



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? _____

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

- | | |
|--|--------------------|
| <input type="checkbox"/> Cardiac disease below age 40 | If yes, who? _____ |
| <input type="checkbox"/> Heart problems/high blood pressure/chest pain | If yes, who? _____ |
| <input type="checkbox"/> Lung problems/shortness of breath | If yes, who? _____ |
| <input type="checkbox"/> Cancer | If yes, who? _____ |
| <input type="checkbox"/> Diabetes | If yes, who? _____ |
| <input type="checkbox"/> Osteoporosis/Osteopenia | If yes, who? _____ |
| <input type="checkbox"/> Stroke/TIA | If yes, who? _____ |
| <input type="checkbox"/> 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: _____

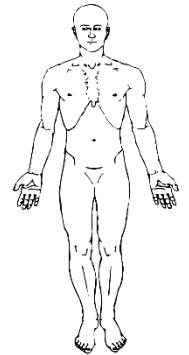
PATIENT SYMPTOM FORM

(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	

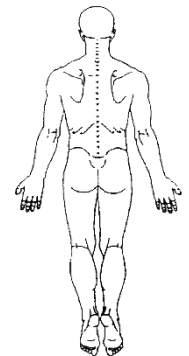


- What makes the symptom better? (check all that apply)

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
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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?

Patient Name: _____ Date: _____

AUTO ACCIDENT MECHANISM OF INJURY FORM

Date of Accident/Collision _____ Time of Accident/Collision _____ AM or PM

Please describe how the collision occurred: _____

What were the weather conditions at the time of the accident? _____

What street(s) were you on? _____

What direction were you heading? **N S E W** What direction was the **OTHER** vehicle heading? **N S E W**

What is the Make, Model and Year of the **OTHER** vehicle? _____

Were you the only one in **YOUR** vehicle? If not, who was in **YOUR** vehicle? _____

ABOUT YOUR VEHICLE

What is the Make, Model and Year of **YOUR** vehicle? _____

What was the approximate speed of **YOUR** vehicle when the accident occurred? _____ mph

Did you strike another vehicle? **YES or NO** Did another vehicle strike your vehicle? **YES or NO**

What was the angle of impact? (Check one) ___ **Front** ___ **Back** ___ **Left** ___ **Right** ___ **Other** _____

If second collision, angle of 2nd impact: ___ **Front** ___ **Back** ___ **Left** ___ **Right** ___ **Other** _____

Were you braking on impact? **YES or NO**

ABOUT YOU

What was your position in the car? (check one) ___ **Driver** ___ **Front Passenger** ___ **Left Rear** ___ **Right Rear**

If Driver, were your hands on the steering wheel? (check one) ___ **Both** ___ **Left** ___ **Right**

Did the airbags deploy? **YES or NO**

In relation to the back of your head, was your headrest set ___ **Low** ___ **Middle** ___ **High**

Were you surprised by the impact? **YES or NO or PARTIALLY**

If, "NO", how did you brace? **WITH HANDS or WITH FEET**

Where was your head facing at the time of impact? ___ **Straight** ___ **Left** ___ **Right** ___ **Behind** ___ **Up** ___ **Down**

Were you leaning forward at the time of impact? **YES or NO**

Were you wearing a seatbelt? **YES or NO** What type? ___ **Lap Belt** ___ **Shoulder belt** ___ **Both**

Were you braking on impact? **YES or NO**

Did you feel pain immediately after the accident? **YES or NO**

Were you rendered unconscious as a result of the accident? **YES or NO**

Did you strike anything in the vehicle at the time of impact? **YES or NO** If yes, specify what part of your body struck which part of the vehicle.

