NOBLE CHIROPRACTIC
+ Movement Lab

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CONFIDENTIAL PATIENT INFORMATION

When a person seeks chiropractic care and we accept a person for such care, it is essential for both to be working for the same objective. The following definitions help clarify some of the fundamentals of chiropractic;

- **Health**: The state of optimal physical, mental, social, and spiritual well-being, not merely the absence of symptoms and/or disease.
- **Subluxation**: Misalignment and abnormal motion of spine which causes nerve interference resulting in a decrease of neurology, biology, health of body and performance.
- **Adjustment**: Gentle and specific application of forces to the spine to correct the subluxations.

Our Chiropractic Principles:

- Optimal health results in optimal performance in all areas of life.
- Your body is self-healing and self-regulating at 100% by design.
- The nervous system (brain, spinal cord, nerves) controls and coordinates ALL functions of the body, including performance.
- Subluxations or nerve interference is caused by the body's inability to adapt to physical, chemical and emotional stress. Nerve interference results in loss of communication between the brain and the body much like static on a cell phone results in loss of communication between those callers. The loss of communication between the brain and body results in a decline in health and performance.
- Chiropractors locate and correct subluxations with specific adjustments, allowing the body to heal and move toward optimum health which leads to peak performance.

If we encounter non-chiropractic or unusual findings during evaluation, we will advise you and will recommend that you seek the services of a health care provider who specializes in that area

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Would you like to receive our email newsletter about health? □ Yes □ No	
Would you like to receive email or text reminders? □ Text □ Email	
Date of birth:	**Age:**
No. of children:	**Pregnant? Yes □ No □**
Height:	**Weight:**
Marital status: M S W D	**Spouse/guardian name:**
Occupation:	
Employer's name & address:	
Spouse's Occupation/Employer:	
Name of person responsible for account:	

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Peak Performance, please skip to the **"General Health History"**.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

_____

_____

Since the problem started is it: About the same? □ Getting better? □ Getting worse? □

What have you done for this condition? Was it of benefit?

_____

_____

I do (do not) have a family history of this or similar symptoms (Please explain):

_____

_____

Which activities aggravate your condition? _____

_____

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	□
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	□
Medical Doctor	□
Dentist	□
Other (please describe)	□

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

_____

_____

Is this condition interfering with any of the following:

Work □	Sleep □	Daily routine □	Sports/exercise □	Other □ (please explain):

What lesson(s) have you taken home from your healing process to date?

_____

General Health History

Often times, accumulation of life's stress can lead to health problems, influence our ability to heal, and a decrease in performance. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes □ No □
2. Type:	When?	Hospitalized? Yes □ No □
3. Type:	When?	Hospitalized? Yes □ No □

Have you ever had x-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes □ No □

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

_____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

_____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health, well-being, and performance?	Yes □ No □ Maybe □
If dietary changes are indicated would you be willing to make changes in your diet?	Yes □ No □ Maybe □
Would you take whole food supplements if indicated?	Yes □ No □ Maybe □
If specific exercises or stretching would help would you consider adding them to your program?	Yes □ No □ Maybe □
If reducing stress would help you perform better, would you like to know ways to reduce stress?	Yes □ No □ Maybe □

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day **| W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) **| M -** Consume this monthly **| O -** Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

The type of diet I usually follow is classified as: _____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

□ Alcoholism	□ Allergy	□ Anemia	□ Arteriosclerosis	□ Arthritis	□ Asthma
□ Back Pain	□ Cancer	□ Cold Sores	□ Constipation	□ Convulsions	□ Depression
□ Diabetes	□ Diarrhea	□ Eczema	□ Emphysema	□ Epilepsy	□ Gall Bladder Problems
□ Gout	□ Headaches	□ Heart Attack	□ Heart Disease	□ High Blood Pressure	□ HIV (Aids)
□ Irregular Periods	□ Low Blood Sugar	□ Malaria	□ Measles	□ Menstrual Cramps	□ Migraines
□ Miscarriage	□Multiple Sclerosis	□Mumps	□ Neck Pain	□ Nervousness	□ Neuritis
□ Pleurisy	□ Pneumonia	□ Polio	□ Rheumatic Fever	□ Ringing in ears	□Sinus Problems
□ Stroke	□ Thyroid Problems	□Tuberculosis	□ Ulcers	□ Venereal Disease	□ Whooping Cough

Other (please explain) _____

_____

Stressors

Because accumulation of stress affects our health, ability to heal, and leads to a decrease in performance, please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. _____
   b. _____
   c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____
   c. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent □	Good □	Fair □	Poor □	Getting better □	Getting worse □

How do you grade your emotional/mental health?

