



HISTORY & INTAKE

FOR OFFICE USE ONLY:				
Insurance: _____	Date: _____	File Number: _____	DOL: _____	Claim Number: _____

PATIENT INFORMATION (Please COMPLETE EVERY SPACE)

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER:	
ADDRESS			DRIVER'S LICENCE #	STATE
CITY	STATE	ZIP CODE	EMPLOYER/ SCHOOL <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> RET <input type="checkbox"/> UNEMP	
HOME PHONE () ()	CELL PHONE () ()		OCCUPATION	WORK PHONE EXT. () ()
E-MAIL			NAME OF SPOUSE (or responsible party if minor) DATE OF BIRTH MM DD YYYY / /	
DATE OF BIRTH SEX MARITAL STATUS MM DD YYYY / / M/ F <input type="checkbox"/> Sing. <input type="checkbox"/> Mar. <input type="checkbox"/> Div. <input type="checkbox"/> Wid. <input type="checkbox"/> Partn.			EMERGENCY CONTACT NAME RELATION TO YOU	
PREFERRED METHODS OF CONTACT <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> Mail <input type="checkbox"/> Other			EMERGENCY PHONE () ()	

PAST HEALTH HISTORY

In general would you say your overall health is: excellent very good good fair poor

Have you been treated for any health conditions by a physician in the last year? Describe _____

Place a mark on "Yes" or "No" to indicate if you have any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure (including pregnancy)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Problems, Rash, change in mole	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of Phlebitis or clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint pain or stiffness (arthritis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness of arms or legs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain or tightness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease or stones	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	
Coughing, wheezing, or lung problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Cramping of legs while walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Speech or Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Depression, Anxiety or panic attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine/ Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes (including pregnancy)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness or Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pace Maker	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No		

WOMEN ONLY:	
Premenstrual cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Premenstrual headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unable to get pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pregnant or trying to	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hysterectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tubal ligation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Menopausal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suffer from hot flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	

Any past Auto Accidents? <input type="checkbox"/> No <input type="checkbox"/> Yes (describe)	Any past Work Related Accidents? <input type="checkbox"/> No <input type="checkbox"/> Yes (describe)
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Do you suffer from any conditions other than those on registration form? No Yes (describe)

Major Surgeries? No Yes (describe)

Hospitalizations? (other than above) No Yes (describe)

Other major Accidents, Traumas or Falls? No Yes (describe)

FAMILY HEALTH HISTORY Indicate which of **your relatives** have had any of the following diseases:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer (specify type): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol/ addiction: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Health Conditions: _____	Other: _____	

EXERCISE	WORK ACTIVITIES	HABITS
<input type="checkbox"/> None <input type="checkbox"/> Yes, ____ days/ week Type of exercise: _____	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Smoking per day _____ Type _____ how long? ____ years <input type="checkbox"/> Alcohol drinks per week ____ <input type="checkbox"/> High Stress reason _____
MEDICATION	ALLERGIES	VITAMINS/ HERBS/ SUPPLEMENTS
dose? how often? side effects? _____ _____ _____	_____ _____ _____	_____ _____ _____

COMPLAINTS

Reason for visit: _____

Describe your complaint(s) when they are worst: _____

When did your symptoms start? suddenly on _____, gradually, first noticed _____

How did your symptoms begin? _____

Cause of complaint: work related school auto none of these home other _____

If this is a work or auto accident, to whom have you made a report to? not applicable Labor & Industries auto insurance other _____ employer

Has it occurred before? no yes, what was the outcome _____

How often do you experience your complaint(s)? Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

How long do your symptoms last? _____

Describe the nature of your complaint(s): sharp dull ache shooting burning cramps stiffness other _____

Do you have any: numbness no yes, where _____
 tingling no yes, where _____
 weakness no yes, where _____

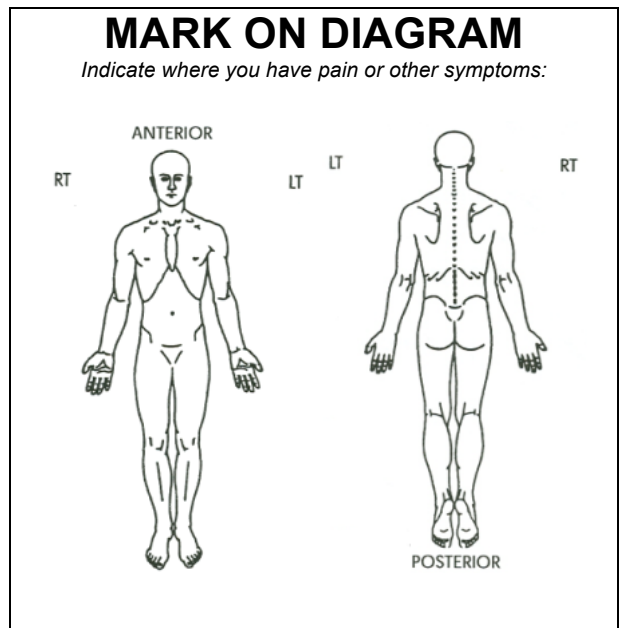
How many hours are you sleeping now? _____ How many hours do you usually sleep? _____

Upon waking, do your symptoms feel: better worse same

Does your complaint(s) interfere with: sleep no yes, if yes does it: prevent sleep wakes you
 daily routine no yes, explain _____
 work no yes, explain _____
 recreation no yes, explain _____

