REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Last Name:	First:	Middle Initial:	Marital Status (check one) ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is patient a minor? ☐ Yes ☐ No	If **Yes**, who is the legal guardian/parent responsible for patient?	Patient Birth Date:	Age:	Sex: ☐ M ☐ F

SSN:	Email Address:

CONTACT INFORMATION

Address:			Home:
City:	State:	ZIP:	Cell: ☐ Text Message appt. reminders? Cell phone company:_____
Occupation:	Employer:		Work:

Referred to clinic by (please check one box): ☐ Dr.

☐ Family ☐ Friend ☐ Sign/location ☐ Yellow Pages ☐ Internet (Which Site?):

☐ Family/Friend/Co-Worker/Other (Name):

INSURANCE INFORMATION

Insurance Carrier Name (i.e., Allstate, Geico, etc.)

Policy Number:

Insurance Policy Holder Name:

Address:

Phone:

ACCIDENT INFORMATION

Type of Accident ☐ Automobile ☐ Work-Related ☐ Home ☐ Other (please indicate):

Have you reported this accident? ☐ Yes ☐ No If **Yes**, please list:

If **automobile accident related**, please complete **Personal Injury Questionnaire**

If **work related**, please complete the following:

Employer:	Date of Injury:	Claim # (if claim is open):

INJURIES / SURGERIES

Have you ever sustained a fall or an injury that required medical attention? ☐ Yes ☐ No

PLEASE COMPLETE THE FOLLOWING WITH AN APPROXIMATE DATE AND A BRIEF DESCRIPTION.

Falls / Head Injuries: _____

Broken Bones / Dislocations: _____

Surgeries: _____

Work Injuries: _____

Auto Accidents: _____

_____

(Please See Reverse Side)

Bothell Chiropractic & Wellness
*10024 Main St. #2C * Bothell, WA 98011 * 425-485-1413 * Fax: 425-485-1283*
*www.bothellchiropractic.com * info@bothellchiropractic.com*

HEALTH HISTORY

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other (please indicate):

Name of doctor(s) who have treated you for your current condition:	Date of Last:
	Physical Exam:
	Spinal Adjustment:
	Spinal X-Ray/MRI:

PLEASE CHECK ALL THAT APPLY

☐	AIDS / HIV	☐	Fever (prolonged)	☐	Mononucleosis	☐	Stroke
☐	Alcoholism	☐	Frequent Colds	☐	Multiple Sclerosis	☐	Thyroid Problems
☐	Allergy Shots	☐	Glaucoma	☐	Mumps	☐	TMJ (Jaw)
☐	Anemia	☐	Goiter	☐	Numbness	☐	Tremors
☐	Anorexia / Bulimia	☐	Gout	☐	Osteoarthritis	☐	Tuberculosis
☐	Appendicitis	☐	Headaches	☐	Osteoporosis	☐	Tumors, Growths
☐	Arthritis	☐	Hearing Loss	☐	Pacemaker	☐	Typhoid Fever
☐	Asthma	☐	Heart Attack	☐	Parkinson's Disease	☐	Ulcers
☐	Bed Wetting	☐	Hemorrhoids	☐	Pinched Nerve	☐	Vision Problems
☐	Bleeding Disorders	☐	Hepatitis	☐	Pneumonia	☐	Whooping Cough
☐	Bronchitis	☐	Hernia	☐	Polio		**Women Only:**
☐	Cancer	☐	Herniated Disc	☐	Prostate Problem	☐	Breast Problems
☐	Chemical Dependency	☐	High Blood Pressure	☐	Prosthesis	☐	Cramps
☐	Chicken Pox	☐	High Cholesterol	☐	Psychiatric Care	☐	Hysterectomy
☐	Diabetes	☐	Infertility	☐	Rheumatic Fever	☐	Irregular Menses
☐	Difficulty Breathing	☐	Kidney Disease	☐	Rheumatoid Arthritis	☐	Menopause
☐	Dizziness	☐	Liver Disease	☐	Ringing in Ears	☐	Miscarriage
☐	Emphysema	☐	Low Back Pain	☐	Scarlet Fever	☐	PMS
☐	Epilepsy	☐	Measles	☐	Sinus Infections	☐	Pregnant
☐	Fatigue	☐	Migraines	☐	STDs		Due Date: _____

MEDICATIONS

Medications:

Allergies (if any):

Vitamins/Herbs/Mineral/Supplements:

PERSONAL LIFESTYLE

Exercise	Work Activity	Stress Level	Habits	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs/day:
☐ 1-2 x week	☐ Standing	☐ Medium	☐ Alcohol	Drinks/week:
☐ 3-4 x week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups/day:
☐ 5+ x week	☐ Heavy Labor	☐ Causes:		

Type of Exercise:

Eating Habits

In the last 24 hours, how many servings of fruits and vegetables have you consumed?

