WELCOME TO CLEAR CHOICE CHIROPRACTIC

Daniel J. Thompson, DC   Katherine McAllister, DC

PATIENT INFORMATION:

First ________________ MI ________ Last ____________________

Address ____________________________ Apt ____________

City ________________________ State ______________ Zip ____________

Birth Date _______/_______/_______ Age __________ Gender: ☐ Male ☐ Female

Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed SSN: _______-______-_______

CONTACT INFORMATION:

Best time/place to reach you:____________________

Home ( ) __________- __________

Cellular ( ) __________- __________

Work ( ) __________- __________

Email: ________________________

EMERGENCY CONTACT:

Relationship to you: ____________________

Home ( ) __________- __________

Cellular ( ) __________- __________

Work ( ) __________- __________

Occupation: ____________________ Employer: ________________ Ph#____________

Employer Address: ____

Spouse Name: ____________________________ Birth Date ________/________/________

Spouse SSN: _______-______-_______ Spouses Employer: ________________________

Referred to this office by: ☐ Street Sign ☐ Phonebook ☐ Web Search ☐ Our Website ☐ Insurance ☐ Other __________
☐ Physician ____________________ ☐ Friend / Family____________________

HEALTH INSURANCE INFORMATION:

Primary Insurance Company: ____________________ Member ID#: ____________ Group#:__________

Secondary Insurance Company: ____________________ Member ID#: ____________ Group#:__________

Other Insurance Subscriber Name: ________________________ Birth Date ______/______/______

ASSIGNMENT & RELEASE:

☐ **Insurance Assignment**: I certify that I have insurance coverage and assign directly to Clear Choice Chiropractic all benefits. I understand that I am liable for full payment, for services and treatments rendered not covered by my insurance.

☐ **Cash Agreement:** I will make payments in full for services rendered at the time of service. Payments made after the initial visit are subject to a 10% finance charge and will be billed on a monthly basis from the date of service.

☐ **Workman's Comp:** Work related injury cases are accepted on assignment with permission of the employer and prior authorization from the employer's compensation insurance carrier. In the event that the carrier should reject the claim, I understand I am liable for payment of all treatment/services rendered.

☐ **Auto Accident/Personal Injury:** We accept assignment for payment from your attorney or insurance company. In the event that this claim should be rejected or reduced by the carrier, I understand that I am liable for payment in full for services and treatments rendered.

☐ **Medicare:** We accept assignment for Medicare. Patient is responsible for their Insurance obligation at the time of service.

Name ______________________________

REASON FOR YOUR VISIT

What is the reason for your visit? ____

Primary Complaint: ☐Neck ☐Upper Back ☐Mid Back ☐ Lower Back ☐Shoulder ☐Wrist ☐Knee ☐Ankle
Secondary Complaint: ☐Neck ☐Upper Back ☐Mid Back ☐ Lower Back ☐Shoulder ☐Wrist ☐Knee ☐Ankle
Tertiary Complaint: ☐Neck ☐Upper Back ☐Mid Back ☐ Lower Back ☐Shoulder ☐Wrist ☐Knee ☐Ankle

Please list any other complaints (not mentioned above):
____

When did your symptoms appear? Date _______________ (if applicable)
☐ A few days ago ☐ A week ago ☐ Couple weeks ago ☐ Month ago ☐ Couple months
☐ Within the last year ☐ 1 year ago ☐ Years ago

What was the cause of your injury?
☐ Auto Accident ☐ Work Injury ☐ Bent down
☐ Fell (bike) (horse) (ice/snow) (ladder) (stairs) ☐ Lifted something heavy ☐ Slept wrong ☐ Sports
☐ Unknown ☐ Other ________________

Rate your intensity of your pain on a scale from ***1*** *(least pain) to* ***10*** *(severe pain)*
Primary Complaint: (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Secondary Complaint: (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Tertiary Complaint: (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Type of pain:
☐ Aching ☐ Burning ☐ Dull ☐ Numbness ☐ Sharp ☐ Shooting ☐ Stiffness ☐ Swelling
☐ Throbbing ☐ Tingling ☐ Radiating, If yes: Where does it radiate: ____________________ ☐ Other ___________

How often are you experiencing your pain?
☐ Constant (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

Activities or movements that is painful to perform?
☐ Bending ☐ Lying Down ☐ Sitting ☐ Standing ☐ Walking ☐ Other ______________________________

Have you used any of these to treat your symptoms? ☐ Ice ☐ Heat ☐ Medication ☐ Other

