



Patient Information Sheet

Name: _____ Date: _____

Address: _____

City: _____ State/Zip: _____

Home Phone: (_____) _____ - _____ Work/Cell Phone: (_____) _____ - _____

Social Security Number: _____ Email Address: _____

Birthdate: ____/____/____ Male: ____ Female: ____
mo day yr

In case of emergency, contact: _____ Phone: (_____) _____ - _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed Student Status ___ Yes ___ No

Visit Information

How did you hear about us? _____

What is the reason for your visit today? _____

Primary Insurance Information

Name of Insurance Company: _____ Phone: _____

Address: _____ City: _____ State: _____

Policy Number: _____

Name of Insured: _____ Subscriber Name: _____

Subscriber Soc Sec#: _____ Subscriber Date of Birth: _____

Subscriber Employer Name: _____ Phone: _____

Secondary Insurance Information

Name of Insurance Company: _____ Phone: _____

Address: _____ City: _____ State: _____

Policy Number: _____

Name of Insured: _____ Subscriber Name: _____

Subscriber Soc Sec#: _____ Subscriber Date of Birth: _____

Subscriber Employer Name: _____ Phone: _____

Is your condition due to an accident _____ or illness _____?

If an accident, did it occur at work? _____ Date of accident: _____

Patient to complete the following sections:

Last Name:	First Name:	MI:	Daytime Phone:
Date:	Patient #:		Evening Phone:

Please list the reasons/condition for your visit in order of importance, most important at the top:	Date you first noticed:	Pain &/or Symptoms Circle the number that best reflects your condition: (0= no effect 10= severe)	Pain &/or Symptoms Circle how much of the time your experience your condition:
A.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
B.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
C.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
D.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%

For each condition listed above, please indicate how it happened:

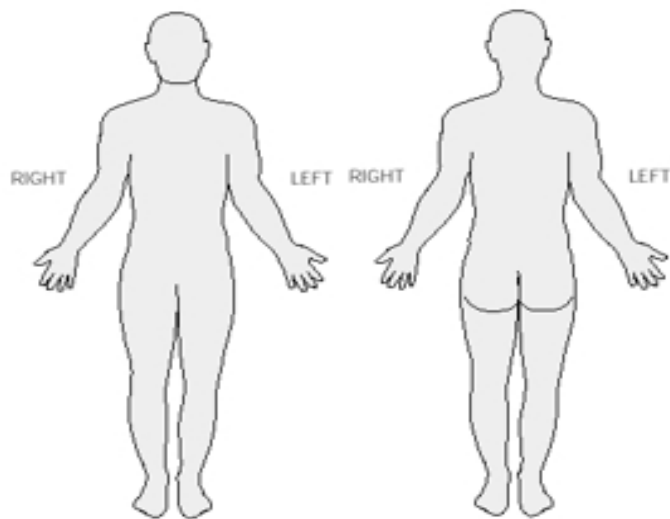
- A. Developed over time Illness Injury Auto accident Other _____ I don't know
- B. Developed over time Illness Injury Auto accident Other _____ I don't know
- C. Developed over time Illness Injury Auto accident Other _____ I don't know
- D. Developed over time Illness Injury Auto accident Other _____ I don't know

For each condition listed above, please indicate if it is better or worse with any of the following:

- | | | | | | |
|----|--|--|--|--|--|
| | Heat | Cold | Rest | Activity | Other: _____ |
| A. | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse |
| B. | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse |
| C. | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse |
| D. | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse |

FRONT

BACK



Please mark the areas of your discomfort on the figures at right, using the symbol which best describes the feeling: +++ sharp, stabbing; 000 pins & needles; VVV dull, aching; /// numbness

Please indicate if your condition limits any of the following activities:

Activity	How much pain? 0-10, 10 is worst	What motion? Front or back Left or Right
Work _____		
Sleep _____		
Bath/Shower _____		
Getting dressed _____		
Cooking _____		
Cleaning _____		
Laundry _____		
House Work _____		
Landscape _____		
Gardening _____		
Other _____		

Comments:

Acute Chiropractic Center

Phone: (253) 426-1000 Fax: (253) 267-1463

10209 Bridgeport Way SW Suite A-10 Lakewood, WA 98499

Patient to complete the following sections:

Patient Last Name: MI:	First Name:	Date:
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During what time of day do you feel worst? _____

Do you sleep well? Yes No

What are your normal sleeping hours? _____

Are you currently under the care of a medical doctor or other health care provider for any condition?

