Name________________________ DOB ___/___/___ Age _____ Today's Date ___/___/___

Address ________________________ City ____________ State ____ Zip ____________

SSN ______-______-______ Gender (Optional) ☐ M ☐ F ☐ Other (check one)

Home________________ Cell________________ Work________________

Email ________________________ Occupation________________

Employer's Name ________________________

Address________________________ City ____________ State ____ Zip ____________

Single Married Divorced Widowed Name of spouse ________________

# of children ________ Names of children ________________________

Who can we thank for referring you to our office?________________________

Was this injury a result of: ☐ Work injury? ☐ Car Accident? ☐ Other injury? (check one)

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT: As a chiropractic office that centers on family wellness, we focus on helping you reach your optimum health potential. Our first goal is to locate and eliminate any and all interference to reaching your maximum potential while addressing the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. We all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes when it's already to late! Your answers to the following questions will give us a general view of the stresses you have faced in your life. This will allow us to better assess our current status and more accurately determine your true health potential.

THE BEGINNING YEARS – Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

BIRTH HISTORY – *Please check all that apply.*

☐ Mother smoked/drank/drugs during pregnancy ☐ Epidural/Med's in Labor ☐ Breech
☐ C-Section ☐ Forceps Delivery ☐ Vacuum Extractor Used ☐ Labor Induced
☐ Complications ☐ Other ________________________

CHILDHOOD YEARS (0-17 years) – *Please check all that apply.*

☐ Childhood illness ☐ Serious Falls ☐ Active in sports ☐ Very Inactive
☐ Car Accident(s) ☐ Surgery/Stitches ☐ Alcohol Abuse ☐ Smoker
☐ Antibiotics ☐ Drug Abuse ☐ OTC Medications ☐ Vaccinated
☐ Broken Bones ☐ Under Chiropractic Care ☐ Severe Emotional Trauma(s)________________

ADULT YEARS (Age 18 to Present) – *Please check all that apply.*

☐ Present Smoker ☐ Former Smoker ☐ OTC Medications ☐ Poor sleep
☐ Alcohol Use ☐ Play Sports ☐ Surgery/Stitches: yrs old? ______ ☐ Work Injury
☐ High Job Stress ☐ High Personal Stress ☐ Poor Diet ☐ Drive a lot
☐ Flat feet ☐ Prescription Medications ☐ Not Enough Sleep ☐ Broken Bones
☐ No Exercises ☐ Severe Health Problems ☐ Wear Orthotics/Lifts ☐ Sit a lot
☐ Car Accidents: ____________________ (age) ☐ *Other Injuries*:

☐ Have been under chiropractic care in the past - How long ago was your last adjustment? ________________

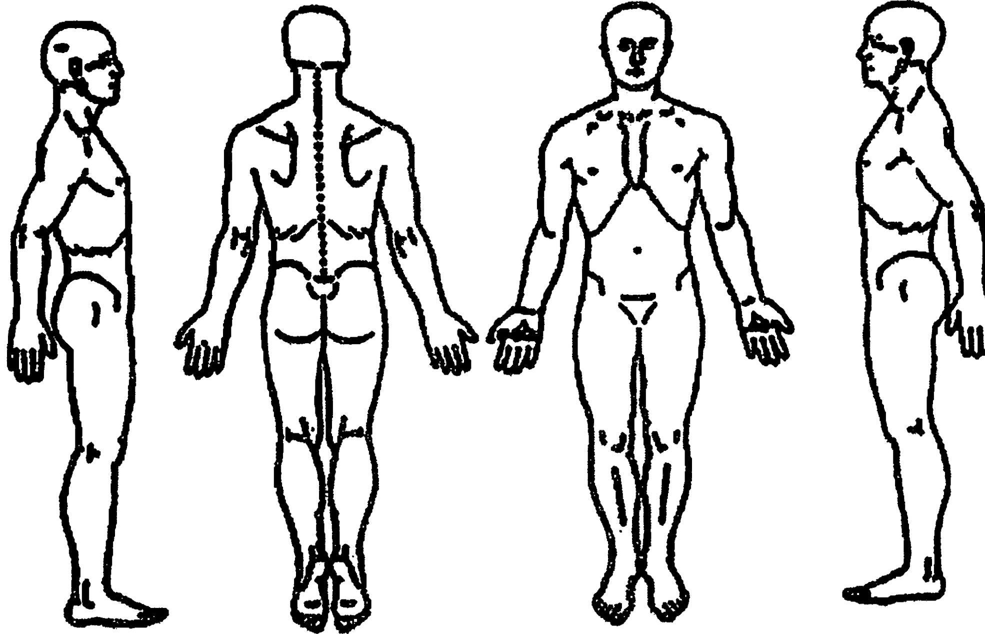
Please list all prescriptions you are currently taking: ________________________

