HANSONCHIROPRACTIC
chiropractic · massage · injury rehabilitation

11300 Roosevelt Way NE Suite 201 Seattle, WA 98125
P: (206)306-2494 // F: (206)306-9351 // W: www.hansonchiropractic.com

Last Name _____ First Name _____ Today's Date ___/___/_____

DOB ____/___/____ Sex: (M / F) Email _____ Cell Phone _____

Address _____ City _____ Zip _____

Occupation _____ Employer _____ Marital Status _____

Emergency Contact (name) _____ (phone) _____ (relationship) _____

How did you hear about our clinic? ☐ Referral ☐Advertisement ☐Social Media ☐ Internet ☐Zocdoc

Referring Physician _____ Patient _____ Attorney _____

Would you like to receive appt confirmations? ☐Call ☐·Text ☐ None

FINANCIAL POLICY

As a courtesy to you, we will bill your insurance company for you. In order for us to do this for you, we will need you to provide us with the following information: the name of the company, the address to which claims are to be billed, your policy identification number, and your group number (if applicable). It is your responsibility to provide any required information (referrals, authorization numbers, claim forms, accident information). It is also your responsibility to follow the policy guidelines of your insurance company. We will bill your secondary insurance as well, provided you have given us complete insurance information as noted above for your secondary company.

Policies vary widely depending on which procedures, services, or items an insurance company will cover. Because policies are often customized, we cannot be sure what your policy covers. To maximize your health insurance benefits, it is very important that you familiarize yourself with the policies and benefits outlined in your health insurance handbook or contact the customer service number on the back of your card.

Insurance Company: _____ Name & Date of Birth of ***Policy Holder*** _____

Member ID _____ Group#: _____

AUTHORIZATION OF RELEASE, ASSIGNMENT OF BENEFITS, STATEMENT OF RESPONSIBILITY

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out or proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable. I understand that if I have insurance, the fees for services I receive will be billed to my insurance company. I also understand that I am responsible for coinsurance or copays at the time I receive the service unless prior arrangements have been made.

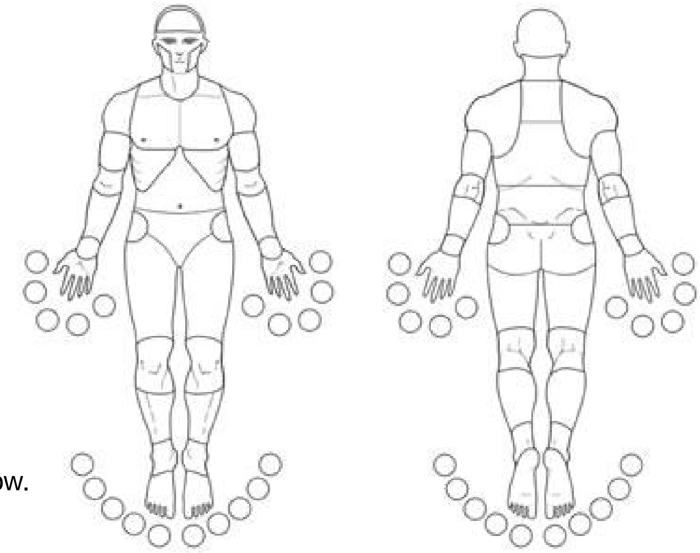
I **have read and understand the terms and conditions stated above.**

Patient Name _____ Date _____

Signature _____

New Patient Complaint History Form

Name: DOB: Date: Provider:



Please mark where you are experiencing any symptoms:

<u>Use the following as a guide:</u>

P = Pain B = Burning
T = Tingling W = Weakness
N = Numbness A = Aching

What was the cause of your symptoms?

____

____

____

____

Fill in the symptoms you are experiencing in the columns below.
In the order of severity.

