**HALEY CHIROPRACTIC CLINIC**
**1919 NO. PEARL ST. #A4**
**TACOMA, WA 98406**

## CONFIDENTIAL PATIENT HISTORY

Name_____ Today's Date: _____

Home #_____ Cell #_____ Cell phone provider:_____

Email Address: _____ Text Message Reminder ☐ OR Email Reminder ☐

Address_____ City_____ State _____ Zip_____

Marital Status: S M W D SSN#_____ Date of Birth _____

Employer_____ Work # _____ Ext: _____

Have you received chiropractic care in the past? ☐ Yes ☐ No

Are you currently under chiropractic care? ☐ Yes ☐ No

**The reason for this visit:** ☐ PI (automobile accident) ☐ L&I (injury on the job)

☐ Other_____

**How did you hear about our office?** ☐ Website ☐ Phonebook ☐ Other _____

## INSURANCE COVERAGE

**We can bill your insurance as a courtesy to you.**

**Will we be billing insurance for you? ☐ Yes ☐ No**

**☐ Private Insurance ☐ Medicare Coverage (also provide your supplemental insurance info)**

Name of Insurance_____ Phone_____

Policy Number_____ Group # _____

Policy Holders Name_____ Employer_____

SS# of policy holder_____ Date of birth _____

***Secondary Insurance or Supplemental Insurance if applies:**

Name of Insurance_____ Phone_____

Policy Number_____ Group # _____

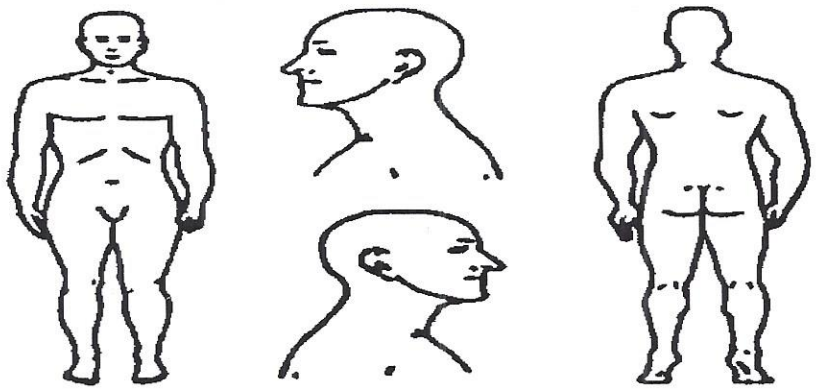
Policy Holders Name_____ Employer_____

SS# of policy holder_____ Date of birth _____

# Haley CHIROPRACTIC Clinic

1919 N Pearl St. Suite A4 Tacoma WA 98406 ph: 253-761-0930

***PLEASE CIRCLE YOUR AREA(S) OF COMPLAINT***



What is your **PRIMARY** complaint? _____ When did your symptoms start? _____

Describe how your symptoms began: _____

_____

How often do you experience your symptoms throughout the day?

☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

What is the severity of your pain? ☐ Mild ☐ Moderate ☐ Severe

What **TYPE** of pain and/or discomfort do you have? (Check all that apply)

☐ Sharp ☐ Dull ☐ Ache ☐ Numb ☐ Tingling ☐ Shooting ☐ Stabbing ☐ Burning

☐ "Tight" ☐ "Stiff" ☐ Pulling ☐ Throbbing ☐ Annoying ☐ Uncomfortable ☐ Other:

Do your symptoms radiate anywhere? ☐ NO ☐ YES If yes, where? _____

Since the onset how are your symptoms changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

How would you rate your pain? (Circle one)

Currently: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

At its worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

What helps relieve your symptoms (ice, heat, massage, etc)? _____

What activities make your symptoms worse (working, exercise, etc)? _____

Have you experienced this type of pain before? ☐ NO ☐ YES If so, what helped relieve pain? _____

How do your symptoms affect your ability to perform activities of daily living (ADL's)? (Check one)

☐ Not at all ☐ Mildly (forgotten with activity) ☐ Moderately (interferes with activity)

☐ Limiting (prevents full activity) ☐ Severe (no activity is possible)

