CLE ELUM CHIROPRACTIC

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PATIENT INFORMATION

Name:_____ Date:_____
(Last) (M.I.) (First)

Sex: ___M ___ F Marital status: (circle) single married divorced partnered widowed

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Please **Circle** best # to call

Email: _____

Occupation: _____ Employer: _____

Name of Spouse: _____ Referred by: _____

Emergency Contact: _____
(Name) (Phone) (Relationship to Patient)

HEALTH INFORMATION DISCLOSURE

I, _____, give permission to Cle Elum Chiropractic to disclose the following health information to _____:

_____ Scheduling Information
_____ Medical Information ***(Please initial any/all applicable categories)***
_____ Financial Information

I understand that this gives Cle Elum Chiropractic permission to disclose only the above-mentioned health information to only those above-mentioned individuals.

PARENT/LEGAL GUARDIAN AGREEMENT FOR MINORS

I, _____, am the individual who authorizes treatment and is responsible for the financial obligations of _____. I authorize treatment and agree to pay for all services provided to _____ here at Cle Elum Chiropractic.

Printed Name: _____
Signature: _____ Date: _____

Name: _____ Date: _____

HEALTH HISTORY

Purpose of Visit: (circle)
Chiropractic
Massage

Is this your 1st time seeing this type of practitioner?
___Y ___N
___Y ___N

Main Complaint: _____

_____

When did this condition begin? _____ How did this condition begin? _____

_____

Do you have any prior history of this problem? ___Y ___N
If Yes, please explain: _____

Is this condition injury related? ___Y ___N If Yes, is it: ___ Work related? ___ Motor vehicle collision related?

Other injury- Please describe: _____

Other doctors/practitioners seen for this condition: _____

_____

What makes this complaint **worse**? _____

What makes the complaint **better**? _____

Pain Intensity (circle the #)	**None**	**Minimal Discomfort/ache/stiff**			**Slight to Moderate Hurts/sore/bearable**				**Severe Sharp/intense pain**		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck discomfort	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back discomfort	0	1	2	3	4	5	6	7	8	9	10
Low Back discomfort	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot symptoms	0	1	2	3	4	5	6	7	8	9	10
Other:	0	1	2	3	4	5	6	7	8	9	10

Pain Frequency	**None**	**Occasional**			**Intermittent**			**Frequent**		**Constant**	
Neck	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid Back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Other:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Do you get headaches? ___Y ___N How frequently? _____
How many hours does your typical headache last? _____

Do you get migraines? ___Y ___N How frequently? _____
How many hours does your typical migraine last? _____
What is/are the cause(s) of your migraines? _____

Name: _____ Date: _____

Please check symptoms with which your pain has been associated:

- ☐ Numbness, tingling or pain into your shoulder, upper arm, lower arm, or hand/fingers? **Circle areas.**
- ☐ Numbness, tingling or pain into your hip/buttock, groin, front of thigh, back of thigh, knee, calf, shin, or foot/toes? **Circle areas.**
- ☐ Increased low back pain with coughing, sneezing, or bearing down to have a bowel movement
- ☐ Excessive fatigue-malaise
- ☐ Weight loss
- ☐ Low grade fever
- ☐ Bowel or bladder disorders (such as urinary or bowel incontinence or difficulty urinating or having bowel movements)
- ☐ Ovarian pain
- ☐ Kidney pain/painful urination
- ☐ Night pain or night time sweats
- ☐ Abdominal pain
- ☐ Balance problems
- ☐ Flu/cold
- ☐ Inflammation
- ☐ Infection
- ☐ Contagious disease

Allergies: _____

Food sensitivities: _____

Describe any allergic/sensitivity reactions: _____

_____

Date of last physical exam and results: _____

Job description: _____
Have you been able to work? ____Y ____N

Recreational activities/hobbies: _____

Do you exercise? ___Y ___N If Yes, please describe: _____

Do you, or have you, smoke cigarettes or use tobacco products? ___Y ___N If Yes, for how long? _____

