



820 OCEAN BEACH HWY, SUITE 116 LONGVIEW, WA 98632
360-414-3220 FAX: 360-353-5350

Date _____

PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs.
If you have any questions or concerns, do not hesitate to ask for assistance, we are happy to help. Please complete this form in ink.

Full Name _____

Address _____ City _____ State _____ Zip _____

Primary Phone (_____) _____ Alt Phone (_____) _____ Social Security # _____

Birth Date _____ Age _____ Male/Female Marital Status (S M W D) Ages of your children _____

Occupation _____ Patient Employer/School _____

Employer/School Address _____ Employer/School Phone (_____) _____

Spouse's or parent's name _____ Spouse's Employer _____

Emergency Contact _____ Relationship _____ Phone (_____) _____

Email Address (please print clearly) _____

Whom may we thank for referring you to us? Friend/Family _____ Doctor _____

Phone Book _____ Online _____ Other _____

*** IF WE HAVE ALREADY TAKEN A COPY OF YOUR INSURANCE CARD PLEASE SKIP THIS SECTION ***

Do you have insurance? Yes No If yes, please fill out the information below:

Insurance Company _____ I.D. # _____ Group # (if applicable) _____

Who is responsible for this account? _____ Relation to patient _____

Are you covered by an additional insurance? Yes No If yes, please fill out the information below:

Insurance Company _____ I.D. # _____ Group # (if applicable) _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient, Parent, or Guardian _____ Date _____

Please Print name signed above _____ Relation to patient _____

Name: _____ DOB: _____ Height: _____ Weight: _____

1st Complaint: _____ (0= no pain) 0 1 2 3 4 5 6 7 8 9 10 (10= unbearable pain)

1. How long has this complaint been present? _____ 2. Side of Complaint: left right both central

3. What do you think caused your complaint? _____

4. Did the complaint begin: suddenly gradually 5. The complaint is (% of day): 0-25% 26-50% 51-75% 76-100%

6. Do you feel this complaint is getting progressively worse? No Yes, please describe _____

7. Does the pain radiate? No Yes, if yes please mark below: 8. Type of pain? sharp dull throbbing numbness

Right upper arm forearm hand thigh calf foot aching shooting burning tingling

Left upper arm forearm hand thigh calf foot cramps stiffness swelling other

9. What makes the pain/complaint worse? Mark all that apply.

- bending sitting standing walking lying down cold/damp driving
- lifting general activity yard work gardening working turning/twisting reaching out/up/down
- pushing / pulling with hands coughing / sneezing other _____

2nd Complaint: _____ (0= no pain) 0 1 2 3 4 5 6 7 8 9 10 (10= unbearable pain)

1. How long has this complaint been present? _____ 2. Side of Complaint: left right both central

3. What do you think caused your complaint? _____

4. Did the complaint begin: suddenly gradually 5. The complaint is (% of day): 0-25% 26-50% 51-75% 76-100%

6. Do you feel this complaint is getting progressively worse? No Yes, please describe _____

7. Does the pain radiate? No Yes, if yes please mark below: 8. Type of pain? sharp dull throbbing numbness

Right upper arm forearm hand thigh calf foot aching shooting burning tingling

Left upper arm forearm hand thigh calf foot cramps stiffness swelling other

9. What makes the pain/complaint worse? Mark all that apply.

- bending sitting standing walking lying down cold/damp driving
- lifting general activity yard work gardening working turning/twisting reaching out/up/down
- pushing / pulling with hands coughing / sneezing other _____

3rd Complaint: _____ (0= no pain) 0 1 2 3 4 5 6 7 8 9 10 (10= unbearable pain)