What activities of daily living are **painful and/or difficult** to perform due to symptoms? (Check all that apply)

| | | |
|---|---|---|
| ☐ Sitting for more than 10 minutes | ☐ Putting on shoes | ☐ Looking over shoulder |
| ☐ Sitting for more than 60 minutes | ☐ Changing positions (sit to stand) | ☐ Reaching overhead |
| ☐ Standing for more than 10 minutes | ☐ Sleeping | ☐ Gripping |
| ☐ Standing for more than 60 minutes | ☐ Turning over in bed | ☐ Pushing |
| ☐ Walking short distances | ☐ Lying on stomach | ☐ Pulling |
| ☐ Getting in and/or out of the car | ☐ Lying on back | ☐ Kneeling |
| ☐ Bending over forward | ☐ Coughing and/or Sneezing | ☐ Balancing |
| ☐ Putting on and/or taking off clothes | ☐ Sexual activities | ☐ Squatting |
| ☐ Picking something off the floor | ☐ Driving | ☐ Going up and/or down stairs |
| ☐ Computer work | ☐ House/Yard work | ☐ Exercise/Running/Biking |

Who have you seen for your current symptoms? (Check all that apply)

☐ No one ☐ Chiropractor ☐ Primary Care Physician ☐ Physical Therapist ☐ Massage Therapist

If so, what treatment was given and/or what medication(s) were prescribed to you? _____

What tests/imaging have been performed for your current symptoms? (Check all that apply):

☐ None ☐ X-RAY *date:* _____ ☐ MRI *date:* _____ ☐ CT Scan *date:* _____ Other *date:* _____

**Are there any *ADDITIONAL* areas of complaint**? ☐ NO ☐ YES If yes where? _____

Describe how symptoms began: _____

When did your symptoms start? _____ What is the severity of your pain? ☐ Mild ☐ Moderate ☐ Severe

How often do you experience your symptoms?

☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

What **TYPE** of pain and/or discomfort do you have? (Check all that apply)

☐ Sharp ☐ Dull ☐ Ache ☐ Numb ☐ Tingling ☐ Shooting ☐ Stabbing ☐ Burning

☐ "Tight" ☐ "Stiff" ☐ Pulling ☐ Throbbing ☐ Annoying ☐ Uncomfortable ☐ Other:

How would you rate your pain? (Circle one)

Currently: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

At its worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

***General Patient Health, Social and Past Health History***

Height: _____ Weight: _____ Occupation: _____

Do you smoke? ☐ NO ☐ YES If yes, how many cigarettes per day? _____

Do you exercise? ☐ NO ☐ YES If yes, how many times per week? _____

In the space provided please enter **"C"** if you **CURRENTLY** or **"P"** if you have had this problem in the **PAST**.

**Musculoskeletal**
_____Spinal Surgery
_____Screws, Pins and/or Plates
_____Muscle Spasms/Cramping
_____Scoliosis
_____Arthritis
_____Osteoporosis
_____Slipped/Herniated Disc
_____Spinal/Extremity Fractures
_____TMJ Issues
_____Hip Disorders

**Cardiovascular**
_____Blood Clots
_____Chest Pain or Tightness
_____Heart Attack
_____Coronary Artery Disease
_____High Blood Pressure
_____Low Blood Pressure
_____Excessive Bruising
_____Swollen Legs or Feet
_____Varicose Veins
_____Leg Pain with Walking

**General**
_____Unexplained Weight Loss/Gain
_____Anemia
_____Diabetes
_____Gout
_____Cancer
_____Thyroid Disease
_____Migraines with Aura
_____Migraines without Aura
_____Changes in Bowel or Bladder Habits

**Neurologic**
_____Tremors
_____Dizziness/Vertigo
_____Fainting
_____Epilepsy and/or Seizures
_____Numbness/Tingling/Weakness
_____Partial or Complete Paralysis
_____Stroke
_____Loss of Vision, Taste or Smell

**Respiratory**
_____Snoring Issues
_____Difficulty Breathing
_____Chronic Cough
_____Emphysema
_____Spitting Blood
_____Wheezing/Asthma
_____Shortness of Breath

**Allergies:**_____
_____
_____

**Eye, Ear Nose & Throat**
_____Blurred or Double Vision
_____Eye Pain or Vision Change
_____Chronic Ear Infections
_____Ringing in Ears
_____Sinus Problems
_____Difficulty Swallowing

**Gastrointestinal**
_____Abdominal Pain
_____Irritable Bowel
_____Food Sensitivities
_____Constipation
_____Hernia
_____Loss of Bowel Control
_____Appendicitis