____

ISSUES THAT BROUGHT YOU TO OUR OFFICE

**If you have no symptoms or complaints and you are here for wellness care please check the box below.
☐ **WISH TO HAVE WELLNESS SERVICES** (Skip to FAMILY HEALTH PROFILE at the bottom of this form.)

Place an "X" anywhere you are experiencing symptoms:



Other doctors/treatments you've tried for this problem (Please list):
☐ Chiropractor___________________________
☐ Medical Doctor *(their names)*___________________________
☐ Other ___________________________

****PLEASE CHECK ALL RECURRING OR SEVERE SYMPTOMS YOU HAVE EVER HAD, EVEN IF THEY SEEM UNRELATED TO YOUR CURRENT PROBLEM:**

☐ Headaches/Migraines
☐ Infertility/Impotence/Miscarriage
☐ Back stiffness/pain
☐ Buzzing/ringing in ears
☐ Numbness in fingers
☐ Stomach Upset
☐ Tension/Stress
☐ Neck stiffness/pain
☐ Diarrhea/Constipation/Gas
☐ Hot Flashes
☐ Problems urinating
☐ Pre-Menstrual Syndrome
☐ Jaw/TMJ Problems
☐ Pins & Needles in legs/feet
☐ Pins & Needles in arms
☐ Loss of balance
☐ Sinus Problems/Issues
☐ Numbness in toes
☐ Fatigue
☐ Irritability/Mood Swings
☐ Cold hands
☐ Foot Problems
☐ Cold Sweats
☐ Heartburn/Acid reflux
☐ Menopause
☐ Other: ___________________________
☐ Recurring Infection
☐ Loss of Smell
☐ Dizziness/vertigo
☐ Nervousness/Anxiety
☐ Loss of taste
☐ Depression
☐ Sleeping Problems
☐ Cold feet
☐ Shortness of breath
☐ Light bothers eyes
☐ High Blood Pressure
☐ Ulcers

FAMILY HEALTH PROFILE – In our office, we are not only interested in your health & well being, but also that of your family and loved ones. Please mention any health conditions or concerns you may have about your:

CHILDREN___________________ SIBLINGS ___________________
SPOUSE ___________________ OTHER ___________________
PARENTS ___________________

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. If the office accepts an assignment of benefits under any insurance plan, the Patient will remain primarily responsible for all bills and shall be obligated to pay any and all sums not actually paid by the insurance carrier. I agree to allow this office to examine me for further evaluation.

___________________________ ____/____/______
Signature Date

Please list your pains / complaints from MOST to LEAST severe & fill out column for each complaint

