ADVANCED CHIROPRACTIC

9212 Evergreen Way, Everett WA 98204
425-353-7246

Name: _____ DOB: _____ M/F Date _____

Cell Phone _____ Email _____

Address _____ Apt# _____

City _____ State _____ Zip _____ SS# _____

Parent/Guardian (if minor) _____ Cell phone _____

Employer _____ Occupation _____ Work # _____

Emergency Contact _____ Phone _____

How did you hear about our office? _____

Financial statement: As a courtesy, we will bill your insurance company for you. Your signature gives us permission to do so and will instruct your insurance company to pay this office for professional services rendered. By signing this you are stating that you understand that the contract you have is between you and the insurance company which holds your contract. In the event that your insurance company fails to pay, the outstanding bill is ultimately your responsibility. We will, as a courtesy, verify your insurance. It is in your best interest to also verify your insurance coverage. This will inform you of all the financial responsibility that may be incurred at this office, including insurance deductible, co-payments, co-insurance and any other services that your insurance my not pay. All charges for co-payments and cash visits are expected at the time of service. This office reserves the right to charge for any missed appointment not canceled 24 hours prior to the appointment.

Consent to treat: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including exams, diagnostic x-rays, physical therapy on me by the licensed doctor of chiropractic at this office. I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include, but are not limited to fractures, dislocation, muscle spasm, rib strains/ separation. Some type of manipulations of the neck have been associated with injuries to the arteries in the neck which can contribute to complications including stroke. This is a very rare occurrence (it has been noted to be one in three million). We screen our patients for indications that they may be a candidate for chiropractic adjustments to the best of our ability prior to treatment. I do not expect the doctor to be able to anticipate all risks and complications during the course of the procedure(s).

I have or will have had the opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had all my questions answered to my satisfaction. I understand that the results are not guaranteed. I have read or have read to me the above explanation of the treatment. By signing below, I state that I have weighed the risks involved in treatment and have decided that it is in my best interest to undergo chiropractic treatment. Having been informed of the risks, I hereby give consent to treatment and for the entire course of chiropractic care in the future.

Print Name _____ Signature _____ Date _____

Signature of patient's representative _____

Name _____ Date _____

Symptom location (circle): Neck, Upper back, Low back, Shoulder, Hip, Arm / Hand, Leg / Foot, Headache

When did the current episode of symptoms start? _____Please explain ***how*** the current symptoms began.

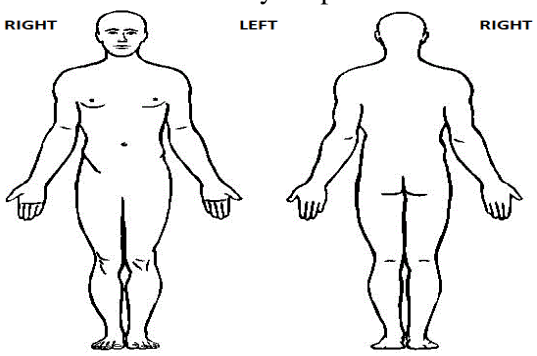
_____

_____

How often do you have these symptoms? Constant / Frequent / Occasional / Intermittent

Have you had similar symptoms in the past? Yes / No When? _____

Please indicate where your pain is.



Describe your pain: Sharp / Dull / Achy / Shooting / Burning / Tingling / Numbness

Any numbness or tingling into arm(s) or leg(s)? **Y/N** Where? _____

What helps your pain: Ibuprofen, Tylenol, Aleve, Vicodin, Percocet, Muscle relaxant, Stretching, Ice, Heat

What makes your pain worse? *reach, carry, twist, bend, lift, exercise, run, stand, walk, sit, yard work, overhead work, drive, in-out of car, sleep, rolling over, dishes, laundry, vacuuming.* Other _____

_____

Are your symptoms: Getting better / Not changing / Getting worse. Rate your pain today: 0,1,2,3,4,5,6,7,8,9,10

How much do your symptoms affect your daily life? Not at all / A little / Moderately / Extremely

Who have you seen for this present problem? No one, Chiropractor, MD, PT, Massage, Other _____

Have you had X-rays or MRI's within the past year for this problem? **Y/N** Where? _____

Review of Symptoms (brief health history). Have you or do you have a problem with any of the following?

General joint pain **Y/N**	General Fatigue **Y/N**	Osteoporosis **Y/N**
Ear, Nose or Throat issue **Y/N**	Cardiovascular issues **Y/N**	Respiratory issues **Y/N**
Genital, kidney, Bladder **Y/N**	Gastrointestinal issues **Y/N**	Skin conditions **Y/N**
Neurological issues **Y/N**	Psychiatric issues **Y/N**	Diabetes / Endocrine **Y/N**
Unexplained weight gain or loss **Y/N**	Female issues **Y/N**	

Family history of any of the above **Y/N**. Please list _____

Do you smoke? **Y/N** How much? _____ Drink Alcohol **Y/N** How much? _____

Current medications _____ Allergies_____

Prior surgeries _____

Any other health issues? _____

_____

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