**Women ONLY:**
Currently pregnant: ☐ NO ☐ YES
Currently nursing: ☐ NO ☐ YES
Birth Control: ☐ NO ☐ YES
Breast implants: ☐ NO ☐ YES
Hormone Replacement: ☐ NO ☐ YES
Menopause Symptoms: ☐ NO ☐ YES

List all the surgical procedures you have had and the dates they were performed:
_____
_____
_____

List all the prescriptions, over-the counter medications and nutritional supplements you are taking:
_____
_____
_____

Have you been involved in previous auto/work/fall accidents? ☐ NO ☐ YES If yes; explain: _____
_____

Have you been hospitalized for any previous illnesses? ☐ NO ☐ YES If yes; explain: _____

Is there anything else that is causing you concern, worry or stress? ☐ NO ☐ YES If yes; explain: _____
_____

# AUTHORIZATION, ASSIGNMENT & RELEASE FORM

Patient Name_____ Date_____

I hereby authorize Haley Chiropractic Clinic to release any information deemed appropriate to my health insurance company and their affiliates, my auto insurance company and their affiliates, or my attorney and/or claims adjuster in order to process any claim for reimbursement of charges incurred.

In the event my insurance company or attorney does not pay Haley Chiropractic Clinic for services and/or product I receive. I understand that I am personally responsible to pay my account balance in full. I also understand that Haley Chiropractic Clinic will make all efforts in my favor to settle or resolve any said claim as we see fit.

In addition to the above, I waive the statute of limitations on collection in the state of WA. I agree that this authorization is irrevocable and ongoing until all monies owed are paid in full. This authorization will be in effect until revoked by both parties.

Our office is required by federal law to maintain the privacy of you Private Health Information (PHI). We will not share your PHI with other healthcare providers or persons unless you have granted us permission to do so.
I hereby give permission for Haley Chiropractic Clinic to share my PHI to the following health care providers and/or persons:

_____

_____

For a complete description of our practice's privacy notice, please ask at the reception desk. By signing below, I acknowledge I have read and understand the above terms.

SIGNATURE_____

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We keep a record of the care we give you. The record also contains other health information about you. We will not discuss your health information to others unless we have your permission to do so, or unless the law allows or requires us to do so. If you have questions about your health information or want to ask about your rights, contact:

Haley Chiropractic Clinic
1919 N. Pearl Street, Suite A4
Tacoma, WA 98406
(253)761-0930

By signing this form, you are letting everyone know that you received a copy of the Notice of Privacy Practices that explain your rights.

SIGNATURE_____ DATE_____

IF MINOR, PARENT/GUARDIAN_____ RELATIONSHIP_____

**Haley Chiropractic Clinic**
**Consent for Treatment**

**Patient Information:**
**Name: _____**
**Date of Birth: _____**
**Phone Number: _____**
**Address: _____**
**_____**

**Introduction:**
I, the undersigned, hereby consent to receiving chiropractic care and treatment from the licensed chiropractors at Haley Chiropractic Clinic. I understand that this care may include, but is not limited to, spinal adjustments, manipulations, physical therapy modalities, exercises, and other chiropractic treatments.

**Purpose of Treatment:**
The purpose of chiropractic care is to address and manage musculoskeletal conditions, alleviate pain, and enhance overall well-being.

**Nature of Treatment:**
Chiropractic care may involve the following:

- Spinal adjustments/manipulations
- Soft tissue therapy
- Exercise and stretches
- Postural training
- Other therapeutic modalities as recommended by the chiropractor

I understand that the chiropractic treatments may cause some discomfort or soreness as part of the healing process, which should resolve within a few days.

**Risk and Benefits:**
As with any form of medical treatment, there are potential risks involved, including but not limited to:

- Temporary soreness or discomfort
- Bruising or Strain
- Risk of injury due to manipulation of the spine or joints

The benefits of chiropractic care can include pain relief, improved mobility, and enhanced physical functioning. However, results are not guaranteed, and success varies from patient to patient.

**Patient's Responsibilities:**
I agree to inform my chiropractor of any medical conditions, past surgeries, or treatments that may affect my care. I also agree to follow the instructions provided for home care and exercises and to attend follow-up visits as recommended by my chiropractor.

**Confidentiality:**
All personal and medical information provided to Haley Chiropractic Clinic will be kept confidential in accordance with HIPAA (Health Insurance Portability and Accountability Act) and other applicable privacy laws.

