## NEW PATIENT FORMS – PLEASE FILL OUT AS COMPLETELY AS POSSIBLE

**Patient Name**: ______________________________________________ **Date:** ____________________
Address: ___________________________________ City: ____________ State: ______ Zip: ___________
Home Phone: _________________Work Phone: ___________________ Cell Phone: __________________
Email Address: _____________________ SEX - **M or F** Marital Status ____ Spouse's Name: ____________
Date of Birth: ___________________ Age: ________ Referred by: _______________________________
Occupation: ________________________________ Employer: _________________________________
Have you ever received Chiropractic Care? (Circle One) **YES or NO** If yes, when? ______________________
Name of most recent Chiropractor: _________________________________________________________

**CURRENT/PAST HEALTH HISTORY -- Please indicate if you have a history of any of the following:**

___Anticoagulant use
___Heart problems/high blood pressure/chest pain
___Bleeding problems
___Lung problems/shortness of breath
___Cancer
___Diabetes
___Osteoporosis/Osteopenia
___Stroke/TIA

**ARE YOU PREGNANT?** (Circle One) **YES or NO** Patient's Initials ____________________
Previous Injuries or Trauma: _______________________________________________________________
Have you ever broken any bones? Which? _____________________________________________________
**ALLERGIES:** ___________________________________________________________________________
**MEDICATIONS: (Please list all medications you are currently taking and why)**

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

**SURGERIES: (Please list types of surgery and date performed)**

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

**SOCIAL HISTORY**

Recreational activities: (hobbies, level of exercise, etc.)

_______________________________________________________________________________________

Do you smoke? YES or NO If yes, how many packs/day? _________________________________
Do you drink alcohol? If yes, how often? _______________________________________________________


4303 West 27th Avenue, Suite E, Kennewick WA 99338 – (509) 783-0834

**FAMILY HEALTH HISTORY -- Please indicate if anyone in your family has a history of any of the following:**

___ Cardiac disease below age 40 If yes, who? _____________________
___ Heart problems/high blood pressure/chest pain If yes, who? _____________________
___ Lung problems/shortness of breath If yes, who? _____________________
___ Cancer If yes, who? _____________________
___ Diabetes If yes, who? _____________________
___Osteoporosis/Osteopenia If yes, who? _____________________
___ Stroke/TIA If yes, who? _____________________
___ Adopted or Unknown Family History

Is there anything else about your health that you would like us to know?
_____________________________________________________________________________________

# ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT TO DOCTOR

**PLEASE READ THIS CAREFULLY**

I hereby instruct and direct my insurance company to pay by check made payable and mailed directly to:

**Canyon Chiropractic & Massage Therapy**
**4303 West 27th Avenue, Suite E**
**Kennewick, WA. 99338**

for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy.

The payment will not exceed my indebtedness to the above mentioned assignee and **I agree to pay any balance of said professional services over and above this insurance payment**. I understand and agree that I am ultimately responsible for all fees including reasonable collection costs and services not covered by my insurance contract. It is my responsibility to obtain and understand my insurance benefits prior to receiving services. This assignment of benefits does not release me from the obligation to pay professional fees. A photocopy of this assignment of benefits shall be considered as effective and valid as the original.

_____________________________________________ _____________________________
Printed Name of Patient Date

_____________________________________________
Signature of Patient or Guardian

**Patient Name: ____________________________________________ Date: ______________________**

## HIPAA NOTICE 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 READ IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) that are permitted or required by law. "Protected Health Information" is information about you. It includes demographic information that may identify you and is related to your past, present, or future physical or mental health condition and related care services.