Yes No Condition: _____

Name of doctor/provider: _____ Phone: _____

Have you ever had an overnight stay in a hospital or surgical procedure of any kind? Yes No

Date and Description: _____

Date and Description: _____

Do you exercise? Yes No

Description: _____ Frequency/Minutes per session: _____

Description: _____ Frequency/Minutes per session: _____

Personal History:

Please read through the following list and check any which may apply to you

•Pain in Body•

- Neck pain with difficulty swallowing
- Extreme neck stiffness with pain or electrical shocks in arms or legs when moving neck
- Leg pain that worsens with exercise but is relieved by resting
- Loss of feeling in inner thighs
- Back pain with urinary problems

•Current Conditions•

- Unable to balance properly
- Recent unexplained weight loss
- Recent progressive muscle weakness or shaking
- Blurred or double vision, dizziness, nausea or faintness when neck is in certain position
- Recent major accident such as a fall from a height, whiplash, or a blow to the head
- Memory loss after injury

•Types of Pain•

- Severe pain interrupts sleep
- Constant pain not improved by changing positions or lying down

•Prior diagnosed condition/Medical History•

- Congenital bone or joint disorder
- Rheumatoid arthritis
- Severe degenerative arthritis
- History of compression fracture
- History of heart attack
- History of stroke or aneurysm
- Past history of cancer or currently diagnosed with cancer
- Diabetes with cold, burning, or numb feet
- Gout
- Lupus
- Ankylosing spondylitis
- Immune suppression due to chemotherapy, organ transplant, etc.
- 3 or more months use of steroid medications or intravenous drugs (past or recent)

Family History

Please read through the following list and check any which apply to you.

- | | | | |
|---|-----------------------------------|---|---|
| <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizure Disorder |

Comments: _____

Notice of Privacy Practices

The **Health Insurance Portability and Accountability Act** concerns the security of your personal and medical information. We respect your privacy and rights, so we follow these guidelines as applicable to our practice.

A partial list of **your rights** includes but is not limited to allowing (or prohibiting) health care providers from **revealing information with your permission, as necessary**, to others involved in your health care, such as insurance carriers, physicians, home care aides, and family members, friends, or other health care proxies who share responsibility for your well-being or billing for services rendered.

Information includes but is not limited to medical records, diagnostic reports, treatments, tests and results, billing, and referrals, as well as personal data such as birthdate, etc.

We will coordinate with all parties necessary for prompt, accurate and effective treatment and proper billing. **We will gladly explain** all aspects of your care to you or assigned persons as you wish.

Privacy Policies of Acute Chiropractic Clinic

The **Health Insurance Portability and Accountability Act (HIPAA)** is in effect. HIPAA has certain requirements with which health care providers are required to comply.

We are required to give each patient a notice of Privacy Practices (*see above*) listing was in which we might use your Protected Health Information. Please sign below, thereby stating that your received the notice.

Patient Name: (printed) _____

Patient Signature: _____ **Date:** _____

Release of Information

I certify that the above information is true and correct to the best of my knowledge. I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above other health care professionals to whom I am referred and to the insurance carrier or other entity responsible for payment, utilization and/or quality review for all or a portion of my care and treatments.

Patient Signature: _____ **Date:** _____

Patient's or Authorized Person's Signature

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless arrangements have been made. I further authorize the release of any medical or other information necessary to process insurance claims. This office is committed to protecting your privacy and ensuring the safety of your personal information.

Patient Signature: _____ **Date:** _____

Insured's or Authorized Patients Signature

I authorize payment of medical benefits to the above named physician or healthcare provider for services described. I also request payment of government benefits to the party who accepts assignment.

Patient Signature: _____ **Date:** _____