Steering Wheel	Windshield
Dashboard	Roof
Left Side Door	Right Side Door
Left Window	Right Window

Patient Name: _____ Date: _____

Did your seat break or bend? **YES or NO**

Immediately after the accident, how did you feel? (check all that apply) ___ Dizzy ___ Dazed ___ Weak

___ Upset ___ Disoriented ___ Nervous ___ Nauseous ___ Other _____

Since the collision, have you experienced any of the following:

Loss of range of motion? **YES or NO** Which body parts? _____

Visual Disturbance? **YES or NO**

Blurring? **L or R** Floaters? **L or R** Vision Loss? **L or R** Hypersensitivity? **L or R**

% of time _____ % of time _____ % of time _____ % of time _____

Dizziness? **YES or NO** % of time _____ Anxiety? **YES or NO** % of time _____

Depression? **YES or NO** % of time _____ Difficulty Sleeping? **YES or NO** % of time _____

Have you missed work as a result of the accident? How many days? _____

Do you have difficulty with **EXCESSIVE**? (check all that apply) ___ Standing ___ Walking ___ Riding

___ Bending ___ Twisting ___ Other _____

Do you have difficulty with **EXCESSIVE** lifting? (check all that apply) ___ Light ___ Moderate ___ Heavy

___ Repetitive

YOUR SYMPTOMS SINCE THE ACCIDENT

Please check **ALL SYMPTOMS** that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Skull or head pain | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Head feels too heavy | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Shoulder stiffness | <input type="checkbox"/> Arm pain | <input type="checkbox"/> Arm numbness |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Numbness in hands and fingers | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Mid back stiffness |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Painful breathing |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Low back stiffness | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Buttock pain | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Leg numbness |
| <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Numbness in feet/toes | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Mental dullness |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Loss of color |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Difficulty focusing |
| <input type="checkbox"/> Pain behind the eyes | <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Buzzing or ringing in ears | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Excessive perspiration | <input type="checkbox"/> Loss of perspiration | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Fever | <input type="checkbox"/> Pain in doing occupation |
| <input type="checkbox"/> Swelling, where? _____ | <input type="checkbox"/> Difficulty riding in car | <input type="checkbox"/> Difficulty bending |
| <input type="checkbox"/> Difficulty standing | <input type="checkbox"/> Difficulty sitting | <input type="checkbox"/> Difficulty walking |
| <input type="checkbox"/> Difficulty lifting | <input type="checkbox"/> Difficulty twisting/turning | <input type="checkbox"/> Difficulty rising to walk |

Patient Name: _____ Date: _____

POLICE & HOSPITAL

Was the accident reported to the police? **YES or NO** Were citations issued? **YES or NO** To whom? _____
Did you go to the hospital? **YES or NO** If "YES", how? ___Ambulance ___Police Car ___Private Vehicle
Were you admitted to the hospital? **YES or NO** If "YES", how long did you stay? _____
Name of Hospital? _____ Attending Physician? _____
What treatment were you given? (check all that apply) ___X-ray ___MRI ___CT ___Pain Medication ___Stitches
___Muscle Relaxants ___Bandages ___Cervical Collar ___Physical Therapy ___Instructions for Concussion
___Instructions for Strains/Sprains ___Referred to an Orthopedist ___Referred to a Private Physician
___Referred to this Office ___Other _____
What other Doctor have you seen as a result of this injury? _____

YOUR PERSONAL INJURY POLICY (PIP)

PLEASE CHECK ONE:

- Bill my automobile policy under the Personal Injury Protection (PIP)
- I **do not** have Personal Injury Protection (PIP) but I will hire an attorney to represent my accident case.

Your PIP coverage will pay medical expenses as a result of the accident up to one year from the date of the injury. This coverage is for your protection so that the bills will be paid in a timely manner. **If the accident was not your fault**, your insurance company will be reimbursed upon settlement by the responsible party's insurance. If your PIP coverage has expired after one year, your treatment may be covered by your private medical insurance.

Is an attorney representing you for this accident? YES or NO, Who? _____
What is the name of YOUR insurance company? _____
What is the name and phone # of YOUR claim adjustor? _____

What is your claim #? _____

My signature below acknowledges that I understand and accept the above policy and give permission for my PIP coverage to be billed for medical services performed related to my accident. I agree that I am ultimately responsible for any charges incurred as a result of my care.

Printed Name of Patient

Date

Signature of Patient or Guardian

Patient Name: _____ Date: _____

The form consists of four rectangular boxes arranged in a 2x2 grid. A vertical dashed line runs down the center, separating the left and right columns. Horizontal dashed lines are positioned between the top and middle rows, and between the middle and bottom rows, separating the four quadrants. Each quadrant is currently empty, intended for a drawing or notes.