How are your symptoms changing? Getting worse Not changing Getting better

Indicate the average intensity of your symptoms: Unbearable (please circle the number that best corresponds) 10 9 8 7 6 5 4 3 2 1 None 0



COMPLAINTS (continued)

Is your complaint affecting any other area of your body? no yes, explain _____

Have any family members suffered from similar complaints? no yes, explain _____

How much has your complaint interfered with your work? (Both work outside the home, and household work)
 extremely quite a bit moderately a little bit not at all

Have you missed any days of work as a result? no yes, how much so far? _____

How much has your complaint interfered with your social activities?
 All of the time most of the time some of the time a little of the time none of the time

Movements that are painful to perform:

<input type="checkbox"/> Sitting	<input type="checkbox"/> Bending	<input type="checkbox"/> Twisting
<input type="checkbox"/> Standing	<input type="checkbox"/> Reaching High	<input type="checkbox"/> Coughing and sneezing
<input type="checkbox"/> Walking	<input type="checkbox"/> Reaching Low	<input type="checkbox"/> Other _____
<input type="checkbox"/> Lying down	<input type="checkbox"/> Reaching	<input type="checkbox"/> Other _____

What aggravates the problem? _____

What have you tried for relief? _____

Have you seen anyone or received treatment for your complaints?
 no
 yes, if so who and when? _____
 what tests were performed? X-ray (date) _____ MRI (date) _____
 CT scan (date) _____ other (date) _____

Chiropractic care previously? Name, location, and date last seen: _____

FOR PATIENTS UNDER 18 YEARS OLD- Consent to Examine, X-Ray and Treat a Minor

I am the parent or legal representative of: _____ who is a minor, _____ years of age. I authorize the performance of diagnostic examination and X-Rays of this child or ward which Strategic Health Chiropractic may consider necessary or advisable in the course of treatment.

Print: _____
 Parent or Legal Representative

Signed: _____
 Parent or Legal Representative

Date: _____

For office use only:

Nature of Condition: Initial onset (within last 3 months) Recurrent (multiple episodes < 3months) Chronic (continuous duration > 3 months)

History of: dizziness, vertigo, nausea, stroke, visual or auditory disturbance? No
 headache and migraine? No Yes

Complaints: A) _____ G) _____
 B) _____ H) _____
 C) _____ I) _____
 D) _____ J) _____
 E) _____ K) _____
 F) _____ L) _____

ADL's/ AUD's: 1) _____ 5) _____
 2) _____ 6) _____
 3) _____ 7) _____
 4) _____ 8) _____

Support/ Supplements: _____

Referral: PCP Orthopedic Neurologic Physiatrist PT LMP Other _____

Additional Notes: _____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Disclosure for Chiropractic Adjustments

TO THE PATIENT: You have the right as a patient to be informed about your condition and the recommend chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature of and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to concerning the results intended from the treatment.

I have read, or have read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I contest to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

PAYMENT POLICY

We believe that a clear definition of our policies will allow us both to concentrate on the big issue of regaining and maintaining your health...

APPOINTMENT POLICY

In order to serve all our patients we ask that you call if you are unable to make your appointment. If you find yourself running late, please call our office and notify the front desk and we will get you in for your visit as soon as possible. When you fail to notify our office, this leaves a time slot open that could otherwise be used to help someone else. Please help us help others.

Thank you.

PAYMENT SCHEDULE

THE FIRST DAY'S CHARGES ARE EXPECTED ON YOUR INITIAL VISIT. WE ACCEPT CASH, CHECK OR CREDIT CARD.

PLAN #1 – INSURANCE-Please present your insurance card today. We will call your insurance company for you to verify your coverage. If you have coverage for your chiropractic care, our office will submit claims for you. After your insurance company has been reached for benefit information a financial payment plan will be presented on your following visit. Until we have the completed necessary insurance information, you will be required to pay for your care on a cash basis.*

PLAN #2 – CASH-Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

PLAN #3 - WORK INJURY-You need to report your accident to your employer, bring in necessary insurance information. Complete and sign a required Accident Report in our office. Until the necessary information is provided OR if the claim is denied you will be required to pay for your care on a cash basis. Approved worker's compensation claims are not required to pay for care as it is rendered. Transfer of Care claims will be verified with the claims manager. Reopening of claims closed past 90 days will require patient to make personal arrangements and will be reimbursed if claim is allowed.*

PLAN #4 - PERSONAL INJURY You need to provide us with the accident report, your auto insurance, health insurance, and attorney if applicable. If the claim is a possible third party liability, please provide us with the other parties' insurance carrier information. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care on a cash basis. Patients with approved personal injury claims are not required to pay for care as it is rendered. Patients who are covered by third party insurance only will need to check with the insurance department to make payment arrangements.*

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Strategic Health Chiropractic will prepare all necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Strategic Health Chiropractic will be to my account on the receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

PATIENT NAME (PRINT)

X _____
Patient, or Parent/ Legal Guardian for patient under 18 years

DATE

NAME, If other than patient

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We are required to make a reasonable effort to have you sign the following form stating that you have reviewed our Notice of Privacy practices.

Thank you,

Dr. Chan

By my signature below I acknowledge receipt of the Notice of Privacy Practices. Parents should sign for children under 18.

PATIENT NAME (PRINT)

X _____
Patient, or Parent/ Legal Guardian for patient under 18 years

DATE

NAME, If other than patient