Medications and reason taken: _____

_____

Vitamins, minerals, or other supplements: _____

_____

Name: _____ Date: _____

Past Surgeries	**Date**	**Reason for surgery**

Past Accidents, Falls or Injuries	**Date**	**Description of injury**

Past Fractures/broken bones	**Date**	**Description/location of fracture**

Health problems of relatives: _____

_____

Other health related concerns or comments: _____

_____

_____

WOMEN: Are you pregnant? ___ Y ___ N If so, how far along are you? _____

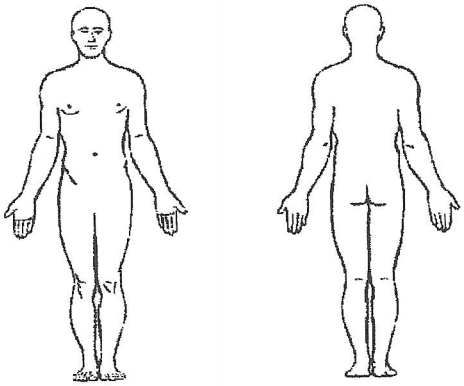
Please list any pregnancy complications or restrictions? _____

_____

Name: _____ Date: _____

Please indicate on the drawing where you experience the following:

pain (P), aches (A), numbness (N), swelling (S)



Please check any of the following that currently affect you or that you have experienced.

MUSCULOSKELETAL

___ Low Back Pain
___ Mid Back Pain
___ Neck Pain
___ Pain between shoulders
___ Arm Pain
___ Shoulder Pain
___ Elbow Pain
___ Wrist pain
___ Finger Pain
___ Hip Pain
___ Thigh Pain
___ Knee Pain
___ Leg Pain
___ Foot Pain
___ Toe pain
___ Ankle pain
___ Jaw Pain
___ Difficulty Chewing
___ Joint Stiffness (Where: _____)
___ Joint Swelling (Where: _____)
___ Fibromyalgia
___ Osteoporosis or Osteopenia
___ Arthritis
___ Rheumatoid Arthritis
___ Postural Deviations
___ Headache
___ Muscle Weakness or Weak Grip
___ Disc bulge/herniation (Where: _____)
___ Vertebrae Condition

NERVOUS SYSTEM

___ Multiple Sclerosis
___ Paralysis
___ Spinal Cord Injury
___ Stroke
___ Seizures/Convulsions
___ Numbness/tingling in extremities
___ Cold extremities
___ Twitching/Ticks
___ Fainting
___ Depression
___ Poor balance/coordination

CIRCULATORY

___ Anemia
___ Abdominal Aneurysm
___ Hemophilia
___ High Blood Pressure
___ Low Blood Pressure
___ Raynaud's Disease
___ Varicose Veins
___ Hemorrhoids
___ Heart Condition/Attack
___ Blood Clots/Phlebitis
___ Chest Pain
___ Irregular heartbeat
___ Ankle Swelling
___ Light Headedness
___ Body too cold
___ Body too hot

DIGESTIVE

___ Abdominal pain
___ Constipation
___ Frequent Nausea
___ Gall bladder problems
___ Liver problems/hepatitis
___ Vomiting
___ Diarrhea
___ Gas/Bloating
___ Indigestion/heartburn
___ Black or bloody stool
___ Excessive thirst
___ Excessive appetite

URINARY

___ Bladder trouble/infection
___ Discolored urine
___ Painful urination
___ Excessive urination
___ Scant urination
___ Kidney Problems

RESPIRATORY

___ Lung Congestion
___ Sinus Congestion/infection
___ Asthma
___ Difficulty Breathing
___ Dizziness
___ Lung Condition

SKIN

___ Fungal Infections
___ Dermatitis/Eczema
___ Psoriasis
___ Open Wound or Sore
___ Rashes
___ Warts/Moles
___ Athletes Foot
___ Ring Worm

OTHER

___ Diabetes or Hypoglycemia
___ Anxiety/Nervousness
___ Muscle Cramping
___ Trouble Sleeping
___ Menstrual Problems
___ Cancer
___ Substance Abuse
___ Herpes
___ Fatigue
___ HIV/AIDS
___ Lupus
___ Postoperative Situation
___ Swelling
___ Prosthetics
___ Implanted device (ie: pacemaker)
___ Joint Replacement
___ Transplanted Organ
___ Other:

