Northwest Family
CHIROPRACTIC & MASSAGE

New Client Registration Form (please complete entire form)

Today's Date:______________ Primary Care Provider:______________________ Phone #:_______________

Client Information:

Legal Last Name:______________________ Legal First Name:______________________ Middle Initial:____

Nickname:________________________ Former Name:________________________

Birth date:___________ Age:_______ Relationship status: single / married / divorced / separated / widowed

Occupation:___________________________

Gender: Male / Female / Preferred Pronoun____________ Prefer not to answer _________________

Home phone #:_________________ Cell phone #:__________________ Work phone #:_________________

I would like text message reminders for my appointments sent to my cell phone # provided above: Yes / No

Emergency Contact:____ Phone #:______________________

Billing address:___________________________ City:___________________ State:_________ Zip:_________

Email Address:___________________________________ Email reminders? Yes / No

How did you hear about the office? ____

Are you covered by medical insurance? Yes / No

Does your insurance require a referral from your PCP? Yes / No (Please ask front desk for more info if needed)

Primary Insurance:___________________________________

Subscribers Name:____________________________________ Subscribers date of birth:__________________

Clients relationship to insurance subscriber: self / spouse / child / domestic partner / other:_____________

Who is the financially responsible party for the bill? ☐ Self ☐ Other: (Please fill out below)

Name:_____________________________________ Date of birth:________________

Address:_______________________________ City:__________________ State:__________ Zip:__________

Phone Number:______________________________ Employer:______________________________________

1. I understand that I am responsible for charges not covered or reimbursed by my health plan or similar payer. I agree to pay you directly if my insurer, health plan, employer program or similar benefits program does not pay.
2. I authorize my insurer, health plan, employer program or similar benefits program to release information to you regarding my coverage
3. My right to payment for care, treatment, supplies and other services are hereby assigned to you. This assignment covers any and all benefits under Medicare, other government sponsored programs, insurance, employer programs and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. If my insurer, health plan, employer program or similar benefit program does not accept assignment of benefits, or if payments are made directly to me or my representative I will endorse such payment to you.
4. I understand and authorize release of all health information about me to my insurer, health plan, employer program or similar benefits program identified above to obtain payment for care, treatment, supplies and other services. The above information is true to the best of my knowledge.

Client / Guardian Signature:____ Date:_________________

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Confidential Patient Information

Name: ____ Date: ______________Date of birth: _____________

About You

What is the primary reason/complaint that you are seeking Chiropractic and/or Massage care?
____
When did it begin? ____
What do you think caused this? (car accident or work injury please inform front desk)
____
Is it getting worse? Yes/No
Specifically, what makes it better? ____
Specifically, what makes it worse? ____
Is the complaint: □Constant □ Frequent □ Intermittent □ Occasional
Is the complaint worse in the: □Morning □Afternoon □Evening □While sleeping
Is the complaint getting: □Better □Worse □Staying the same
Rate the severity of the complaint (0=no pain / 10=severe pain) 0 1 2 3 4 5 6 7 8 9 10
Do you experience any radiating pain? □ Yes □ No
If yes, where? ____
Do you have increase pain with coughing and sneezing? □ Yes □ No
If yes, where?____
Are you experiencing any weakness or loss of function? □ Yes □ No
If yes, where?____
Describe the pain (please check all that apply):
□ Sharp □Dull □Throbbing □Aching □Numb □Shooting
□ Burning □Tingling □Cramping □Stiffness □Swelling □Pressure
Are there any other (secondary) complaints? Please list: ______________________________________
____

How does your complaint affect the following aspects of your life:

Length and quality of your sleep: ____

Exercise: ____

Work: ____

Family: ____

Social interaction: ____

Specifically list activities that you are avoiding due to your complaint and your goal for that activity:

Activity:___________________________________Goal:______________________________________

Activity:___________________________________Goal:______________________________________

Activity:___________________________________Goal:______________________________________

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Past/current care information

Have you ever seen a Chiropractor before? □Yes □No A Massage Therapist? □Yes □No
If yes, who:____
Have you seen any other health care provider for this complaint? □Yes □No
List provider name: ____ Phone: _________________________
List provider name: ____ Phone: _________________________
List all medication:
____
____
List all supplements:
____
____
List any allergies:
____
Do you smoke? Yes / No; Consume alcohol? Yes / No use recreational drugs? Yes / No