**Voluntary Consent:**
I acknowledge that I have been provided with information regarding the treatment options available to me and the potential risks and benefits. I understand that I am free to withdraw my consent or discontinue treatment at any time, without affecting my future care.

**Emergency Care:**
In case of an emergency during treatment, I authorize the clinic to take necessary measures to ensure my safety and well-being.

**Acknowledgement and Signature:**
By signing below, I give my informed consent to the chiropractic treatment as outlined above and agree to the terms and conditions set forth. I understand that I have the right to ask questions regarding my treatment and that I can withdraw my consent at any time.

**Patient's Signature: _____**
**Date: _____**

# HALEY CHIROPRACTIC CLINIC PAYMENT POLICY

**PATIENTS WITHOUT INSURANCE OR INSURANCE THAT DOES NOT COVER CHIROPRACTIC CARE:**
Patients are expected to pay for services in full at the time services are rendered. If any questions regarding these fees have not been answered please let us know and we will be happy to go over these fees with you. If payment arrangements need to be made please consult with the office manager before making an appointment A $10.00 Service Fee may be applied to your account if your estimated portion due is not received at the time of service.

**PATIENTS WITH INSURANCE COVERAGE FOR CHIROPRACTIC CARE:** If your private insurance policy provides chiropractic benefits we will be happy to submit a claim to them for you. In accordance with our contracts with all insurance companies you are responsible for paying you portion at the time of service.
Your estimated portion will be calculated by the benefit deductibles, co-pays, and/or a specific percentage your insurance company has established for your individual policy. A billing fee may be charged to your account if payment is not received at the time services are rendered. Please discuss any need for payment arrangements with our office manager before scheduling an appointment. Please let us know if you have new insurance since your last visit. A $10.00 Service Fee will apply if not informed at the time of service of your current insurance, and a claim needs to be reprocessed due to incorrect billing information.

********IT IS THE PATIENTS RESPONSIBILITY TO KNOW THEIR OWN BENEFITS. WE MAY LOOK UP YOUR BENEFITS AS A COURTESY. THIS IS NOT A GUARANTEE OF BENEFITS AND/OR PAYMENT DUE. THIS IS SUBJECT TO ONLY THE INFORMATION AVAILABLE TO US THROUGH THE WEBSITE. THE AMOUNT YOU WILL BE CHARGE FOR SERVICES RENDERED IS BASED ON THE CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.

**BILLING SCHEDULE:** Statements will be mailed every other month to patients with balances due by them after all Explanation of Benefits are received from your insurance company(s). If patient payments are not received after the first notice is sent to you a billing fee may be charged to your account for every 60 days your account is past due (I.E. 90 days, 120 days). If payment from you is not made within 120 days of your first notice from our office your account may be turned over to a collections agency.

**WORKERS COMPENSATION AND MOTOR VEHICLE COLLISION INJURIES:** Please notify us if you have been injured on the job or in a motor vehicle accident. Worker's compensation does cover necessary chiropractic treatments if your claim has been approved and is currently open. A new claim will require necessary forms to be completed by the patient and the doctor before it will be considered by the worker's compensation department. If your injury claim is not allowed it is your responsibility to pay any outstanding balances. Your auto insurance company will pay for any necessary chiropractic treatment if you had "PIP" coverage (Personal Injury Protection) included in your auto insurance policy at the time of the injury. You must file a claim with your auto insurance company and complete and return a "PIP" application to them before they will issue any payment towards your account. Workers compensation/Auto insurance policies will not cover any cost incurred by retail charges (i.e. braces, ice packs, etc).

I have read the above policies of Haley Chiropractic Clinic and fully understand that I am responsible for the payment of my account. If a minor, a parent or guardian must sign this form and be responsible for payment.

PLEASE GIVE 24 HOURS NOTICE IF YOU ARE UNABLE TO MAKE YOU SCHEDULED APPOINTMENT. NO SHOW APPOINTMENTS WILL BE SUBJECT TO A $40.00 NO SHOW FEE. PLEASE NOTIFY US OF ANY CHANGES TO INSURANCE, ADDRESS, OR PHONE NUMBERS PROMPTLY.

SIGNATURE_____ DATE_____

PATIENTS NAME_____

IF MINOR, PARENT/GUARDIAN_____