_____
_____
_____

Name: _____ Date: _____

PATIENT COMPLIANCE FORM

My initials and signature on this document indicates that:

1) I acknowledge that all the information I have given is accurate to the best of my knowledge and is necessary in order to receive the best possible care. I agree and take responsibility for notifying my practitioner if any physical or mental changes occur with my health (ie: injury, illness, pregnancy, etc) to ensure that the most appropriate and effective care continues to be given.

_____

2) I hereby acknowledge that I have read and fully understand the **NOTICE OF PRIVACY PRACTICES** outlining the policies and procedures concerning the privacy of my Patient Health Information and if there is anyone I do not want to receive my medical records, I have informed the center in writing. I agree to allow this wellness center to use my Patient Health Information for the purpose of treatment, payment, healthcare operations and not share my health information with anyone, unless I have signed a Records Release Form.

_____

3) I understand that it is **my responsibility to make it to all scheduled appointments and to notify the office/practitioner at least 24 hours in advance if a situation arises that leads to cancellation or rescheduling. I agree to pay the missed appointment fee, which is equal to the charge of that visit in the event I miss my appointment or cancel last minute.**

_____

4) I have read and fully understand this wellness center's **FINANCIAL POLICIES** and know that I am ultimately responsible for any charges incurred at this office. I know that it is my responsibility to pay at the time of service if a cash patient or a co-payment for regular insurance patients. I know that in the event that I am on an injury claim and the claim closes or stops being paid by the insurance company, that I am responsible for payment, which is due at the time of service. I authorize the use of this signature on all insurance submissions.

_____

5) I give my permission and consent to the general procedure or treatment I will receive and know that if at any time I no longer wish to receive a specific treatment (or an aspect of), I have the right to inform my practitioner. I will ask my practitioner if I have any questions concerning the general procedure.

_____

Signature: _____ Date: _____

CLE ELUM CHIROPRACTIC, PLLC

Informed Consent for Reiki Treatment

You are the ultimate decision maker for your health care. Part of our role is to provide you with the information necessary to assist you in making informed choices in your health care. To do so, it is important that you read and understand the information contained in this document, and that you are aware of the benefits and risks associated with Reiki treatment. If you have any questions related to the information in this or any other form you are presented by Cle Elum Chiropractic, please bring it to our attention.

Generally speaking, Reiki is a hands-on healing practice. **As part of Reiki treatment, the practitioner's hands may lightly rest on your body, in a variety of locations, including some that may be personal or sensitive. It is an important part of the healing process for you to be comfortable and relaxed. If at any time you are uncomfortable, it is your responsibility to inform the practitioner, so that they can switch hand positions, use the floating hands method, or otherwise take the necessary steps to ensure that you are comfortable. The practitioner will not continue any actions or treatment to which you object.** There is no difference in the benefits experienced by the physical placement of the practitioner's hands on your body versus the floating hands method, whereby the practitioner will float their hands over your body. Any specific preferences you may have related to hand positions or the floating hands method should be voiced to your practitioner. They will be happy to accommodate any reasonable requests.

By your signature below, you hereby acknowledge the foregoing and accept the following:

I hereby request and consent to the performance of Reiki treatment on me (or on the patient named below for whom I am legally responsible) by the Reiki practitioner who now or in the future will treat me while employed by Cle Elum Chiropractic.

I understand that Reiki is not a replacement for traditional medical treatment. Reiki is a relaxation and stress reduction technique. I acknowledge that Reiki treatments are only for the purpose of helping me to relax, relieve stress, and facilitate general healing. Reiki practitioners do not diagnose conditions, prescribe substances, or otherwise perform medical treatments. I further acknowledge and accept that the Reiki treatment I receive from Cle Elum Chiropractic is not construed as a substitute for medical examination, diagnosis, or treatment, and that there are treatment options available other than Reiki treatment. It is recommended that I see a licensed health care professional for any physical or mental ailments I may have.

