Active Seattle
CHIROPRACTIC + SPORTS THERAPY

Confidential Patient Information

Name: _____ Gender: Male Female Birthdate: _____ /_____ /_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____ Office: _____

Email: _____

Marital Status (circle): Single Married Other Name of Partner: _____

Emergency Contact: _____ Relationship: _____ Contact Number: _____

Medical Doctor: _____ Last Visit: _____

Have you ever seen a Chiropractor?: No Yes Who?: _____

How did you hear about our office? _____

Insurance:

Employer: _____ Occupation: _____

Subscriber Name: _____ Birthdate: _____ Relationship: _____

Health Plan: _____ Subscriber ID: _____ Group Number: _____

Authorization and Release:

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. **Initials:** _____
- I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. **Initials:** _____
- I understand that my 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. **Initials:** _____
- I understand that many insurance companies now require prior authorization that can not be requested until after the appointment. ASCST will make every reasonable effort to receive authorization, but authorization is at the discretion of the insurance company. ASCST will not be responsible for appealing any denial of authorization. In this case, the patient will be responsible for the cost of service. **Initials:** _____

Late Charges:

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. **Initials:** _____

Other Fees:

We realize emergencies come up. If you need to cancel an appointment for any reason, we request that you make every attempt to give 24 hours notice. By giving adequate notice, you allow us to help others more quickly. If you do not contact our office prior to your appointment you will be billed a missed appointment fee of $50. For any returned checks there will be a charge of a $35 return check fee. **Initials:** _____

Consent to Treat a Minor:

As parent or legal guardian, I have the authority to authorize and do hereby grant the Chiropractor at ASCST to administer chiropractic care as they deem necessary to my son/daughter/ward. **Initials:** _____

Patient: _____ **Date:** _____

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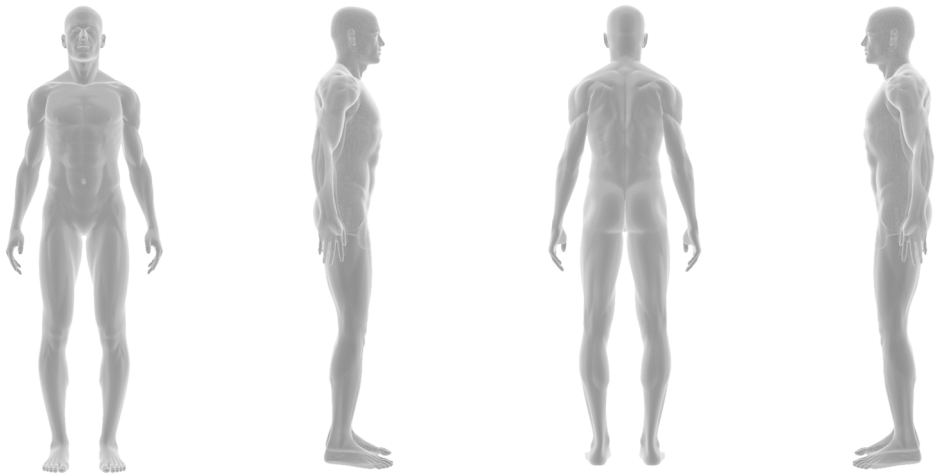
What services are you interested in (circle): Active Release Graston Chiropractic Kinesio Tape

Height: _____

Weight: _____



What is the reason for your appointment? _____

When did this condition begin? _____ Date: _____ /_____ /_____

Has your condition been getting: Better Worse Same

Have you ever experienced anything like this before? _____

How did this happen?: Sudden Gradual Unknown

Due to: Car Accident Work Accident Injury Sickness/Illness Overuse Unknown

What does this complaint feel like (circle all that apply):

Ache Stiff Stabbing Sharp Shooting Throbbing

Tingling Weak Burning Numb Swelling Dull

Do you feel the sensation/pain anywhere else? No Yes (explain): _____

Does coughing or sneezing affect your condition? No Yes (explain): _____

Rate your pain on a scale of 0-10 (0 no pain, 10 is the worst pain imaginable):

