking)**

- 0 I can talk as much as I want without pain, fatigue, or discomfort.
- 1 I can talk as much as I want, but it causes some pain, fatigue and/or discomfort.
- 2 I can't talk as much as I want because of pain, fatigue and/or discomfort.
- 3 I can't talk much at all because of pain, fatigue and/or discomfort.
- 4 Pain prevents me from talking at all.

### **2. Normal living activities (brushing teeth/flossing).**

- 0 I am able to care for my teeth and gums in a normal fashion without restriction, and without pain, fatigue or discomfort.
- 1 I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/discomfort, jaw tiredness results.
- 2 I do manage to care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort, jaw tiredness no matter how slow and careful I am.
- 3 I am unable to properly clean all my teeth and gums because of restricted opening and/or pain.
- 4 I am unable to care for most of my teeth and gums because of restricted opening and/or pain.

### **3. Normal living activities (eating, chewing).**

- 0 I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.
- 1 I can eat and chew most anything I want, but it sometimes causes some pain/discomfort and/or jaw tiredness.
- 2 I can't eat much of anything I want, because it often causes pain/discomfort, jaw tiredness or because of restricted opening.
- 3 I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue and/or restricted opening.
- 4 I must stay on a liquid diet because of pain and/or restricted opening.

### **4. Social/recreational activities (singing, playing musical instruments, cheering, laughing, social activities, playing amateur sports/hobbies, and recreation, etc.)**

- 0 I am enjoying a normal social life and/or recreational activities without restriction.
- 1 I participate in normal social life and/or recreational activities but pain/discomfort is increased.
- 2 The presence of pain and/or fear of likely aggravation only limits the more energetic components of my social life (sports, exercising, dancing, playing musical instruments, singing).
- 3 I have restrictions socially, as I can't even sing, shout, cheer, play and/or laugh expressively because of increased pain/discomfort.
- 4 I have practically no social life because of pain.

### **5. Non-specialized jaw activities (yawning, mouth opening and opening my mouth wide).**

- 0 I can yawn in a normal fashion, painlessly.
- 1 I can yawn and open my mouth fully wide open, but sometimes there is discomfort.
- 2 I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.
- 3 Yawning and opening my mouth wide are somewhat restricted by pain.
- 4 I cannot yawn or open my mouth wide more than two finger widths (28-32cm) or, if I can, it always causes greater than moderate pain.

**6. Sexual function (including kissing, hugging and any and all sexual activities to which you are accustomed).**

- 0 I am able to engage in all my customary sexual activities and expressions without limitation and/or causing headache, face or jaw pain.
- 1 I am able to engage in all my customary sexual activities and expression, but it sometimes causes some headache, face or jaw pain, or jaw fatigue.
- 2 I am able to engage in all my customary sexual activities and expression, but it usually causes enough headache, face or jaw pain to markedly interfere with my enjoyment, willingness and satisfaction.
- 3 I must limit my customary sexual expression and activities because of headache, face or jaw pain or limited mouth opening.
- 4 I abstain from almost all sexual activities and expression because of the head, face or jaw pain it causes.

**7. Sleep (restful, nocturnal sleep pattern).**

- 0 I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.
- 1 I sleep well with the use of pain pills, anti-inflammatory medication or medicinal sleeping aids.
- 2 I fail to realize 6 hours restful sleep even with the use of pills.
- 3 I fail to realize 4 hours restful sleep even with the use of pills.
- 4 I fail to realize 2 hours restful sleep even with the use of pills.

**8. Effects of any form of treatment, including, but not limited to, medications, in-office therapy, treatments, oral orthotics (e.g. splints, mouthpieces), ice/heat, etc.**

- 0 I do not need to use treatment of any type in order to control or tolerate headache, face or jaw pain and discomfort.
- 1 I can completely control my pain with some form of treatment.
- 2 I get partial, but significant, relief through some form of treatment.
- 3 I don't get "a lot of" relief from any form of treatment.
- 4 There is no form of treatment that helps enough to make me want to continue.

**9. Tinnitus, or ringing in the ear(s).**

- 0 I do not experience ringing in my ear(s).
- 1 I experience ringing in my ear(s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.
- 2 I experience ringing in my ear(s) and it interferes with my sleep and/or daily activities, but I can accomplish set goals and I can get an acceptable amount of sleep.
- 3 I experience ringing in my ear(s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.
- 4 I experience ringing in my ear(s) and it is incapacitating and/or forces me to use a masking device to get any sleep.

**10. Dizziness (lightheaded, spinning and/or balance disturbances).**

- 0 I do not experience dizziness.
- 1 I experience dizziness, but it does not interfere with my daily activities.
- 2 I experience dizziness which interferes somewhat with my daily activities, but I can accomplish my set goals.
- 3 I experience dizziness which causes a marked impairment in the performance of my daily activities.
- 4 I experience dizziness which is incapacitating.

Score: \_\_\_\_\_

## 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 \_\_\_\_\_

## 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 \_\_\_\_\_

## 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 \_\_\_\_\_

## 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 discussion 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.**