	MOST	>	>	LEAST
	Complaint #1	Complaint #2	Complaint #3	Complaint #4
Today, you have the following physical complaints:				
Is this complaint: Sharp, Dull, Achy, Throbbing, Numb, Shooting, or Other? (explain)	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Electric/Shooting	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Electric/Shooting	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Electric/Shooting	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Electric/Shooting
How often do you feel this complaint? Constant, Daily, Off & On, Weekly?	☐ Constant ☐ Daily ☐ Off & On ☐ Weekly ☐ Monthly ☐ Other________	☐ Constant ☐ Daily ☐ Off & On ☐ Weekly ☐ Monthly ☐ Other________	☐ Constant ☐ Daily ☐ Off & On ☐ Weekly ☐ Monthly ☐ Other________	☐ Constant ☐ Daily ☐ Off & On ☐ Weekly ☐ Monthly ☐ Other________
How long have you had this?				
Is it getting better, worse, or staying the same?	☐ Better ☐ Worse ☐ Same	☐ Better ☐ Worse ☐ Same	☐ Better ☐ Worse ☐ Same	☐ Better ☐ Worse ☐ Same
What makes it better?				
What makes it worse?				
On a scale of 1-10 Rate your discomfort:	Circle one 10 9 8 7 6 5 4 3 2 1 0 10 = Excruciating 0 = No Discomfort	Circle one 10 9 8 7 6 5 4 3 2 1 0 10 = Excruciating 0 = No Discomfort	Circle one 10 9 8 7 6 5 4 3 2 1 0 10 = Excruciating 0 = No Discomfort	Circle one 10 9 8 7 6 5 4 3 2 1 0 10 = Excruciating 0 = No Discomfort
How have you taken care of this in the past? How has it worked for you?				
This issue is affecting my:	☐ Job ☐ Childcare ☐ Marriage ☐ Sex ☐ Exercise ☐ Finance ☐ Playing with kids ☐ Bowels ☐ Urine	☐ Job ☐ Childcare ☐ Marriage ☐ Sex ☐ Exercise ☐ Finance ☐ Playing with kids ☐ Bowels ☐ Urine	☐ Job ☐ Childcare ☐ Marriage ☐ Sex ☐ Exercise ☐ Finance ☐ Playing with kids ☐ Bowels ☐ Urine	☐ Job ☐ Childcare ☐ Marriage ☐ Sex ☐ Exercise ☐ Finance ☐ Playing with kids ☐ Bowels ☐ Urine
Helping this issue would increase my quality of life by:	☐ 10-20% ☐ 30-40% ☐ 50-60% ☐ 70-80% ☐ 90% ☐ 100%	☐ 10-20% ☐ 30-40% ☐ 50-60% ☐ 70-80% ☐ 90% ☐ 100%	☐ 10-20% ☐ 30-40% ☐ 50-60% ☐ 70-80% ☐ 90% ☐ 100%	☐ 10-20% ☐ 30-40% ☐ 50-60% ☐ 70-80% ☐ 90% ☐ 100%

Print NAME:____ **DATE:**____________________

Name:

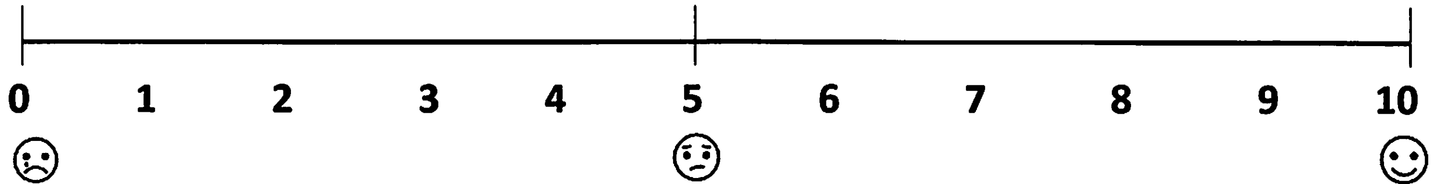
Date:

Lifestyle and Wellness Scorecard

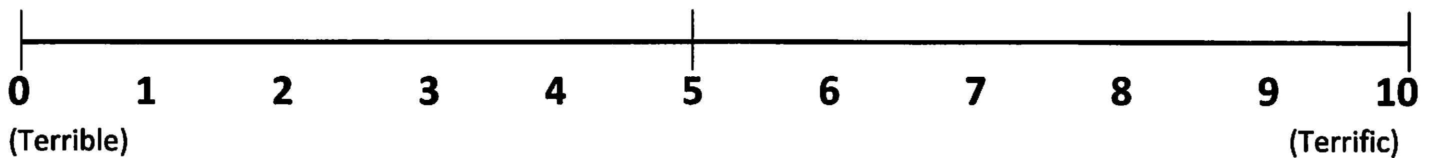
D-R-E-A-M

(**D**iet – **R**est – **E**xercise – **A**lignment – **M**ental Hygiene)