**Use and Disclosures of Protected Health Information**
Your protected health information may be used and disclosed by your physician, staff and others outside of your physician's office that are involved in your care and treatment for the purpose of providing healthcare services to you, pay your healthcare bills, to support the operations of the physicians practice or any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your healthcare services.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fund raising activities and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors and organ donation. We must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

________________________________________ ________________________

Signature of Patient or Representative Date

________________________________________

Printed Name

## Informed Consent for Chiropractic Treatment or Massage Therapy & No Show Policy Acknowledgement for Massage Therapy

**TO THE PATIENT:** *You have the right to be informed about your condition, the recommended chiropractic or massage therapy treatment and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision about whether or not to have the treatment.*

I request and consent to chiropractic treatment and/or massage therapy. The chiropractic treatment may include adjustments, other chiropractic procedures including various modes of physical therapy and diagnostic x-ray. The chiropractic treatment will be performed by a Chiropractic Doctor. The massage therapy will be performed by a Licensed Massage Therapist.

I will have the opportunity to discuss with the Chiropractor or Licensed Massage Therapist my diagnosis, the nature and purpose of my treatment, the risks and benefits of my chiropractic or massage therapy treatment, the alternatives to my treatment and the risks and benefits of alternative treatment including no treatment at all.

I understand that there are some risks involved in chiropractic and massage therapy treatment including but not limited to **broken bones, dislocations, sprains or strains, increased symptoms and pain, temporary pain or discomfort, bruising, swelling, sensitivity or allergy to massage oil or lotion and no improvement in symptoms or pain.**

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical (neck) adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control the eye movements, and death.

I do not expect the doctor or the massage therapist to be able to anticipate and explain all risks or complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

**I have read or have had read to me the above consent. I have also had the opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment. I intend this consent form to cover the entire course of treatment within this office.**

If you are unable to keep your Massage Therapy appointment, please cancel at least **24 hours** prior to your scheduled visit. If the clinic is closed, please leave a message on the answering machine. A No Show Fee of **$35.00** will be charged to your account if you cancel less than 24 hours prior or do not keep your appointment. This fee is **not** submitted to your insurance and is strictly patient responsibility. Your signature below indicates you understand and agree to this policy.

_______________________________________ _______________________
Printed Name of Patient Date

_______________________________________
Signature of Patient or Guardian

_______________________________________ _______________________
Signature of Doctor Date

**PATIENT NAME:** ________________________________________ **DATE:** __________________________________

**Please check the line next to the symptoms you currently have.**

**PULMONARY/LUNG RELATED**
__ Asthma/difficulty breathing
__ COPD
__ Emphysema
__ Other
__ **NONE OF THE ABOVE**

**CARDIOVASCULAR/HEART RELATED**
__ Heart Surgeries
__ Congestive Heart Failure
__ Murmurs or valvular disease
__ Heart Attack/MI
__ Heart Disease/Problems
__ **Hypertension**
__ Pacemaker
__ Angina/Chest Pain
__ Irregular heartbeat
__ Other __________________
__ **NONE OF THE ABOVE**

**NEUROLOGICAL/NERVE RELATED**
__ Visual changes/loss of vision
__ One sided weakness of face/body
__ History of seizures
__ Headaches
__ One sided decreased feeling of face/body
__ Memory loss
__ Tremors
__ Vertigo
__ Loss of sense of smell
__ Strokes/TIA
__ Other __________________
__ **NONE OF THE ABOVE**

**ENDOCRINE/GLANDULAR/HORMONAL**
__ Thyroid Disease
__ Hormone replacement therapy
__ Injectable steroid replacements
__ Diabetes
__ Other __________________
__ **NONE OF THE ABOVE**

**RENAL/KIDNEY RELATED**
__ Renal calculi/stones
__ Hematuria (blood in urine)
__ Incontinence
__ Bladder infections
__ Difficulty urinating
__ Kidney disease
__ Dialysis
__ Other __________________
__ **NONE OF THE ABOVE**

**GASTROENTEROLOGICAL/STOMACH RELATED**
__ Nausea
__ Difficulty swallowing
__ Ulcerative disease
__ Abdominal pain
__ Hiatal hernia
__ Constipation
__ Pancreatic disease
__ Irritable bowel/colitis
__ Hepatitis or liver disease
__ Bloody or black stools
__ Vomiting blood
__ Bowel incontinence
__ Reflux/heartburn
__ Other __________________
__ **NONE OF THE ABOVE**