Any major accident or injuries? ☐ Yes ☐ No If YES, Please explain:
____

Have you ever been knocked unconscious? ☐ Yes ☐ No If YES, Please explain:
____

Have X-Rays, MRI or CT Scan been taken in the last 6 months? ☐ Yes ☐ No
If YES, where & when?
____

Are you currently taking any medications? ☐ Yes ☐ No If YES, Please list:
____

Do you have any allergies to? ☐ **NONE APPLY**
☐ Eggs ☐ Fish or Shellfish ☐ Milk or Lactose ☐ Peanuts ☐ Soy ☐ Sulfites ☐ Wheat/Glutens ☐ Other

Name ______________________________

PAST TRAUMAS, SURGERIES AND PROCEDURES: ☐ **NONE APPLY**

☐ Heart ☐ Appendectomy ☐ Carpal Tunnel ☐ C-Section ☐ Gall Bladder ☐ Gastro-Intestinal
☐ Hernia ☐ Hysterectomy ☐ Spine ☐ Knee(s) ☐ Prostate ☐ Shoulder(s)
☐ Joint Replacement ______________________________ ☐ Other ______________

HEALTH HISTORY:

Please check if you have or have ever had any of the following. (**CHECK ALL THAT APPLY)**
☐ **NONE APPLY**

☐ Alcoholism/Drug Abuse
☐ Allergies/Sinus Trouble
☐ Anemia
☐ Appendicitis
☐ Arthritis
☐ Artificial Valves/Bones
☐ Asthma/Emphysema
☐ Breast Lump
☐ Cancer
☐ Chemotherapy
☐ Chicken Pox/Measles/Mumps
☐ Chronic Cough
☐ Chronic Fatigue
☐ Congenital Heart Defect
☐ Cramps/Backache
☐ Crossed Eyes
☐ Deafness
☐ Diabetes
☐ Difficult Breathing/Wheezing
☐ Dizziness
☐ Earaches/Ear Noises
☐ Eczema
☐ Edema
☐ Fainting/Seizures/Epilepsy
☐ Frequent Colds
☐ Glaucoma
☐ Headaches
☐ Heart Attack/Stroke
☐ Heart Disease
☐ Heart Surgery/Pacemaker
☐ Hepatitis
☐ High/Low Blood Pressure
☐ HIV/AIDS
☐ Hives/Sensitive Skin
☐ Hot Flashes
☐ Insomnia
☐ Irregular Cycle/Painful Periods
☐ Jaundice
☐ Kidney/Liver/Gall Bladder
☐ Mental Disorder
☐ Miscarriage(s)
☐ Muscle Spasms
☐ Neck/Mid Back/Low Back Pain
☐ Nose Bleeds
☐ Pain in Joints/Limbs
☐ Painful Tailbone
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Poor Circulation
☐ Poor Digestion
☐ Poor Vision
☐ Pregnancy Back Pain
☐ Prostate Trouble
☐ Psoriasis
☐ Rapid Heart/Slow Heart
☐ Rheumatic Fever
☐ Sensitive Skin
☐ Shingles
☐ Spitting/Vomiting Blood
☐ Swelling of ankles
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcers/Colitis
☐ Vaccinations
☐ Venereal Infection
☐ Vertigo
☐ Whooping Cough
☐ Other ______________

FAMILY HISTORY:

(Please indicate which conditions have been experienced by the above by marking appropriate boxes)

☐ This section does not apply
☐ Adopted, Unknown History

	Grandparent(s)	Parent(s)	Sibling(s)
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Heart Conditions / Stroke	☐	☐	☐
Hypertension	☐	☐	☐
Spinal Problems	☐	☐	☐
Thyroid	☐	☐	☐

Name ________________________________

SOCIAL HISTORY:

Do you smoke cigarettes? ☐ Yes ☐ No #_____/day
Do you drink coffee? ☐ Yes ☐ No #_____/day
Do you drink soft drinks? ☐ Yes ☐ No #_____/day
Do you drink alcohol beverages? ☐ Yes ☐ No #_____/day
Do you take diet nutritional supplements? ☐ Yes ☐ No
Do you exercise? ☐ None ☐ Moderately ☐ Daily ☐ Heavy

NOTES

____
____
____
____

REVIEW OF SYSTEMS:

Please enter: **1** *(never)*, **2** *(previously)*, **3** *(presently)* **in front of all the following signs and symptoms on line or check √ appropriate box.**