	Symptom 1	**Symptom 2**	**Symptom 3**	**Symptom 4**
Location of symptom?				
Mechanism of injury	○ of unknown origin ○ after a fall ○ after a long drive ○ after a long flight ○ after a poor sleep ○ after a slip ○ after lifting an object ○ after household chores ○ after yardwork ○ after sitting too long ○ assoc. with chronic illness ○ OTHER	○ of unknown origin ○ after a fall ○ after a long drive ○ after a long flight ○ after a poor sleep ○ after a slip ○ after lifting an object ○ after household chores ○ after yardwork ○ after sitting too long ○ assoc. with chronic illness ○ OTHER	○ of unknown origin ○ after a fall ○ after a long drive ○ after a long flight ○ after a poor sleep ○ after a slip ○ after lifting an object ○ after household chores ○ after yardwork ○ after sitting too long ○ assoc. with chronic illness ○ OTHER	○ of unknown origin ○ after a fall ○ after a long drive ○ after a long flight ○ after a poor sleep ○ after a slip ○ after lifting an object ○ after household chores ○ after yardwork ○ after sitting too long ○ assoc. with chronic illness ○ OTHER
When did it start?				
Severity of symptom?	1 2 3 4 5 6 7 8 9 10 (1 =mild, 10=severe)	1 2 3 4 5 6 7 8 9 10 (1 =mild, 10=severe)	1 2 3 4 5 6 7 8 9 10 (1 =mild, 10=severe)	1 2 3 4 5 6 7 8 9 10 (1 =mild, 10=severe)
How frequently do you experience it?	○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring	○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring	○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring	○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring
What is the quality/ characteristic of the symptom?	○ Aching ○ Annoying ○ Burning ○ Deep ○ Dull ○ Heavy ○ Intolerable ○ Numb ○ Pulling ○ Sharp ○ Shock-like ○ Stabbing ○ ñStiffnessò ○ Throbbing ○ ñTightnessò ○ Tingling	○ Aching ○ Annoying ○ Burning ○ Deep ○ Dull ○ Heavy ○ Intolerable ○ Numb ○ Pulling ○ Sharp ○ Shock-like ○ Stabbing ○ ñStiffnessò ○ Throbbing ○ ñTightnessò ○ Tingling	○ Aching ○ Annoying ○ Burning ○ Deep ○ Dull ○ Heavy ○ Intolerable ○ Numb ○ Pulling ○ Sharp ○ Shock-like ○ Stabbing ○ ñStiffnessò ○ Throbbing ○ ñTightnessò ○ Tingling	○ Aching ○ Annoying ○ Burning ○ Deep ○ Dull ○ Heavy ○ Intolerable ○ Numb ○ Pulling ○ Sharp ○ Shock-like ○ Stabbing ○ ñStiffnessò ○ Throbbing ○ ñTightnessò ○ Tingling
Does it radiate? To where?	Y / N	Y / N	Y / N	Y / N

