RIVERWOODS CHIROPRACTIC & MASSAGE PLLC
820 Ocean Beach Hwy, Suite 116 Longview, WA 98632
360-414-3220 Fax: 360-353-5350

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.

Date _____

Full Name _____

Address _____ City _____ State _____ Zip _____

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

Birth Date _____ Age _____ Select One Marital Status Select One 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 _____

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Name: Date of Birth: Today's Date:

Height Weight

1. Where are the symptoms located that have brought you to our office? Please list and rate each symptom individually on the scale provided.

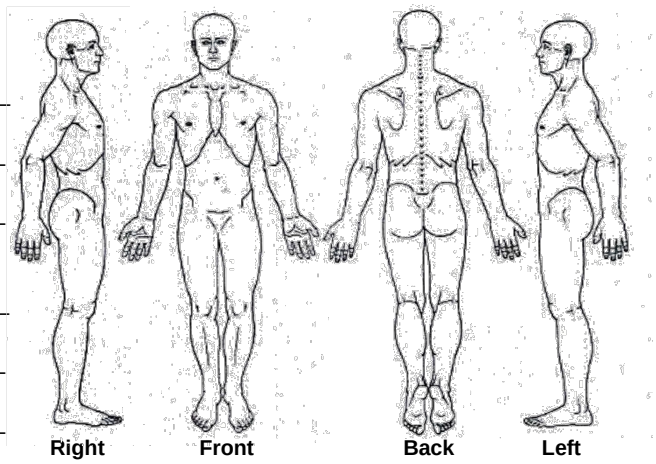
_____ (1= no pain) Select One (10= unbearable pain)

_____ (1= no pain) Select One (10= unbearable pain)

_____ (1= no pain) Select One (10= unbearable pain)

_____ (1= no pain) Select One (10= unbearable pain)

Using the pictures below, please circle all affected areas.
Please indicate pain = (x x x), numbness = (o o o), tingling = (+ + +), and weakness = (- - -)



2. How long have these complaints been present? _____

_____

_____

3. What do you think caused your complaints? _____

_____

_____

4. Did the complaints begin: ☐ suddenly ☐ gradually

5. The pain/complaints are (% of day): ☐ constant (76-100%) ☐ frequent (51-75%) ☐ occasional (26-50%) ☐ intermittent (0-25%)

6. Do you feel these complaints are getting progressively worse? ☐ No ☐ Yes

DOCTOR'S NOTES

Please describe _____

7. The symptoms are worse: ☐ morning ☐ afternoon ☐ evening ☐ non-applicable

8. Complaints are due to: ☐ sports injury ☐ work injury ☐ auto accident ☐ other

9. Have you had prior similar complaints? ☐ No ☐ Yes, please describe _____

_____

_____

10. Does the pain radiate? ☐ No ☐ Yes, (mark below)

Right ☐ upper arm ☐ forearm ☐ hand ☐ thigh ☐ calf ☐ foot

Left ☐ upper arm ☐ forearm ☐ hand ☐ thigh ☐ calf ☐ foot

11. Type of pain? ☐ sharp ☐ dull ☐ throbbing ☐ numbness ☐ aching ☐ shooting
☐ burning ☐ tingling ☐ cramps ☐ stiffness ☐ swelling ☐ other

12. What makes the pain/complaints worse? Please mark all that apply.

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

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DOCTOR'S NOTES

13. What makes the pain/complaints better? Please mark all that apply.

☐ Ice ☐ medication _____
☐ heat ☐ rest
☐ stretching ☐ other _____

14. Are there any other symptoms that you feel are related to your pain/complaints?

_____

15. Does your pain/complaints interfere with:
☐ nothing at this time ☐ activities of work ☐ activities of daily living ☐ sleep

Please describe _____

16. What treatment have you received for your current condition?
☐ none ☐ chiropractic ☐ physical therapy ☐ surgery ☐ meds ☐ x-rays/MRI

Providers? _____

Treatment? _____

17. Have you ever had chiropractic care in the past? ■ No ☐ Yes
If yes, with whom and how long? _____

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

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

19. Have you been treated by a physician for any condition this past year? Doctor_____ Condition? _____

20. Are you pregnant? ☐ No ☐ Yes, due-date_____

21. When was your last physical exam? _____ Were there any unhealthy findings? ☐ No ☐ Yes, please describe

_____

22. Have you ever been involved in an auto accident? ☐ No ☐ Yes, when? _____
Were you treated? ☐ No ☐ Yes, by whom _____

23. List other past significant injuries or falls with dates _____

24. List any surgeries/hospitalizations with dates _____

25. List medications and/or vitamins _____

26. Describe exercise level: ☐ never ☐ seldom ☐ occasional ☐ frequent, what type_____

27. Describe your daily work activities _____

28. How much tobacco do you use? _____/packs per day Alcohol? _____/drinks per week Caffeine? _____/drinks per day

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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)**