I understand that Reiki may, and often does, involve the physical laying of hands on the recipient of the treatment. I understand and acknowledge that I will experience a series of hand positions on and/or near my body. I further acknowledge that it is my responsibility to inform the practitioner immediately if I experience discomfort in any way, and that I should inform the practitioner prior to undergoing treatment if I have any particular sensitives or concerns.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content. By signing below, I acknowledge that I understand and agree to the information presented above and the risks inherent to Reiki treatment, and hereby agree to be bound by the terms of this statement of informed consent. I further intend that this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name: _____ **Patient Signature:** _____

Name of Patient (if under 18 years of age): _____ **Date:** ____/____/_____

Parent/Guardian of Minor Signature: _____ **Relationship:** _____

CLE ELUM CHIROPRACTIC, PLLC

Informed Consent for Chiropractic Treatment

You are the ultimate decision maker for your health care. Part of our role is to provide you with the information necessary to assist you in making informed choices in your health care. To do so, it is important that you read and understand the information contained in this document, and that you are aware of the benefits and risks associated with chiropractic care, alternatives to chiropractic care, and the potential effects on your health if you choose not to receive chiropractic care. If you have any questions related to the information in this or any other form you are presented by Cle Elum Chiropractic, please bring it to our attention.

Generally speaking, chiropractic care is centered around what is known as a chiropractic adjustment. **When providing an adjustment, we use our hands or an instrument to reposition anatomical structures such as vertebrae, muscles, bones, ligaments, etc. To provide adjustments, we must physically touch certain parts of your body, some of which may be personal or sensitive. This is a necessary part of the chiropractic adjustment process, but we do not want you to be uncomfortable. It is your responsibility as the patient to inform the doctor if you are uncomfortable, in any way, with the treatments being performed. Our doctors will not perform any treatments to which you object.**

By your signature below, you hereby acknowledge the foregoing and accept the following:

I hereby request and consent to the performance of chiropractic procedures on me (or on the patient named below for whom I am legally responsible for) by the chiropractic doctor who now or in the future will treat me while employed by Cle Elum Chiropractic.

I understand and I am informed that, as is with all medical treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as with all medical treatments, in the course of administering chiropractic treatments, side-effects may result. This may include, but is not limited to, dizziness, nausea, flushing, bruising, muscle spasms for short periods of time, stroke, exacerbating and/or temporarily increase in symptom presentation, lack in improvements of symptoms, fractures, disc injuries, strokes, dislocations, and sprains to those pre-disposed. I do not expect the doctor to be able to anticipate and explain all risks and complications, and in the course of treatment, I wish to rely on the doctor's judgment to make those treatment suggestions which the doctor feels at that time, and based upon the facts then known, is in my best interest. I understand and acknowledge that, as part of my treatment, the doctor may wish to refer me to another medical organization.

I further understand that chiropractic adjustments and supportive treatment is designed to correct and/or reduce pain, involuntary spasms/contractures, range of motion, posture, biomechanics, and segmental dysfunctions, with the goal of aiding the body's return to improved health. Such treatments may also alleviate certain symptoms through a conservative approach, potentially avoiding the need for more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure.

I further understand that there are treatment options available for my condition other than chiropractic and manual therapy. These options may include, but are not limited to, self-administered over the counter analgesics and rest; medical care with prescription drugs, such as anti-inflammatories, muscle relaxants, and painkillers; physical therapy; steroid injections; bracing; and/or potential surgical intervention. I understand and have been informed that I have the right to seek a second opinion and to secure other treatment options as I may see fit.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content. By signing below, I acknowledge that I understand the information presented above and the risks inherent to medical treatment, and hereby agree to be bound by the terms of this statement of informed consent. I further intend that this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

[SIGNATURE PAGE FOLLOWS]

Patient Name: _____ **Patient Signature:** _____

Name of Patient (if under 18 years of age): _____ **Date:** ____/ ____/ _____

Parent/Guardian of Minor Signature: _____ **Relationship:** _____