

PATIENT INTRODUCTION FORM

Last Name:	MI:	First Name:
Home Address:		
City:	State:	Zip:
E-Mail:		Cell phone:
Date of Birth:	Age:	Gender: M F
		Able to receive text? Yes No
Employer:		Work phone:
How did you hear about us?		Social Security #:
Who can we thank for the referral?		
Do you have insurance that you would like us to bill? YES NO (Please provide a copy of your card.)		
		Name of Company:
Emergency Contact: Name:		Relationship:
Address:		Phone:

IS THIS VISIT RELATED TO A:

- | | | |
|--|--|--|
| <input type="checkbox"/> Work Related Injury | <input type="checkbox"/> Car Crash Injury | <input type="checkbox"/> Home Injury |
| <input type="checkbox"/> Sports or Recreational Injury | <input type="checkbox"/> Non-Injury Symptoms | <input type="checkbox"/> Check-up Only |
| <input type="checkbox"/> Other (Describe): | | |

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Our office will provide insurance billing services for you if you so desire as a courtesy.

Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier.

Your signature on this document indicates that you:

- 1) *Agree to pay for any outstanding bills incurred in this office.*
- 2) *Authorize the release of health information necessary to secure the payment of benefits.*
- 3) *Authorize insurance payments to be made directly to Summit Chiropractic & Massage.*
- 4) *Authorize the use of this signature on all insurance submissions.*
- 5) *Authorize us to communicate through text/email. (Treatment related only and will NOT be shared)*

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR TIME OF SERVICE PATIENTS AND THE CO-PAYMENT, DEDUCTIBLE OR CO-INSURANCE FOR REGULAR INSURANCE PATIENTS.

Signature of responsible party (Patient or Parent): _____ Date: _____

Patient Information

Summit Chiropractic & Massage

7302 NE 18th Street, suite #102, Vancouver WA 98661 * 360-750-7220

Name: _____ Date: _____

Welcome to Summit Chiropractic & Massage. We want you to enjoy life to the fullest of your potential.

Reason for your visit today (check all that apply):

- stay healthy peak performance wellness evaluation fix the problem pain relief only

Complete this section only if you have symptoms
(this will be necessary for most insurances)

Date problem began? _____

Describe how this problem began (fall, lift, etc.)?

Circle your current pain level: 0 1 2 3 4 5 6 7 8 9 10

Check how often do you experience your symptoms:

- Constantly (90-100%) Frequently (70-80%)
 Intermittently (40-60%) Occasionally (10-30%)
 1x/month 2-3x/month 1x/week 2-4x/week Daily

Since it began is your complaint (circle): better worse same?

Does the complaint radiate anywhere? No Yes

If yes, Where? Leg Arm Other _____

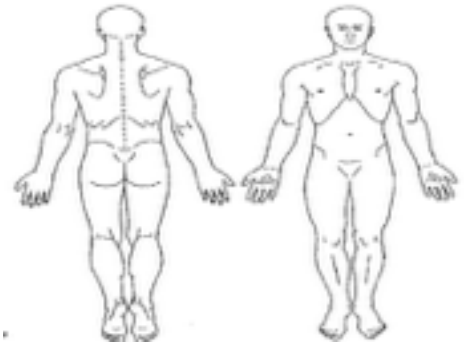
What makes your symptoms better _____

What makes your symptoms worse? _____

What daily activities are being affected? _____

Prior care/treatments? _____

Circle your current complaint area?



What best describes your complaint? (circle all that apply)

- | | | |
|----------|-----------|-----------|
| tension | stiffness | tightness |
| achy | sharp | burning |
| shooting | throbbing | stabbing |
| numbness | tingling | weakness |
| other: | | |

Office/Doctor use

Summit Chiropractic & Massage Patient Information

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HAS YOUR COMPLAINT BEEN ASSOCIATED WITH OR HAVE YOU RECENTLY HAD:?

None of the following Check all that apply.

<input type="checkbox"/> Recent excessive fatigue	<input type="checkbox"/> fever	<input type="checkbox"/> night pain / night sweats
<input type="checkbox"/> Unintentional weight loss/gain	<input type="checkbox"/> Change in bowel or bladder habits	<input type="checkbox"/> difficulty with talking/balance/confusion/dizziness
<input type="checkbox"/> Abdominal pain / pulsations	<input type="checkbox"/> Kidney pain / change in urination	<input type="checkbox"/> changes in vision (double/blurred)
<input type="checkbox"/> Chest pain / shortness of breath	<input type="checkbox"/> Weakness / numbness in a limb	<input type="checkbox"/> vomiting/diarrhea/constipation
<input type="checkbox"/> skin rash	<input type="checkbox"/> pain worse with rest	<input type="checkbox"/> other symptoms not mentioned:

SURGERY?

