Active Seattle
CHIROPRACTIC + SPORTS THERAPY

Confidential Patient Information

Name: _____ Gender (circle): M F 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:** _____

Late Charges:

If I do not pay the entire new balance with 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 (if allowed by law). 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 care of default on payment of this account, I agree to pay collection costs and reasonable attorney feels incurred in attempting to collect on this amount or any future outstanding account balances.

Initials: _____

Other Fees:

We realize emergencies come up, but if you need to cancel an appointment for any reason, we request that you make every attempt to give us 24 hours notice. By giving adequate notice of cancellation 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 she deems necessary to my son/daughter/ward. **Initials:** _____

Signature: _____ **Date:** _____

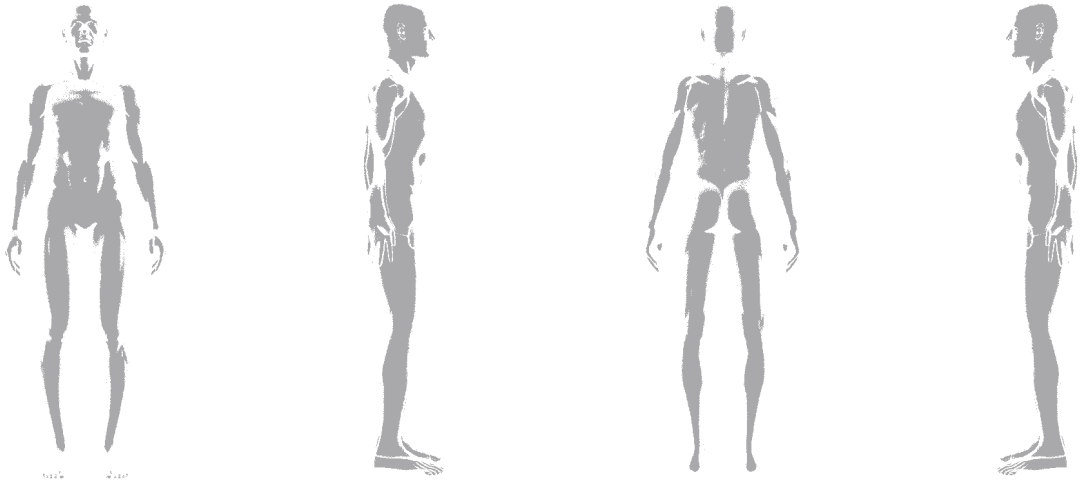
2366 Eastlake Avenue East | Suite 429 | Seattle Washington 98102
Office: 206.420.7926 | Fax: 206-458-6072
Email: info@activeseattlechiropractic.com | Web: activeseattlechiropractic.com

Active Seattle
CHIROPRACTIC + SPORTS THERAPY

Intake / Chief Complaint 1 of 2

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

Involved Areas (circle):



Height: _____

Weight: _____

What is the reason for your appointment? _____

When did this condition begin? _____

Has your condition been getting (circle): Better Worse Same

Have you ever experienced anything like this before? _____

How did this happen (circle): Sudden Slow Gradual

Due to (circle): Car Accident Work Accident Injury Sickness/Illness 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 (circle): 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 (circle): Morning Afternoon Evening At Night With Activity

What makes your condition feel worse? _____

What makes your condition feel better? _____

2366 Eastlake Avenue East | Suite 429 | Seattle Washington 98102
Office: 206.420.7926 | Fax: 206-458-6072
Email: info@activeseattlechiropractic.com | Web: activeseattlechiropractic.com

Active Seattle
CHIROPRACTIC + SPORTS THERAPY

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 & 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	Personaility 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 conciousness	No	Yes	Memory loss	No	Yes	Head Trauma	No	Yes
Double/blurred vision	No	Yes	Fever	No	Yes	Abnormal menstral period	No	Yes

2366 Eastlake Avenue East | Suite 429 | Seattle Washington 98102
Office: 206.420.7926 | Fax: 206-458-6072
Email: info@activeseattlechiropractic.com | Web: activeseattlechiropractic.com

Active Seattle
CHIROPRACTIC + SPORTS THERAPY

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
_____Spiting 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
Get up _____times/night to urinate
_____Breast lump or pain
_____Venereal Disease
_____Sexual difficulty

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):_____

2366 Eastlake Avenue East | Suite 429 | Seattle Washington 98102
Office: 206.420.7926 | Fax: 206-458-6072
Email: info@activeseattlechiropractic.com | Web: activeseattlechiropractic.com

Active Seattle
CHIROPRACTIC + SPORTS THERAPY

I,_____the undersigned, have voluntarily requested that Dr. Natasha N. Whittaker / Dr. Maia Veague 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 Dr. Natasha N. Whittaker / Dr. Maia Veague is a chiropractor and that her services are not to be construed or serve as a substitute for standard medical care. Dr. Natasha N. Whittaker / Dr. Maia Veague 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.

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.

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 it is common to experience muscle soreness in 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 Dr. Natasha N. Whittaker / Dr. Maia Veague 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 abnormally 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 treatments 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.

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.

2366 Eastlake Avenue East | Suite 429 | Seattle Washington 98102
Office: 206.420.7926 | Fax: 206-458-6072
Email: info@activeseattlechiropractic.com | Web: activeseattlechiropractic.com

Active Seattle
CHIROPRACTIC + SPORTS THERAPY

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 disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reactions to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks or 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 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 Signature : _____

Witness : _____

Date : _____

2366 Eastlake Avenue East | Suite 429 | Seattle Washington 98102
Office: 206.420.7926 | Fax: 206-458-6072
Email: info@activeseattlechiropractic.com | Web: activeseattlechiropractic.com