

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 _____

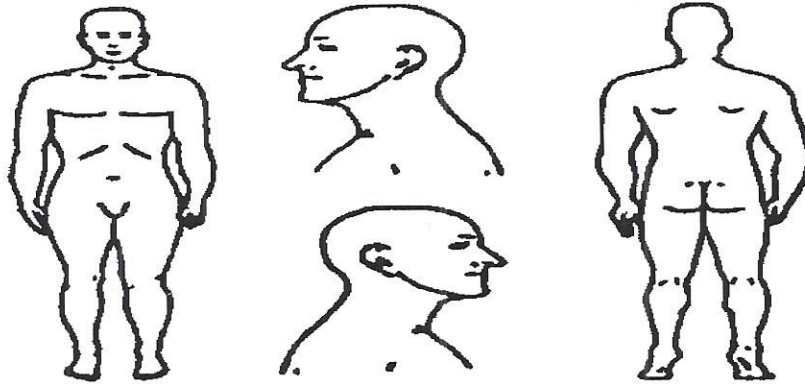
***Secondary Insurance or Supplemental Insurance if applies:**

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)

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

PATIENT'S NAME _____

IF MINOR, PARENT / GUARDIAN _____