If female:

Date of menarche (first menstrual cycle): ____
Do you experience symptoms during your cycle: ____
Are you currently pregnant? □Yes □No □ I don't know If yes due date:_______________
If pregnant, who is your OB or midwife?:____
Are you currently breastfeeding? □Yes □No
Number of Pregnancies:____
If you have been pregnant in the past, how did you deliver? □ Vaginally □ C-Section □ Vbac
Describe any complications during delivery:____

Have you or anyone in your <u>immediate family</u> experienced:

Cancer: □Self □mother □father □other____
Heart Disease: □Self □mother □father □other____
Arthritis: □Self □mother □father □other____
Scoliosis: □Self □mother □father □other____
Diabetes: □Self □mother □father □other____
Parkinsons: □Self □mother □father □other____
Alzheimers: □Self □mother □father □other____

Have you experienced any:

Car accidents: □Yes □No ____
Work related injuries: □Yes □No ____
Hospitalizations: □Yes □No ____
Surgeries: □Yes □No ____

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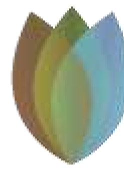

Name: ______________________________ DOB: ___________________ Todays Date: ________________

Please check any boxes that apply to your health, past or current.

General-
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin-
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head-
□ Headache
□ Head injury
□ Neck Pain

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks
□ Glaucoma
□ Cataracts
□ Last eye exam: _________

Nose-
□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain

Throat-
□ Bleeding
□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores

Neck-
□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

Respiratory-
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular-
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Swelling
□ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□Yellow eyes or skin

Urinary-
□ Change in frequency
□ Change in urgency
□ Burning or pain
□ Blood in urine
□ Incontinence
□ Change in urinary strength

Vascular-
□ Calf pain with walking
□ Leg cramping

Musculoskeletal-
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Hematologic-
□ Ease of bruising
□ Ease of bleeding

Endocrine-
□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite

Psychiatric-
□ Nervousness
□ Stress
□ Depression
□ Memory loss

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Additional information

Is there anything else in your health history that you would like the doctor / LMP to know?

____

____

____

Authorization and Informed Consent to Evaluate and Care for Individual:

I, ____ do herby authorize, request, and direct the staff and doctors of Northwest Family Chiropractic & Massage to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary. Chiropractic treatment is one of the safest methods of treating back pain. Still, unexpected problems can occur, such as soreness and stiffness, especially at the start of care. More significant problems, such as fracture of weakened bone or sprain/disc injuries are rare. A stroke following neck manipulation is an extremely rare complication, occurring in less than 1 per million treatments. We screen our clients to insure their safety and refer out to supporting providers when necessary.

Patient's signature: ____Date: _______________________

Our Mission is to provide a profound health care experience in a professional and genuine environment. We empower our clients through individualized Chiropractic programs and lifestyle coaching and inspire our clients to uncover the natural healing power from within.

Welcome to NW Family Chiropractic & Massage

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Claims Escalation to the Washington State Office of the Insurance Commissioner

In the event of an unreasonable claim denial, unresolvable claims issue, or claim decision that could be a violation of state law; it is possible to escalate claims issues to the Washington State Office of the Insurance Commissioner. In order to solve the issue, the Insurance Commissioner's office does require the patient's name, ID and/or group number, DOB, explanation of benefits, and possible discussion of any claims related communication between the patient, our office, and the insurance carrier.

Please choose from the following options:

- ☐ **Option 1:**
  I give NW Family Chiropractic permission to release my information, as specified above, to the Office of the Insurance Commissioner; in order to resolve claims issues as they deem appropriate.
- ☐ **Option 2:**
  I may release my information to the Office of the Insurance Commissioner but only on a case by case basis. Please seek my written approval for any applicable claims issue.
- ☐ **Option 3:**
  Under no circumstances do I wish for NW Family Chiropractic to release my information to the Office of the Washington State Insurance Commissioner.

The insurance commissioner does not regulate out of state or self-funded health plans.

