BELFAIR CHIROPRACTIC CENTER

131 NE Roy Boad Rd. Suite A
MAIL: PO Box 625
Belfair WA 98528
PHONE: (360)-275-4411
FAX: (360)-275-4412

NAME _____ **BIRTHDATE** _____

ADDRESS _____ **CITY/STATE** _____ **ZIP** _____

MAILING ADRESS (IF DIFFERENT) _____

HOME PHONE _____ **MOBILE PHONE** _____

OCCUPATION _____ **EMPLOYER** _____

SPOUSE _____

CHILDREN (NAMES/AGES) _____

E-MAIL ADDRESS _____

WHO REFERRED YOU TO US? _____

PAST CHIROPRACTIC/MASSAGE CARE? YES/NO PROVIDER'S NAME/LOCATION _____

CURRENT MEDICAL CARE? YES/NO WHY? _____

REASON FOR CONSULTING THIS OFFICE _____

PLEASE CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH/WELLBEING.

- ❑ I am only concerned about relief of a particular symptom.
- ❑ I am only concerned about relief of a particular symptom, and preventing its return.
- ❑ I want optimum health and wellbeing on every level available to me.

WE ACCEPT PAYMENT BY CASH, CHECK AND CREDIT CARD
I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.
Balances still owed after 90 days will be charged a 1% finance fee. Returned check fee is $55.

Massage no-show or late cancellation fee is $50.00 _____(initial)
I understand I must give notice of 24 hour of cancellation _____(initial)
I am responsible for remembering my own appointments, this office offers text reminders but they are a courtesy, not a reliable way to remember appointments_____(initial)

Signature _____ Date _____

BELFAIR
CHIROPRACTIC CENTER

360.275.4411
www.belfairchiropracticcenter.com

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Belfair Chiropractic Center.

I understand that the Notice describes the uses and disclosures of my protected health information by Belfair Chiropracticcenter and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

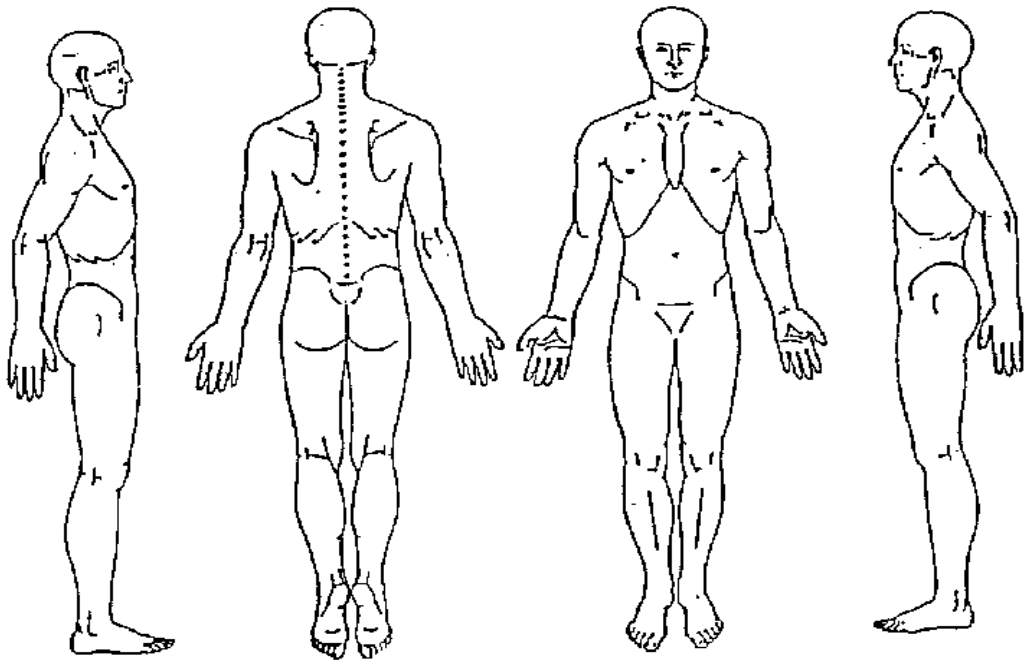
_____

HEALTH HISTORY

Please mark your symptoms on the diagram:

Mark “P” for pain

Mark “N” and “T” for numbness and tingling



Rate your overall pain today

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild			Moderate			Severe		Worst Possible

Progression (circle): Improving Not-Improving Worsening

What makes it worse?_____

What makes it better?_____

In general, how would you rate your current overall health?