I have never had any surgery If you have had any previous surgery, (circle) indicate type and when:

Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine surgery (neck or back)		<input type="checkbox"/> Cancer / chest / head / pelvis	
<input type="checkbox"/> shoulder / arm / hip / leg / hand / foot		<input type="checkbox"/> Other	

MEDICAL CONDITIONS / ILLNESS ?

I have no prior/current other conditions /illnesses. Check all that you currently have or have ever had.

<input type="checkbox"/> Diabetes / Pre-Diabetes	<input type="checkbox"/> cancer (any type)	<input type="checkbox"/> heart attack / stroke	<input type="checkbox"/> heart disease
<input type="checkbox"/> scoliosis	<input type="checkbox"/> arthritis (anywhere)	<input type="checkbox"/> seizures / neurological	<input type="checkbox"/> osteoporosis / osteopenia (weak bones)
<input type="checkbox"/> herniated / degenerated discs	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> abdominal aneurysm	<input type="checkbox"/> arm / leg numbness tingling weakness
<input type="checkbox"/> high cholesterol	<input type="checkbox"/> anxiety / depression	<input type="checkbox"/> asthma / allergies	<input type="checkbox"/> Crohn's / psoriasis / ulcerative colitis
<input type="checkbox"/> other conditions not mentioned:			

PRIOR INJURY HISTORY?

I have no history of previous painful injury. If you have had prior injuries or pain, please check below:

<input type="checkbox"/> low back injury	<input type="checkbox"/> neck/mid-back injury	<input type="checkbox"/> leg/arm injury	<input type="checkbox"/> sports injury	<input type="checkbox"/> vehicle/motorcycle injury	<input type="checkbox"/> Other:
Details:					

FRACTURES/BROKEN BONES?

I have never had any broken bones. If you have broken any bones, indicate where and when:

Region	Year	Region	Year
<input type="checkbox"/> Spinal (neck/back)		<input type="checkbox"/> Skull / Pelvis	
<input type="checkbox"/> Arm / leg / foot / hand		<input type="checkbox"/> other:	

MEDICATIONS?

I am not taking any medications currently. Check any of the following that you are taking currently.

<input type="checkbox"/> Muscle relaxants/anti-inflammatory/steroids Details:	<input type="checkbox"/> Blood pressure/stroke /heart/cholesterol Detail:	<input type="checkbox"/> Diabetic Detail:
<input type="checkbox"/> Pain: prescription or over the counter Detail:	<input type="checkbox"/> Osteoporosis medications. Details:	<input type="checkbox"/> Other: Details:

LIFESTYLE

Rate the following:

Exercise/week: 1 2 3 4 5 6 7	Diet: poor / good / excellent
Stress level: Low Moderate High	Tobacco: yes / never / past

ILLNESSES / CONDITIONS IN YOUR FAMILY: _____

OCCUPATION _____ Physical demands _____

SIGNATURE _____ DATE _____

To the best of my ability, the information I have supplied is complete and truthful.

Functional Rating Index

Name: _____
(Print)

For use with Neck and/or Back Problems

Date: _____

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

1. Pain Intensity

0-----1-----2-----3-----4
No Mild Moderate Severe Worst
pain pain pain pain possible
pain

6. Recreation

0-----1-----2-----3-----4
Can do Can do Can do Can do Cannot
all most some a few do any
activities activities activities activities activities

2. Sleeping

0-----1-----2-----3-----4
Perfect Mildly Moderately Greatly Totally
sleep disturbed disturbed disturbed disturbed
sleep sleep sleep sleep sleep

7. Frequency of pain

0-----1-----2-----3-----4
No Occasional Intermittent Frequent Constant
pain pain; 25% pain; 50% pain; 75% pain; 100%
of the day of the day of the day of the day

3. Personal Care (washing, dressing, etc.)

0-----1-----2-----3-----4
No Mild Moderate Moderate Severe
pain; pain; pain; need Moderate Severe
no no to go slowly pain; need pain; need
restrictions restrictions assistance assistance

8. Lifting

0-----1-----2-----3-----4
No Increased Increased Increased Increased
pain with pain with pain with pain with pain with
heavy heavy moderate light any
weight weight weight weight weight

4. Travel (driving, etc.)

0-----1-----2-----3-----4
No Mild Moderate Moderate Severe
pain on pain on pain on pain on pain on
long trips long trips long trips short trips short trips

9. Walking

0-----1-----2-----3-----4
No pain; Increased Increased Increased Increased
any pain after pain after pain after pain after
distance 1 mile ½ mile ¼ mile all walking

5. Work

0-----1-----2-----3-----4
Can do Can do Can do Can do Cannot
usual work usual work 50% of 25% of work
plus unlimited no extra usual usual
extra work work work work

10. Standing

0-----1-----2-----3-----4
No pain Increased Increased Increased Increased
after pain pain pain pain
several after several after after
hours hours 1 hour ½ hour standing

Signature: _____

Total Score: _____ /40 _____ %