Excellent □	Good □	Fair □	Poor □	Getting better □	Getting worse □

How do you grade your level of performance?

Excellent □	Good □	Fair □	Poor □	Getting better □	Getting worse □

Is there anything else which may help to better understand you which has not been discussed?

_____

_____

_____

Why are you here at this point in time?

_____

_____

_____

I consent to a professional and complete chiropractic examination.
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by **Dr. Steven B. Noble** and/or other licensed doctor's of chiropractic who now of in the future may practice in, work or associated with, or be employed by **Noble Chiropractic, P.S., currently located at 119 Grand Ave Suite C, Bellingham, WA 98225.**

I have had an opportunity to discuss with Dr. Noble the nature and purpose of chiropractic adjustments and other procedures.

The following points have been explained to me, to my satisfaction, and I have had opportunity to discuss them with Dr. Noble and/or other clinic personnel:

1. Chiropractic care is the science, philosophy and art of locating and correcting spinal and extremity joint subluxations, and as such, is oriented toward improvement of spinal function relative to range-of-motion, muscular and neurologic aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease, or condition as a result of treatment in this clinic. If during the course of a chiropractic examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, a diagnosis or treatment for these findings, we will recommend that you seek the services of a health care provider who specializes in that area.

2. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click".

3. As with the practice of medicine, the practice of chiropractic is not an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

4. It is not reasonable to expect my chiropractor to be able to anticipate, or explain all possible risks and complications of a given procedure on any particular visit and I wish to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest.

5. An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment.

I have read the above consent, or had it read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided and consent to chiropractic treatment and management on that basis.

_____ _____

Patient's Printed Name Date

_____ _____

Patient's Signature Parent/Guardian

NOTICE OF PRIVACY PRACTICE SUMMARY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Noble Sports Chiropractic, P.S., in accordance with applicable federal and state law, is committed to maintaining the privacy of your protected health information (PHI). In other words, the private information about your health condition and the care and treatment you receive from the Practice. We will use and disclose elements of your PHI the following ways:

- Treatment
- Payment
- Health care operations
- When release is required by law, including judicial settings and to health oversight regulatory agencies and law enforcement
- In emergency situations or to avert serious health/safety situations
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in their duties
- To organ, tissue and other donation organizations, upon or proximate to your death, if we have no indication on hand about your donation preferences

Special Cases:

- Appointment reminders, treatment alternatives and other health related benefits and services
- Office newsletter
- Sponsor of your health plan

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your Rights: You have the following rights concerning your PHI:

- **Restrictions:** To request restricted access to all or part of your PHI. To do this, please make the request in writing. We are not required to grant your request
- **Confidential communications:** To receive correspondence of confidential information by alternative means or location. To do this, please make a request in writing
- **Access:** To inspect or receive copies of your PHI. To do this, please submit a request in writing
- **Amendments:** To request changes be made to your PHI. To do this, please submit a request in writing
- **Accounting:** To receive an accounting of the disclosures by us of your PHI in the six years prior to your request. To do this, please submit a request in writing
- **This notice:** To get updates or re-issue of this notice, at your request
- **Complaints:** To complain to your office or the U.S. Department of Health and Human Services if you feel your privacy rights have been violated. To register a complaint with us, please submit your request in writing. The law forbids us from taking retaliatory action against you if you complain

Our duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy contact: To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Dr. Steven B. Noble at Noble Chiropractic, P.S., 119 Grand Ave Suite C, Bellingham, WA 98225.

Effective date: This notice is in effect as of October 1, 2006. A complete copy of the Notice of Privacy Practice is available at the reception desk.

Patient acknowledgement: By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____	_____	_____
Please Print Name	Signature	Date