Excellent Very good Good Fair Poor

Please list all accidents, injuries, scars, surgeries and falls with approximate dates (year of occurrence).

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please check all that apply

___ Abdominal Problems	___ Allergies	___Anxiety / irritability	___ Arthritis
___ Asthma	___ Ankle Problems	___ Auto-immune	___ Back Pain
___ Bone Spurs	___ Breast Lumps	___ Breast Pain	___ Breast Implants
___ Bronchitis	___ Bunions	___ Bursitis	___ Buttocks Pain
___ C-Section	___ Cancer	___ Carpal Tunnel	___ Chest Pain
___ Constipation	___ Depression	___ Diabetes	___ Digestion
___ Dizziness	___ Ear Problems	___ Edema (swelling)	___ Fatigue
___ Fibromyalgia	___ Fibroids / cysts	___ Fracture(s)	___ Falls on Tailbone
___ Gallbladder	___GERD	___ Golfers elbow	___ Hamstring(s)
___ Hay Fever	___ Headaches	___ Heart Problem	___ Hemorrhoids
___ Hernia	___ High BP	___ Hip Replacement	___ Infertility
___ Jaw Problems	___ Joint Replacement	___ Liver Problems	___ Lung Problems
___ Migraines	___ Mood swings	___ Knee Problems	___ Neck Pain
___ Numbness/tingling	___ Orthotics	___ Osteoporosis	___ Pain
___ Pelvic Problems	___ Plantar Fasciitis	___ PMS	___ Prostate Problems
___ Rib Problems	___ Sacral Problems	___ Sciatica	___ Scoliosis
___ Shin Splints	___ Shingles / Herpes	___ Shoulder Problems	___ Sinus Problems
___ Sleep Problems	___ Smoker	___ Tennis Elbow	___ Tendonitis

What are your favorite hobbies or activities?_____

_____

Currently Affected? □Yes □No

What activities do are you looking forward to doing long term (even in retirement)?

_____
_____
_____

Massage Therapy Client Release Form

- I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.
- During the session hot stones or hot towels may be used.
- During the session Cupping Therapy may be performed. If I should choose to experience this treatment I understand the potential effects and the after-care recommendations.
- It has been explained to me there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned in my Health History Intake form, to avoid any complications.
- It has been explained to me that there can be some discolorations that may occur from the release and clearing of stagnation and toxins from the body.
- I also understand that this reaction is not bruising, but due to cellular debris, pathogenic factors, old stagnation and toxins being drawn to the surface to be cleared away by my circulatory system.
- I further understand that the discolorations will dissipate from a few hours to as long as two weeks in some cases and in relation to my after-care activities.
- I understand that Cupping Therapy modalities should not be combined with aggressive exfoliation, 4 hours after shaving, after sunburn or when I am hungry or thirsty.
- I understand that I should avoid excessive exposure to extreme cold, wet, and/or windy weather conditions, very hot showers, baths, saunas, hot tubs and aggressive exercise for 24 hours. It has been explained to me that exposure to such extremes can produce undesirable effects and I should avoid and or limit such situations.
- I understand that I should avoid caffeine, alcohol, sugary foods and drinks, dairy and processed meats. I understand I should drink plenty of clean water.

I_____ agree to allow the Massage Practitioner to perform Massage Therapy and/or Cupping Therapy. I have read and understand all the information stated above and will not hold the practitioner responsible.

_____ _____
Signature Date

I_____ agree to be on time for my massage appointment. Out of mutual respect, **I** will arrive at least 10 minutes early to take care of payment, using the bathroom, etc. Arriving late disrupts the concentrated energy for bodywork and causes scheduling issues for those after me. If **I** am more than 15 minutes late **I** forfeit my massage and will pay the no-show fee.

_____ _____
Signature Date

Belfair Chiropractic Center
Dr. Josef H. Scott

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____

Signature Date

Consent to evaluate and adjust **a** minor child:

I am the parent or legal guardian of _____ and I have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature Date

Belfair Chiropractic Center
Dr. Josef H. Scott