Change in complaint	○ Improved ○ Stayed same ○ Not changed ○ Worsened	○ Improved ○ Stayed same ○ Not changed ○ Worsened	○ Improved ○ Stayed same ○ Not changed ○ Worsened	○ Improved ○ Stayed same ○ Not changed ○ Worsened
Relieved by	○ Adjustments ○ Cold packs ○ Exercise ○ Heat packs ○ Massage ○ OTC meds ○ Physical therapy ○ Presc. meds ○ Rest ○ Stretching ○ Work ○ Nothing ○ Other	○ Adjustments ○ Cold packs ○ Exercise ○ Heat packs ○ Massage ○ OTC meds ○ Physical therapy ○ Presc. meds ○ Rest ○ Stretching ○ Work ○ Nothing ○ Other	○ Adjustments ○ Cold packs ○ Exercise ○ Heat packs ○ Massage ○ OTC meds ○ Physical therapy ○ Presc. meds ○ Rest ○ Stretching ○ Work ○ Nothing ○ Other	○ Adjustments ○ Cold packs ○ Exercise ○ Heat packs ○ Massage ○ OTC meds ○ Physical therapy ○ Presc. meds ○ Rest ○ Stretching ○ Work ○ Nothing ○ Other
Aggravated by	○ None ○ unknown action ○ any movement ○ bathing ○ bending ○ caring for family ○ carrying ○ changing positions ○ climbing stairs ○ computer use ○ concentrating ○ cooking ○ cough/sneeze ○ daily child or pet care ○ driving ○ eating ○ falling/staying asleep ○ getting in/out of car ○ getting out of bed ○ up from lying down ○ up from sitting ○ grocery shopping ○ household chores ○ lifting ○ looking over shoulder ○ lying down ○ pulling ○ pushing ○ reaching ○ reading ○ repetitive motions ○ resting ○ running ○ sitting ○ squatting ○ standing ○ stress ○ stretching ○ talking on the phone ○ turning	○ None ○ unknown action ○ any movement ○ bathing ○ bending ○ caring for family ○ carrying ○ changing positions ○ climbing stairs ○ computer use ○ concentrating ○ cooking ○ cough/sneeze ○ daily child or pet care ○ driving ○ eating ○ falling/staying asleep ○ getting in/out of car ○ getting out of bed ○ up from lying down ○ up from sitting ○ grocery shopping ○ household chores ○ lifting ○ looking over shoulder ○ lying down ○ pulling ○ pushing ○ reaching ○ reading ○ repetitive motions ○ resting ○ running ○ sitting ○ squatting ○ standing ○ stress ○ stretching ○ talking on the phone ○ turning	○ None ○ unknown action ○ any movement ○ bathing ○ bending ○ caring for family ○ carrying ○ changing positions ○ climbing stairs ○ computer use ○ concentrating ○ cooking ○ cough/sneeze ○ daily child or pet care ○ driving ○ eating ○ falling/staying asleep ○ getting in/out of car ○ getting out of bed ○ up from lying down ○ up from sitting ○ grocery shopping ○ household chores ○ lifting ○ looking over shoulder ○ lying down ○ pulling ○ pushing ○ reaching ○ reading ○ repetitive motions ○ resting ○ running ○ sitting ○ squatting ○ standing ○ stress ○ stretching ○ talking on the phone ○ turning	○ None ○ unknown action ○ any movement ○ bathing ○ bending ○ caring for family ○ carrying ○ changing positions ○ climbing stairs ○ computer use ○ concentrating ○ cooking ○ cough/sneeze ○ daily child or pet care ○ driving ○ eating ○ falling/staying asleep ○ getting in/out of car ○ getting out of bed ○ up from lying down ○ up from sitting ○ grocery shopping ○ household chores ○ lifting ○ looking over shoulder ○ lying down ○ pulling ○ pushing ○ reaching ○ reading ○ repetitive motions ○ resting ○ running ○ sitting ○ squatting ○ standing ○ stress ○ stretching ○ talking on the phone ○ turning
Have you experienced it before? If so, when?				
What previous testing have you had? **Date & location?**	○ X-ray ○ MRI ○ CAT scan ○ EMG/NCV ○ Blood tests	○ X-ray ○ MRI ○ CAT scan ○ EMG/NCV ○ Blood tests	○ X-ray ○ MRI ○ CAT scan ○ EMG/NCV ○ Blood tests	○ X-ray ○ MRI ○ CAT scan ○ EMG/NCV ○ Blood tests

REVIEW OF SYSTEMS

Musculoskeletal
- ☐ arthritis
- ☐ cramping
- ☐ elbow/wrist pain
- ☐ foot/ankle pain
- ☐ fracture
- ☐ gout
- ☐ hip disorders
- ☐ implants or plates
- ☐ joint or muscle pains/stiffness
- ☐ knee injuries
- ☐ osteoporosis
- ☐ pins or screws
- ☐ poor posture
- ☐ scoliosis
- ☐ shoulder problems
- ☐ swelling
- ☐ redness
- ☐ deformity of joint(s)
- ☐ TMJ issues

Respiratory
- ☐ apnea
- ☐ asthma
- ☐ blood in sputum
- ☐ emphysema
- ☐ hay fever
- ☐ persistent cough
- ☐ pneumonia
- ☐ shortness of breath
- ☐ snoring issues
- ☐ tuberculosis
- ☐ wheezing

Cardiovascular
- ☐ blood clots
- ☐ chest pain or tightness
- ☐ congenital heart defects
- ☐ coronary artery disease
- ☐ dizziness
- ☐ dyspnea
- ☐ excessive bruising
- ☐ heart attack
- ☐ heart murmur
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ leg pain upon walking
- ☐ low blood pressure
- ☐ lower extremity edema
- ☐ palpitations
- ☐ rheumatic fever
- ☐ swollen legs or feet
- ☐ varicose veins

Neurological
- ☐ anxiety and/or panic
- ☐ depression
- ☐ difficulty concentrating
- ☐ dizziness
- ☐ epilepsy or seizures
- ☐ headache
- ☐ loss of smell or taste
- ☐ memory issues
- ☐ numbness
- ☐ pins and needles
- ☐ sleeping issues
- ☐ stroke
- ☐ loss of vision/smell/ hearing
- ☐ weak muscles

Endocrine
- ☐ Cushing's syndrome
- ☐ Diabetes
- ☐ excessive thirst
- ☐ feeling hot or cold all the time
- ☐ heat or cold intolerance
- ☐ hyperparathyroidism
- ☐ hyperthyroidism
- ☐ hypothyroidism
- ☐ increase size of hands or fee
- ☐ increase urination
- ☐ pancreatic conditions
- ☐ polydipsia
- ☐ polyuria
- ☐ purple striae
- ☐ steroid treatments
- ☐ testosterone deficiency
- ☐ thyroid problems