At worst: _____

On average: _____

Right now: _____

Do you feel this sensation: Constantly (76-100%) Frequently (51-75%) Occasionally (26-50%) Comes and goes (0-25%)

How long does this sensation last? On average: _____

When bad: _____

When is your condition more pronounced: Morning Afternoon Evening At night With activity

What makes your condition feel worse? _____

What makes your condition feel better? _____

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Have you seen other health care provider(s) for this condition? No Yes (explain): _____

Have you tried over the counter medication for this condition? No Yes (explain): _____

Were any diagnostic images taken for this complaint? No Yes (circle): X Ray CT Scan MRI Ultrasound Other

(explain): _____

Has your condition affected your daily activities? No Yes (explain): _____

Have you lost any days of work because of this condition? No Yes (explain): _____

Does your condition affect your sleep? No Yes (explain): _____

Do you wake rested? No Yes (explain): _____

Last restful sleep: _____

Previous falls and/or accidents:

Fractured bones No Yes (describe): _____

Sprain (joint) No Yes (describe): _____

Strain (muscle) No Yes (describe): _____

Concussions No Yes (describe): _____

MVA (car accident) No Yes (describe): _____

Work (L&I) No Yes (describe): _____

Other No Yes (describe): _____

Surgeries and operations? No Yes (describe): _____

Have you ever been hospitalized? No Yes (describe): _____

Is there anything else I should know about your condition?: _____

_____

_____

Have you experienced any of the following in the last 2 weeks?

Nausea	No	Yes	Personality change	No	Yes	Diarrhea	No	Yes
Vomiting	No	Yes	Recurrent headache	No	Yes	Car accident	No	Yes
Vertigo	No	Yes	Extended car/truck travel	No	Yes	Major/minor fall	No	Yes
Difficulty walking	No	Yes	Skin rash/infection	No	Yes	Night sweats	No	Yes
Lack of coordination/clumsiness	No	Yes	Speech problem	No	Yes	Loss of strength	No	Yes
Numbness	No	Yes	Tinnitus (ringing in ears)	No	Yes	Painful bowel movement	No	Yes
Loss of consciousness	No	Yes	Memory loss	No	Yes	Head Trauma	No	Yes
Double/blurred vision	No	Yes	Fever	No	Yes	Abnormal menstrual period	No	Yes

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Confidential Health History

In the space provided please enter "C" if you currently or "P" if you have ever had this problem.

General
- ☐ Weight loss/gain
- ☐ Allergies
- ☐ Bleeding problem
- ☐ Anemia
- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid disease
- ☐ Alcoholism
- ☐ Drug abuse
- ☐ HIV risk factor

Eye, Ear Nose & Throat
- ☐ Poor vision
- ☐ Loss of vision
- ☐ Pain in eyes
- ☐ Deafness/difficulty hearing
- ☐ Nosebleeds
- ☐ Sinus problems
- ☐ Dental problems
- ☐ Hoarseness
- ☐ Tonsillectomy

Cardiovascular
- ☐ Irregular heart beat
- ☐ Pain over heart
- ☐ High blood pressure
- ☐ Previous heart trouble
- ☐ Myocardial infarction
- ☐ Ankle Swelling
- ☐ Varicose Veins
- ☐ Rheumatic fever
- ☐ Stroke

Skin
- ☐ Itching
- ☐ Bruises easily
- ☐ Changes in mole(s)
- ☐ Skin Cancer

Health Habits
- ☐ Smoking - current
- ☐ Smoking - past
- ☐ Drinking
- ☐ Recreational drug use

Exercise
- ☐ None
- ☐ 1-2x/week
- ☐ 3-5x/week
- ☐ 6-7x/week

Respiratory
- ☐ Difficulty breathing
- ☐ Chronic cough
- ☐ Spitting phlegm
- ☐ Spitting blood
- ☐ Wheezing/Asthma
- ☐ Pneumonia
- ☐ Tuberculosis