1. How long has this complaint been present? _____ 2. Side of Complaint: left right both central

3. What do you think caused your complaint? _____

4. Did the complaint begin: suddenly gradually 5. The complaint is (% of day): 0-25% 26-50% 51-75% 76-100%

6. Do you feel this complaint is getting progressively worse? No Yes, please describe _____

7. Does the pain radiate? No Yes, if yes please mark below: 8. Type of pain? sharp dull throbbing numbness

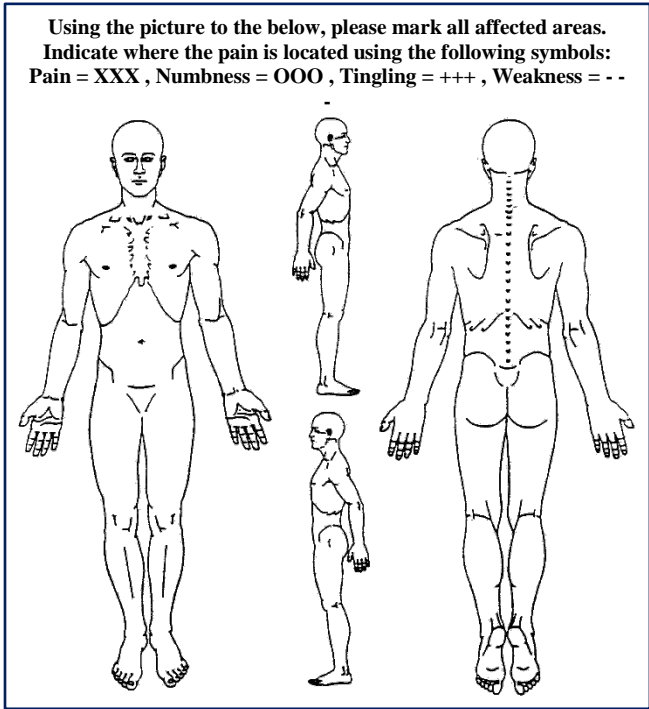
Right upper arm forearm hand thigh calf foot aching shooting burning tingling

Left upper arm forearm hand thigh calf foot cramps stiffness swelling other

9. What makes the pain/complaint worse? Mark all that apply.

- bending sitting standing walking lying down cold/damp driving
- lifting general activity yard work gardening working turning/twisting reaching out/up/down
- pushing / pulling with hands coughing / sneezing other _____

1. Are the complaint(s) previously listed worsen:
 morning afternoon evening non-applicable
2. Have you had prior similar complaint(s)?
 No Yes, please describe _____
3. What makes the complaint(s) better? Please mark all that apply.
 ice heat stretching rest
 chiropractic massage physical therapy acupuncture
 medication _____ other _____
4. Do your complaint(s) interfere with:
 activities of work activities of daily living sleep hobbies
- 5a. What treatment have you received for your complaint(s)? none
 chiropractic physical therapy surgery meds x-rays/MRI
- 5b. Provider(s) _____
- 6a. Have you had chiropractic care in the past? No Yes
- 6b. If yes, where and when was your last treatment? _____



7. Please check all those conditions below which apply to your personal health history:

- | | | | | |
|---------------------------------------|--|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Polio | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Eye/Vision Problems | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Sig. Weight Change | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Genetic Spinal Disorder | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Sprain/Strain | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Minor Heart Trouble | <input type="checkbox"/> Stroke/ Heart Attack | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Tumor | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Ulcer(s) | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Osteoporosis | |

8. Have you been treated by a physician for any condition this past year? Doctor _____ Condition? _____
9. Are you pregnant? No Yes, due-date _____
- 10a. Date of last physical exam? _____ 10b. Unhealthy findings? No Yes, please describe _____
- 11a. Have you ever been involved in an auto accident? No Yes, when? _____
- 11b. Were you treated? No Yes, by whom _____
12. List other past significant injuries or falls with dates _____
13. List any surgeries/hospitalizations with dates _____
14. List medications and/or vitamins _____
15. Describe exercise level: never seldom occasional frequent, what type _____
16. Describe your daily work activities _____
17. How much tobacco do you use? _____/packs per day Alcohol? _____/drinks per week Caffeine? _____/drinks per day



CONSENT & TERMS OF ACCEPTANCE

I consent to the use or disclosure of my protected health information by Riverwoods Chiropractic & Massage, PLLC for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Riverwoods Chiropractic & Massage, PLLC.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Riverwoods Chiropractic & Massage, PLLC is not required to agree to the restrictions that I may request. However, if Riverwoods Chiropractic & Massage, PLLC agrees to a restriction that I request, the restriction is binding on Riverwoods Chiropractic & Massage, PLLC.

I have the right to revoke this consent, in writing, at any time, except to the extent that Riverwoods Chiropractic & Massage, PLLC has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information identifies me.

I understand I have a right to review Riverwoods Chiropractic & Massage, PLLC’s Notice of Privacy Practices prior to signing this document.

The Riverwoods Chiropractic & Massage, PLLC Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Riverwoods Chiropractic & Massage, PLLC.

The Notice of Privacy Practices for Riverwoods Chiropractic & Massage, PLLC is also provided at – 820 Ocean Beach Hwy, Ste 116, Longview, WA 98632-4081. Riverwoods Chiropractic & Massage, PLLC reserves the right to change the privacy practices that are described within the Notice of Privacy Practices. I may obtain a revised copy by request in the mail or at the time of my next appointment to the office at Riverwoods Chiropractic & Massage, PLLC.

I understand that Riverwoods Chiropractic & Massage, PLLC does not offer to diagnose or treat any disease. Riverwoods Chiropractic & Massage, PLLC only offers to diagnosis either vertebral subluxations or neruo-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, Riverwoods Chiropractic & Massage, PLLC will advise me. I know that if I desire advice, diagnosis or treatment for those findings, Riverwoods Chiropractic & Massage, PLLC will recommend that I seek the services of another health care provider.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

(SIGNATURE)

(DATE)