Vancouver Chiropractic

Seth Hutton, DC | Trevor Schwanz, DC | Lindsey Philpott, DC

NAME_____ DOB___/___/___ TODAY'S DATE ___/___/___

PHONE (HOME) ____-____-_____ (CELL) ____-____-_____ (WORK) ____-____-_____

ADDRESS_____ CITY _____ STATE ____ ZIP_____

AGE_____ EMAIL_____ PRIMARY PHYSICIAN_____

EMERGENCY CONTACT_____ RELATION_____ PHONE_____

I would like to receive appointment reminders via: EMAIL☐ PHONE☐ TEXT☐ NONE☐

EMPLOYER_____ OCCUPATION_____

ARE WE BILLING INSURANCE? IF YES, PLEASE GIVE CARD TO RECEPTIONIST

Reason for today's visit and current symptoms_____
Date of injury/onset of symptoms_____
Describe how the condition started___ _____

Has this happened before? YES☐ NO☐

Has your condition been treated before? YES☐ NO☐
Have you received any diagnostic testing? (MRI, X-Ray, lab work, etc.)_____
What has worked in the past? (Medications, therapy, etc.)_____ List any medications/herbs you are currently taking_____

Have you had any spinal surgeries? YES☐ NO☐ If YES, list all and years_____

Do you suffer from headaches? YES☐ NO☐ Location_____ How long do they last?_____ How many times per week/month?_____

Are you currently pregnant? YES☐ NO☐ If YES, how far along?_____

Conditions you have been diagnosed as having:

Anxiety	Diabetes	Depression	Acid reflux
Bleeding disorder	Arthritis	Stroke	Numbness/tingling
Asthma	Cancer	High blood pressure	High cholesterol
Memory loss	Heart attack	Kidney stones	Scoliosis
Ringing in ears	Anemia	Thyroid disease	Dizziness

Other_____
Fractures (describe)_____
Is there anything else we may be able to help you with?_____
Who can we thank for referring you?_____

703 Broadway Street Suite 500 Vancouver, WA 98660
2501 NE 134th Ave Suite 300 Vancouver WA 98686
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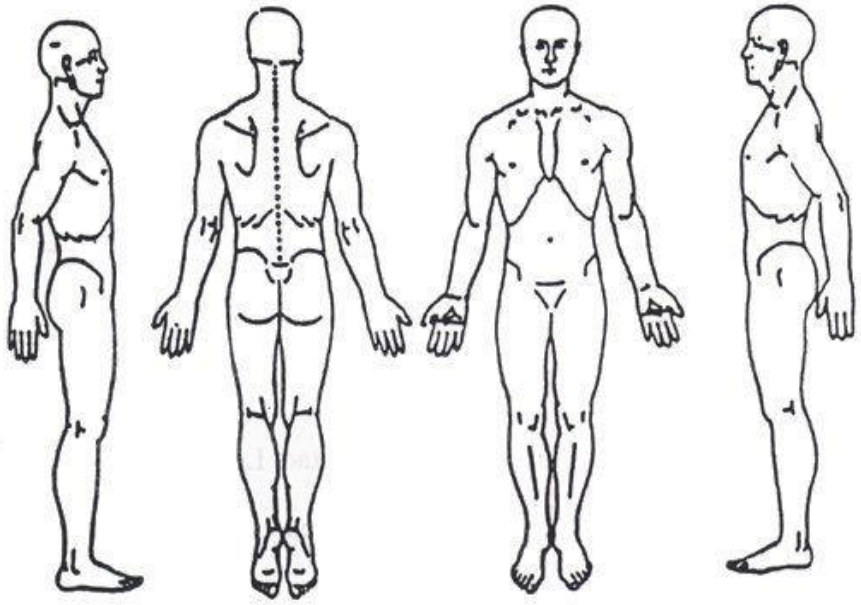
Have you been treated by a chiropractor before? YES ☐ NO ☐

PAIN DRAWING

Please be sure to fill this out accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark the areas of radiating pain and include all affected areas. You may draw in the faces as well.

Numbness ---------- Pins & Needles ooooooo Burning Pain xxxxxxx

Stabbing Pain ///////// Aching Pain ((((((((((



Please mark on the line the pain level that most accurately represents your pain:

0 1 2 3 4 5 6 7 8 9 10

A. Right now: _____
B. Average pain: _____
C. At best: _____
D. At worst: _____

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Financial Policy

Please take a few minutes to review the following information prior to your appointment. We hope you understand that our financial policy is established to comply with the requirements of our legal contracts with the insurance companies that allow us to treat you.

Co-payments (the fixed amount your insurance company sets) are due at the time of service. If you do not have insurance, or have choose not to use it, our Time of Service Fees apply on your date of service.

About Health Insurance

Your insurance policy is an agreement between you and the insurance company. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply; (1) your health plan requires prior authorization, in which we are not able to obtain; or referral by a PCP before receiving services at Vancouver Chiropractic, and you have not obtained such an authorization or referral; (2) you receive services in excess of such authorization or referral; (3) your health plan determines that the services you received at Vancouver Chiropractic are not medically necessary and/or not covered by your insurance plan; (4) your health plan coverage has lapsed or expired at the time you receive services; or (5) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier plan provider directly.

In some instances, on a case by case basis, you may qualify for “financial hardship”. Each insurance company has a different agreement with you, the patient, and us, the providers. It is very important that we comply with our contracts. Please note, many insurance companies do not allow, under any circumstance, that we not collect a co-payment or co-insurance.

Signature_____Date_____

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.

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Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and the function (primarily the nervous system) as that relationship may effect 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 infirmary.

One disturbance to the nervous system is called **vertebral sublaxation**. 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 my result in pain and dysfunction or may be entirely asymptomatic.

Sublaxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral sublaxation. 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 inclined.

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 from 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.

_____	_____	_____
Print Name	Signature	Date

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.

Notice of Privacy

We keep a record of the health care services provided. You may ask to see and receive a copy of that record. You may also seek to have to record corrected. This information will not be disclosed to others unless under your direction or as required by law.

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The Privacy Notice (available for review at the Front Desk) explains this information in great detail.

My signature below signifies that I have read and understand the Privacy Notice provided.

_____	_____	_____
Print Name	Signature	Date

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