Is this typical? ☐ Yes ☐ No

Average fast food you eat per week: ☐ 0 (None) ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 4+

ASSIGNMENT

I, the undersigned, certify that I (or my dependent) have insurance with _____ and I authorize direct payment to Bothell Chiropractic & Wellness, PLLC for any insurance benefits otherwise payable to me for the services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure benefits. I authorize the use of this signature on all insurance claims. I understand that a copy of my insurance card is to be kept on file for the purposes of billing for all services rendered herein. The above information is true and correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges incurred in this office. All fees are payable at the time of service, unless other arrangements are made in advance.

_____ _____

Patient/Guardian signature *Date*

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PAIN DIAGRAM &
FUNCTIONAL RATING INDEX

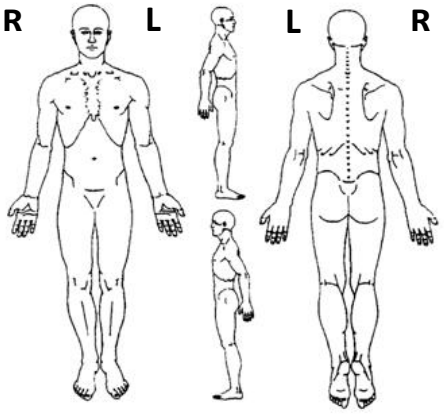
Name: _____ Date: _____

My Chief Complaint is: _____

2nd Complaint: _____

3rd Complaint: _____

Please draw the location and type of pain on the body outlines:



Ache	**Burning**	**Numbness**
MMM	-- -- --	○ ○ ○

Pins and Needles	**Stabbing**	**Other**
oooooooooooo	/////////	X X X X X

FUNCTIONAL RATING INDEX

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage every day activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Intensity of problem

0	1	2	3	4
None	Mild	Moderate	Severe	Worst Possible

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain/ No restrictions	Mild Pain/ no restrictions	Moderate Pain/ need to go slowly	Moderate Pain/ need some assistance	Severe Pain/ need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No Pain	Occasional pain/ 25% of the day	Intermittent pain/ 50% of the day	Frequent pain/ 75% of the day	Constant pain/ 100% of the day

8. Lifting

0	1	2	3	4
No Pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Signature: _____ Date: _____

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Patient's Informed Consent

I hereby request and consent to the performance of chiropractic adjustments, computerized range of motion, examination procedures, including diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by any licensed chiropractor who treats me at Bothell Chiropractic & Wellness. I am responsible for informing the doctor if I am pregnant or might be pregnant PRIOR to having x-rays.

I will have an opportunity to discuss with my doctor and/or other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that patients experience an audible "pop" during a manual adjustment and this is a normal part of treatment. Our doctors perform full spine adjustments, which may include areas other than my chief complaint, in an effort to correct the biomechanics of my spine as a whole.

I understand and am informed that, as in the practice of medicine, the practice of chiropractic has some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interest. According to research the probability of serious injury is 1:1,000,000. I understand that 40% of non-symptomatic patients have disc herniations, which may exist in my spine and become symptomatic whether or not I receive treatment.

I have read, or have had read to me, the above consent and I understand. I will also have an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) and for which I seek treatment.

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

If Patient is a Minor, Physically or Legally Incapacitated
To be completed by Patient's Representative

Patient's Name: _____

Relationship or Authority of Patient's Representative: _____

Printed Name of Representative: _____

Signature of Representative: _____ **DATE:** _____

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Consent to Use or Disclose Health Information
(HIPAA Disclosure)

I authorize **Bothell Chiropractic & Wellness** to use and disclose the health and medical information of _____ for the purposes of Treatment, Payment and Health Care Operations.*

*__Treatment__ (includes activities performed by a health care provider, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

*__Payment__ (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

*__Health Care Operations__ (includes the necessary administrative and business functions of our office).

You may review **Bothell Chiropractic & Wellness's** "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Please verify that you have received a copy of our Notice by placing your initials here _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so <u>in writing</u>, except to the extent that Bothell Chiropractic & Wellness has already used or disclosed the information in reliance on this Consent.

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

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