**HEMATOLOGICAL/BLOOD RELATED**
__ Anemia
__ Regular Anti-Inflam med use
__ HIV Positive
__ Abnormal bleeding/bruising
__ Sickle cell anemia
__ Enlarged lymph nodes
__ Hemophilia
__ **History of blood clots/DVT**
__ Anticoagulant therapy
__ Regular aspirin use
__ Other __________________
__ **NONE OF THE ABOVE**

**DERMATOLOGICAL/SKIN RELATED**
__ Significant burns
__ Significant rashes
__ Skin Grafts
__ Psoriatic disorders
__ Other __________________
__ **NONE OF THE ABOVE**

**MUSCULOSKELETAL/BONE OR MUSCLE RELATED**
__ Rheumatoid arthritis
__ Gout
__ Osteoarthritis
__ Broken bones
__ Spinal fractures
__ Joint surgery
__ Arthritis (unknown type)
__ Scoliosis
__ Metal implants
__ Other __________________
__ **NONE OF THE ABOVE**

I have read the above information and certify it to be true and correct to the best of my knowledge.

______________________________________________ ________________________________

Patient or Guardian Signature Date

Patient Name: _____________________________________________ Date: ___________________________

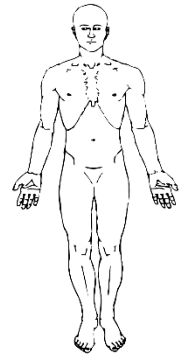
# PATIENT SYMPTOM FORM

**(Please list each of your symptoms individually ie: headache, neck pain, tingling etc. Use additional pages if needed)**

SYMPTOM ________________________________________________________________________________

- On a scale of 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time. 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time when you are awake do you experience the above symptom at the above intensity? 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ___________________________________________________________
- Did the symptom begin SUDDENLY or GRADUALLY (circle one)
- How did the symptom begin? ____________________________________________________________
- Was the symptom a result of a motor vehicle collision? YES or NO (circle one)
    - If yes, did you have the symptom before the motor vehicle collision? YES or NO (circle one)
    - If yes, what was the intensity? On a scale of 0-10, with 10 being the worst, please circle the number that best describes the intensity most of the time. 0 1 2 3 4 5 6 7 8 9 10
- What makes the symptom worse? (check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| | Bending neck forward | | Bending neck backward | | Tilting head to left |
| | Tilting head to right | | Turning head to left | | Turning head to right |
| | Bending forward at waist | | Bending backward at waist | | Twisting left at waist |
| | Twisting right at waist | | Sitting | | Standing |
| | Getting up from sitting | | Lifting | | Any movement |
| | Driving | | Walking | | Running |
| | Nothing | | Other | | |

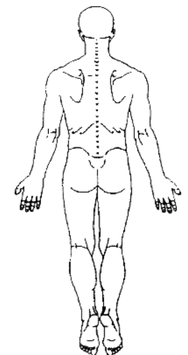


- What makes the symptom better? (check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| | Ice | | Heat | | Exercise |
| | Massage | | Pain Medication | | Muscle Relaxers |
| | Nothing | | Other | | |

- Describe the quality of your symptom. (check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| | Sharp | | Dull | | Achy |
| | Burning | | Throbbing | | Piercing |
| | Stabbing | | Deep | | Nagging |
| | Shooting | | Stinging | | Other |



- Does the symptom radiate to another part of your body? YES or NO (circle one)
    - If yes, where does the symptom radiate? ___________________________
- Is the symptom worse at certain times of the day or night? (check one)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Morning | | Afternoon | | Evening | | Night |

Please indicate on the diagrams to the right where your symptom is located ⇨

Is there anything else you would like the doctor to know about your symptom?

_________________________________________________________________________________________