Genitourinary
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in Urine
- ☐ Kidney Disease
- ☐ Urinary infection
- ☐ Inability to control urine
- ☐ Difficulty starting urine flow
- ☐ Breast lump or pain
- ☐ Venereal Disease
- ☐ Sexual difficulty

Get up _____ times/night to urinate

Neurologic
- ☐ Weakness
- ☐ Twitching
- ☐ Tremors
- ☐ Headache
- ☐ Dizziness/Vertigo
- ☐ Epilepsy
- ☐ Numbness/tingling
- ☐ Arm/leg pain
- ☐ Mental Disorder
- ☐ Partial or complete paralysis

Other
- ☐ Tropical infection
- ☐ Parasitic Infection

Men Only
- ☐ Testicular Pain
- ☐ Prostate Problems

Women Only
- ☐ Live births
- ☐ Miscarriage
- ☐ Painful Period
- ☐ Excessive flow
- ☐ Irregular cycle
- ☐ Hot flashes

_____ /_____ /_____ Date of last period
_____ /_____ /_____ Date of last PAP
_____ /_____ /_____ Date of last mammogram

Gastrointestinal
- ☐ Poor appetite
- ☐ Poor digestion
- ☐ Difficulty swallowing
- ☐ Vomiting blood
- ☐ Pain over abdomen
- ☐ Ulcer
- ☐ Bloody stool
- ☐ Liver problems
- ☐ Gallbladder problems
- ☐ Jaundice
- ☐ Hernia
- ☐ Loss of bowel control
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Appendicitis

Musculoskeletal
- ☐ Neck Stiffness/pain
- ☐ Pain between shoulders
- ☐ Low back pain
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Muscle aches/soreness
- ☐ Spinal curvature
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Slipped/herniated disc

Family History
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Kidneys disease
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Cancer
- ☐ Epilepsy
- ☐ Stroke
- ☐ Gout
- ☐ Allergies
- ☐ Blood disease
- ☐ Other

Medication
Prescription (list): _____

_____

_____

Vitamins/supplements (list): _____

_____

Nutrition (describe): _____

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I, _____ the undersigned, have voluntarily requested and discussed that Active Seattle Chiropractic and Sports Therapy Doctors of Chiropractic (ASCST doctors) assist me in the management of my health concerns. I have understood and agreed to all policies and terms provided in the Office Policies and Procedures. I understand that ASCST doctors are chiropractors and that their services are not to be construed or serve as a substitute for standard medical care. ASCST doctors recommends that I undergo regular routine medical check-ups by my medical doctor.

Medical doctors, doctors of chiropractic, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

Although spinal manipulation/adjustment is considered to be a safe and effective form of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise, Graston and Active Release Techniques may result in muscle soreness following the first few treatments. Active Release Technique and Graston technique may occasionally leave slight bruising and tenderness.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform ASCST doctors if you experience these symptoms.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.

A thorough health history and tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results: I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and other person of the doctor's choosing.

Imaging: I understand that ASCST does not utilize routine imaging in the absence of suspected pathology in an attempt to reduce radiologic exposure. I understand that ASCST doctors will recommend imaging prior to treatment if deemed necessary. The patient has the right to refuse imaging. The doctors have the right to refuse therapy in the absence of imaging.

I,_____ do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues. Exercise and nutritional counseling may also be used.

Alternative Treatments Available: Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery. As appropriate or upon request, the ASCST doctors will counsel alternative treatment options or refer out to appropriate providers.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of great value, but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for conditions such as joint instability or serious disc rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reactions to anesthesia, and prolonged recovery.

Injections: Injections can be utilized to reduce pain and inflammation. Repetitive use of corticosteroids can be harmful to soft tissue, cartilage and bone.

Non-Treatment: I understand that potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment, making future recovery and rehabilitation more difficult and lengthy.

I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read and/or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction **PRIOR TO MY SIGNING THIS CONSENT FORM**. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient (print name): _____

Patient Signature (or parent/guardian): _____

Witness: _____

Date: _____