Renton Office
819 South 3rd Street
Renton, WA 98057
Tel.: (425) 687-2707 Fax: (206) 309-9063

Bellevue Office
12505 Bel-Red Road, Suite 188
Bellevue, WA 98005
Tel.: (425) 484-9023

WELCOME

Our goal is to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if you would benefit from chiropractic care. However, the history and physical examination are not considered treatment. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to an appropriate health care provider.

PATIENT INFORMATION

Last Name _____ First Name: _____ Middle: _____
Birth Date: _____ Age: ____ Gender: M / F Marital Status: Single / Married / Other _____
Home Address: _____ City:_____ State: ____ Zip: _____
Home Phone: (_____) _____ Cell/Work: (_____) _____ Email: _____
Social Security # _____ Occupation _____

Emergency Contact

Last Name _____ First Name: _____ Middle: _____
Home Phone: (_____) _____Cell/Work: (_____) _____ Relationship: _____

ASSIGNMENT OF INSURANCE BENEFITS - SIGNATURE ON FILE

Payment Method · Cash · Check · Visa/Master Card · Insurance

Insurance

Primary Insurance Company: _____ Phone #: (_____) _____
Insurer's Name: _____ID/ Policy #/Claim #: _____
Secondary Insurance Company: _____ Phone #: (_____) _____
Insurer's Name: _____ID/ Policy #/Claim #: _____

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this clinic chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The clinic will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

*I hereby authorize payment directly to current chiropractic clinic
*I authorize Chiropractic & Wellness Clinic to act as my agent in helping me to obtain payment from the insurance company.
*I understand that I am financially responsible to the charges not covered by this assignment.
*I authorize the doctor, attorney, or insurance company to release any information required for this claim.
*I permit a copy of this authorization to be used in place of the original.

_____ _____
Date Signature (Signature of Parent if minor Patient)

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INFORMED CONSENT

CHIROPRACTIC

Chiropractic is a health care system that promotes health by working with the body naturally. Chiropractic believes that the body has its own innate healing capability to heal itself, if the body is allowed to express itself in its optimal environment, by being free from subluxation. A subluxation is a minor misalignment or malfunction of the joints of the body to the extent that it puts pressure on the surrounding tissues, especially the nerve tissues, and causes problem where ever the nerves travel to, resulting in either over stimulation or under stimulation. Either condition causes an alteration in the normal function of the body, thus resulting in a loss of health. Many things in our daily life can cause subluxation in the body; it may be due to birth process, aging, injury, physical or emotional trauma, stress, chemical imbalance, activity of daily living, etc. Chiropractic corrects the subluxation by giving an adjustment. An adjustment involves the use of controlled force by hand or instrument. Other modalities may be given to help facilitate the healing of the body, to reduce the interferences in the body and restore the normal function. When the body is functioning at its optimum, then you will be healthy.

INFORMED CONSENT FOR CHIROPRACTIC CARE

I give Chiropractic doctor permission and authority to care for my condition in accordance with the chiropractic tests, diagnosis and analysis. Chiropractic treatment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, illnesses, or pathologies may render the patient susceptible to injury. I promise to inform doctor and staff any time I feel my well-being is threatened or compromised. It is my responsibility to let the doctor know all the health condition I am suffering from. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. Chiropractic doctor and staff will not give a chiropractic treatment, or health care, if he is aware that such care may be contraindicated. I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by doctor and other members of my health care team. I agree to participate in the self care program we select.

RESULTS

The results of chiropractic care depends on many variables; such as the status of your condition (acute or chronic), how traumatic is your condition, and your overall health. You should notice great improvement within two weeks into your care. In most cases there is a more gradual, but quite satisfactory response.

RETRACING

On rare occasion, especially when your body is fragile, retracing occurs before “true” healing can take place. Retracing is the release and healing of unresolved problems. After the correction, old injuries, old distortions, old subluxations and old symptoms (both physical and emotional) may resurface while the body is going through the unwinding process of healing.

Patients may report of having "cleansing" symptoms such as diarrhea, pus, mucus, headache, generalized ache and pain, fever, etc. as toxins leave the body. These symptoms may take the form of emotional releases, old memories coming up or unusual dreams.

It is very important, especially at this time, to maintain regular treatment schedule to facilitate the healing process.

Please discuss any question or concern you have with the doctor before signing this statement of policy.
I have read and understand this Informed Consent.

_____ _____

Signature Date

Patient Questionnaire

Have you ever had any falls, Accidents or injuries? Yes [ ] please explain No [ ]	Month, Year	Type of Accident	Describe Injury
Have you ever had Surgery? Yes [ ] please explain No [ ]	Month, Year	Type of Surgery	Why was surgery performed?
Have you presently taking medicaton? Yes [ ] please list No [ ]	Name of Drug	Doses per day	What are you taking it for?

Alcohol Use: Yes [ ] No [ ] Frequency & Quantity: Daily Weekly Monthly

Are you smoke? Yes [ ] No [ ] Frequency & Quantity: Daily Weekly Monthly

Do you exercise on a regular basis (or more times each week)? Yes [ ] No [ ]

Please describe:

History of family disease? Yes [ ] No [ ]

Please explain:

Please check your current problems and your concern below:

[ ] Headaches	[ ] Neck pain & stiffness	[ ] Cold hands / fingers	[ ] Heart attack
[ ] Shooting head pains	[ ] Muscle spasms in neck	[ ] Cold feet / toes	[ ] Stroke
[ ] Binging in ears	[ ] Pain in shoulders & arms	[ ] Swollen ankles	[ ] Cancer
[ ] Dizziness	[ ] Tightness in shoulders	[ ] High blood pressure	List Type:
[ ] Loss of balance	[ ] Tingling in arms/hands/fingers	[ ] Low blood pressure	[ ] allergies
[ ] Fainting spells	[ ] Numbness in arms/hands/fingers	[ ] Chronic tiredness	List Type:
[ ] Loss of memory	[ ] Mid back pain & stiffness	[ ] Shortness of breath	[ ] Thyroid trouble
[ ] Difficulty concentrating	[ ] Mid back muscle spasms	[ ] Chest pain	[ ] Gall bladder trouble
[ ] Blurred vision	[ ] Low back pain & stiffness	[ ] Indigestion	[ ] Ulcers
[ ] Lights bother eyes	[ ] Low back muscle spasms	[ ] Stomach pain	[ ] Kidney trouble
[ ] Difficulty swallowing	[ ] Pain in legs	[ ] Frequent ear infections	[ ] Prostrate trouble
[ ] Loss of smell/ taste	[ ] Pain in feet	[ ] Frequent colds	[ ] Rheumatoid arthritis
[ ] Irritability	[ ] Tingling in legs / feet	[ ] Frequent sore throats	[ ] Diabetes
[ ] Inner tension	[ ] numbness in legs/ feet	[ ] Frequent constipation	[ ] Anemia
[ ] Nervousness	[ ] Hip pain & stiffness	[ ] Frequent diarrhea	[ ] Sinus trouble
[ ] Depression	[ ] Knee pain	[ ] Frequent urination	[ ] Asthma
[ ] Trouble sleeping	[ ] Ankle pain	[ ] Menstrual problems	

Patient Signature: _____

Date: _____