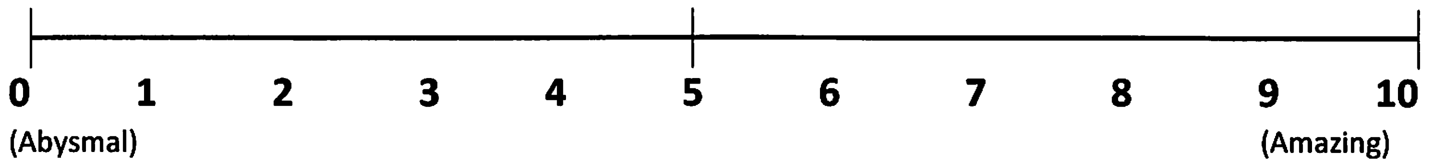
Diet/Nutrition



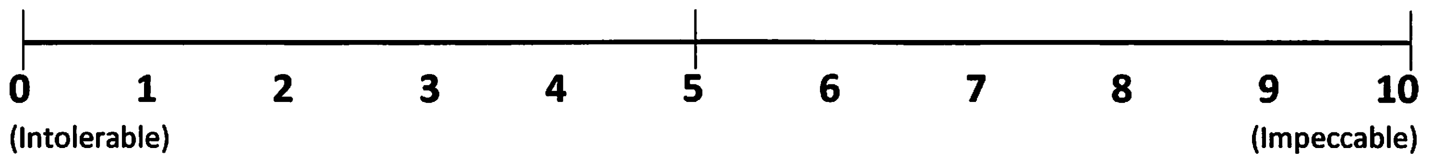
Rest/Regeneration/Recuperation



Exercise/Movement/Activity



Mental Hygiene



Total Lifestyle Score:_____/40

If your lifestyle habits were graded on a traditional scale:

36-40 = A
32-35 = B
28-31 = C
24-27 = D
Below 24 = F **Your Grade:____**

Professional Fee Schedule

Consultation.................................No Charge
Chiropractic Examination.................$60—$210
Chiropractic Office Visits (averages)....$45—$110
Chiropractic X-ray Studies (averages)..$70—$280
Massage Therapy ....$60—$120

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. This form has been prepared for your convenience and will enable us to better serve you and avoid misunderstandings in the future. We offer several methods of payment for your Chiropractic care at our office and you may choose the plan which best fits your needs. If special arrangements are necessary please consult with the Doctor.

Our main concern is your health and well-being and we will do our best to help you achieve your goals.

Plan #1-Insurance– If you have insurance that covers Chiropractic care, we will bill your insurance directly. *Please bring us your insurance information before your second visit. Until we have the completed necessary insurance information to verify chiropractic coverage, you will be required to pay for your care.* Remember, insurance companies balk at "maintenance" and long-term rehabilitation and usually you will not get much help after your initial corrective care. Most ordinary "health" policies are designed and intended to only take care of acute problems so you should plan to "get off" insurance and be on your own. At this point, refer to our Health and Wellness Plan (ask Doctor for details).

Plan #2– "Cash" (non-insurance)– Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

Plan #3—Weekly/Monthly Cash Agreement– For those patients who qualify, we will extend credit through this plan; however, should you become inactive by discontinuing your care, your entire unpaid balance will be due immediately. This plan applies to all cases, except work injury or auto injury claims.

Plan #4– Labor and Industries—By law, you need to report your accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by the second visit. We will bill labor and industries directly.

Plan #5—Auto Injury –You need to supply us with the accident report, your car insurance, health insurance, liable parties insurance and (if applicable) attorney information . Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event the check should come to you, you are expected to bring the check to us.

Plan #6—Medicare—Per established Medicare guidelines please bring us your Medicare information on or before your second visit. We will bill Medicare directly. In the event the check should come to you, you are expected to bring the check to us.

Signature ______________________ Date ________________

WERE YOU AWARE THAT:

- Chiropractic Doctors work with the nervous system? _____ Yes _____No
- The nervous system controls all bodily functions? _____ Yes _____No
- You can achieve a higher level of health if Chiropractic care begins at birth _____ Yes _____ No

GOALS FOR YOUR CARE:

People see Chiropractors for a variety of reasons. The doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ Relief Care: Symptomatic relief of pain or discomfort.
- ☐ Corrective Care: Correcting the cause of the problem as well as the symptoms.
- ☐ I want the Doctor to select the type of care appropriate for my condition.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity or disease.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ________________________________, have read and fully understood the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.__________________________ ______________.
(signature) *(date)*

Pregnancy Release (for non-pregnant women only):

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

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 terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature____ Date__________________________

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Ultra Chiropractic
1100 NE 47th Street Suite 101
Seattle, WA 98105
(206)527-0123

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers for my health care services.

Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my chiropractor's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my chiropractor has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ________________________ Date: ____________

Signature: ________________________

If signing on behalf of the patient, Relationship to Patient: ____________________

Dependent family members also covered by this acknowledgement:

____

____

For Office Use Only:
We were unable to obtain patient's written acknowledgement of our Notice of Privacy Practices due to following reason:

The patients refused to sign: ____

Communication barriers: ____

Emergency situation: ____