General Symptoms
___ Headache(s)
___ Fever
___ Chills
___ Excessive Sweating
___ Fainting
___ Dizziness
___ Chronic Fatigue
___ Insomnia
___ Fatigue
___ Nervousness
___ Loss of weight
___ Numb or tingling
___ Allergies

Gastro-Intestinal
___ Poor appetite
___ Poor digestion
___ Excessive hunger
___ Belching or Gas
___ Nausea
___ Vomiting
___ Vomiting blood
___ Pain over stomach
___ Constipation
___ Diarrhea
___ Gall bladder Trouble
___ Liver trouble
___ Jaundice

Ear Eyes Nose Throat
___ Poor vision
___ Crossed eyed
___ Pain in eyes
___ Deafness
___ Earaches
___ Ear noises
___ Nose bleeds
___ Sinus Trouble
___ Tonsillitis
___ Sore throat
___ Hoarseness
___ Frequent colds
___ Enlarged thyroid

Respiratory
___ Difficulty Breathing
___ Chronic cough
___ Spitting Blood
___ Chest pain
___ Asthma
___ Wheezing

Genito-Urinary
___ Frequent urination
___ Painful urination
___ Blood in urine
___ Prostate Trouble
___ urinary incontinence

Muscle & Joints
___ Weakness
___ Whiplash
___ Neck pain
___ Mid back pain
___ Low back pain
___ Painful tailbone
___ Pain in Joints
___ Pain in limb
___ Muscle Spasms

Cardio-Vascular
___ Rapid heart
___ Slow heart
___ High blood pressure
___ Low blood pressure
___ Pain over heart
___ heart trouble
___ Swelling of ankles
___ Poor Circulation
___ Stroke(s)

Skin or Allergies
___ Skin sensations
___ Itching
___ Bruising easily
___ Dryness
___ Psoriasis
___ Sensitive skin
___ Hives
___ Eczema
___ Edema

Female Problems
___ Painful periods
___ Excessive flow
___ Irregular cycles
___ Hot flashes
___ Cramps or Backache
___ Miscarriage(s)
___ Vaginal Discharge
___ Current pregnancy
___ Pregnancy back pain

Name ________________________________

ACTIVITIES OF DAILY LIVING:

Activities:	Effect:			
Carry Children/Groceries:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other:_______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List prescription & non-prescription drugs that you take:

____

____

____

Name ________________________________

Informed Consent:

REGARDING: Chiropractic adjustments, Modalities, and Therapeutic Procedures

I read and understand that chiropractic care, like all forms of health care, hold certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Clear Choice Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctors at Clear Choice Chiropractic, deem necessary to treat my condition at any time throughout the entire clinical course of my care.

________________________________	_____/_____/_____	______________
Patient or Authorized Person's Signature	Date	Witness Initials

FEMALES ONLY --> REGARDING: X-Rays/Imaging Studies ☐ **Check if N/A**

Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ____/____/_____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

________________________________	_____/_____/_____	______________
Patient or Authorized Person's Signature	Date	Witness Initials

Name ________________________________

MEDICAL AUTHORIZATIONS

I hereby authorize release of any medical information necessary for diagnosis including X-Rays and other imaging, diagnostics, treatment plan and chart notes to:

Clear Choice Chiropractic
15 SW 12th Ave
Battle Ground, WA 98604
Phone: (360) 666-7722 Fax: (360) 666-3388

AUTHORIZATION:

I certify that I am the patient or legal guardian listed on the form. I have read/understand the included information in this demographic and case history and certify it to be true and accurate to the best of my knowledge.

I hereby authorize the doctor to release all information necessary to any insurance company through either electronic submissions or appropriate clearinghouses or via paper claim submissions, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use and understand I agreed to the use of my signed statement and use of my information and authorization with my signature for insurance submissions from when I initially applied for care at this office on my first visit, whenever that may have occurred. I understand and agree that all services rendered to me will be charged to me, and that I am fully responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case, from third-parties or by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I authorize the doctors and their staff to examine and treat my condition as the doctors see fit and I consent to treatment for care. I understand that there are always risks to chiropractic such as CVA and fractures when being adjusted. If there are any questions or concerns please advise your doctor prior to treatment. I agree to the collection and use of the above information for use within Clear Choice Chiropractic.

Print Name: ____ **DOB:** ____/_____/______

Patient / Guardian Signature: _________________________________ **Date:** ____/_____/______