Derma./Hemo
- ☐ blood in stool
- ☐ change in hair or nails
- ☐ easy bruising, eczema
- ☐ excessive acne
- ☐ excessive hair loss
- ☐ flushing
- ☐ gum bleeding
- ☐ hyper/hypo pigmentation
- ☐ psoriasis
- ☐ skin cancer
- ☐ skin pigmentation issues
- ☐ skin trouble or rashes

Gastrointestinal
- ☐ abdominal pain
- ☐ black or bloody stool
- ☐ bloating
- ☐ changes in bowel habits
- ☐ colitis
- ☐ colon cancer or colon polyps
- ☐ constipation
- ☐ Crohn's disease
- ☐ difficulty swallowing
- ☐ food sensitivities
- ☐ gastric reflux
- ☐ heartburn
- ☐ hemorrhoids
- ☐ irritable bowel syndrome
- ☐ jaundice
- ☐ liver disease
- ☐ nausea or vomiting
- ☐ pancreatitis
- ☐ severe diarrhea
- ☐ ulcer
- ☐ vomiting

Genitourinary
- ☐ blood in the urine
- ☐ incontinence
- ☐ kidney stones
- ☐ painful or frequent urination
- ☐ sexual dysfunction
- ☐ urgency
- ☐ urinary infections

PERSONAL AND FAMILY HISTORY

Had any surgeries? When? ☐ Y ☐ N _____

Any past illnesses or conditions? ☐ Y ☐ N _____

Past accidents or trauma? ☐ Y ☐ N _____

Currently taking any medication? ☐ Y ☐ N _____

Family illness history?
Diabetes, cancer, hypertension, and neurological diseases? ☐ Y ☐ N _____

WORK AND SOCIAL HABITS

Current work habits:
- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Can't work due to current condition
- ☐ Full-time ☐ Part-time
- ☐ Retired ☐ Student
- ☐ Homemaker ☐ Unemployed

Personal social habits:
- ☐ Smoke/tobacco use
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other

Present exercise habits:
- ☐ No current exercises
- ☐ Exercise daily
- ☐ Exercise 3+/week
- ☐ Can't return to exercise due to current condition

Diet and nutrition habits:
- ☐ Unrestricted
- ☐ Vegan or vegetarian
- ☐ Daily supplements
- ☐ Other

HANSONCHIROPRACTIC
chiropractic · massage · injury rehabilitation

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. The treatment at our office will consist of adjustments/manipulation of the joints and soft tissues using hands and/or a mechanical instrument. You may feel joint movements and you may hear joint "click" or "pop". Physical therapy methods along with therapeutic exercise may also be used.

Chiropractic care has been proven to be very safe and effective. However, as in the practice of health care, there are some risks involved to chiropractic treatment. Minor risks include soreness, stiffness, dizziness and headache which may occur during the treatment plan. Physical therapy treatment may involve muscle spasms, bruising, swelling and local burns from heat generated from equipment. Most significant risks are fractures, sprains and disc injuries. A stroke temporally correlated to neck adjustment is a very rare complication. Stroke has also been correlated to ordinary activities such as hair shampooing or gazing at the stars.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, and is my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (Printed)

Date (MM/DD/YYYY)

Patient or Legal Guardian Signature

HANSONCHIROPRACTIC
chiropractic · massage · injury rehabilitation

HIPAA (Health Insurance Portability & Health Care Information)
Re: Open Room Adjusting & Health Care Information

You can restrict the individuals or organization to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decided to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone that has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments and physical rehabilitation in an open room style with other patients in the same room. Occasionally comments about your symptoms, improvement or lack there of may be discussed during your office visits.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or health related information at any time (#164.524).

This authorization will expire seven years after the date in which you last received services at Hanson Chiropractic & Massage.

I authorize Hanson Chiropractic & Massage to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Authorization to Release Information to Physician

At Hanson Chiropractic & Massage, we believe it is important that all of your physicians work together for your benefit. By signing this release you are authorizing us to release reports and information to your doctor(s) regarding your treatment at Hanson Chiropractic & Massage.

Patient Name (Printed) _____ Date (MM/DD/YYYY) _____

Patient or Legal Guardian Signature _____