RELEASE OF PERSONAL INFORMATION **Please initial: _____**

I authorize the release of my information to the following individual (s)

☐ Self only

☐ Other (please write in below)

Name: ____________________ Relationship: ________________ Phone #: ___________

Name: ____________________ Relationship: _______________ Phone #: ___________

MISSED APPOINTMENT FEES

We allocate a specific time for your appointment to better fit your needs. We understand that there may be times when you must cancel or reschedule an appointment but we do request advance notice for the following services:

24 hours advance notice is required to cancel or change a **massage** or incur a **$70.00** missed appointment fee.

Notice **ahead of the scheduled time** to cancel or change a **chiropractic** appointment or incur a **$20.00** missed appointment fee.

Missed appointment fees may not be billed to insurance. **Please initial:** ______

NOTICE OF PRIVACY PRACTICES

I have read the privacy notice & understand my rights. I authorize NW Family Chiropractic to use and disclose my protected health information for the purpose of treatment, payment, and healthcare operations as described in the privacy notice. If you have questions about any part of this notice or want more information about your privacy rights, please contact Marisa De Lisle DC, at 206-363-4478 within 2 working days. If you are not satisfied with the manner that this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights.

Patient Name:______________________ Patient Signature:_____________________________ Date:_________

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Insurance Verification Form

Patient Name: _______________________________________ Month Benefits Refresh:________________

Policy Holder: ______________________________________ Policy Holder Date of Birth:___________________

Insurance Company Name: ________________________________ Effective date:________________________

Do you have a Secondary Insurance Company?____

Dear Practice member: this form is provided for you to document your Insurance Benefits. Over the years there have been many changes in the insurance world; because of that, we ask that you verify your benefit information so that you understand how your benefits work.

Please verify this information regarding your Chiropractic Benefit:

Spinal Manipulation: # per (Calendar / Plan) year____

Plan Deductible: $_______________ (Does the deductible apply to the spinal manipulation visits? YES / NO)

Co-Pay per visit: $____

Co-Insurance %:____

Massage Therapy Benefit: Combined with PT? __Yes / No___ Covered if performed by LMP?:___Yes / No__

Massage visit max ________ Co-pay? $______ Co-ins? %________

<u>Regence plans</u>: do you need pre-certification for spinal manipulations? YES / NO

<u>Premera plans</u>: do you need pre-certification for PT/MT benefits? YES / NO

Some policies will process services from different benefits within the plan. If you would like to have more in depth information regarding your plan we advise that you verify the following:

X-ray Benefit: ____

Examination Benefit:____

Do any of these benefits apply to deductible? Yes / No ____

If you would like more information about codes we use in office, please ask front desk.

After verifying this information please provide this to the front desk staff

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Name:____ **Date:**____________________

Oswestry Low Back Pain Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1: **Pain Intensity** ☐ I have no pain at the moment ☐ The pain is very mild at the moment ☐ The pain is moderate at the moment ☐ The pain is fairly severe at the moment ☐ The pain is very severe at the moment ☐ The pain is the worst imaginable	Section 2: **Personal Care (Washing, dressing, etc)** ☐ I can look after myself normally without causing extra pain ☐ I can look after myself normally, but it causes extra pain ☐ It is painful to look after myself and I am slow and careful ☐ I need some help but manage most of my personal care ☐ I need help every day in most aspects of self-care ☐ I so not get dressed, I wash with difficulty and stay in bed	Section 3: **Lifting** ☐ I can lift heavy weights without extra pain ☐ I can lift heavy weights, but it gives extra pain ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed, eg. on a table ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned ☐ I can lift very light weights ☐ I cannot lift or carry anything at all
Section 4: **Walking** ☐ Pain does not prevent me from walking any distance ☐ Pain prevents me from walking more than 1 mile ☐ Pain prevents me from walking more than ½ mile ☐ Pain prevents me from walking more than 100 yards ☐ I can only walk using a stick or crutches ☐ I am in bed most of the time	Section 5: **Sitting** ☐ I can sit in any chair as long as I like ☐ I can only sit in my favorite chair as long as I like ☐ Pain prevents me from sitting more than one hour ☐ Pain prevents me from sitting more than 30 minutes ☐ Pain prevents me from sitting more than 10 minutes ☐ Pain prevents me from sitting at all	Section 6: **Standing** ☐ I can stand as long as I want without extra pain ☐ I can stand as long as I want but it gives me extra pain ☐ Pain prevents me from standing for more than 1 hour ☐ Pain prevents me from standing for more than 30 minutes ☐ Pain prevents me from standing for more than 10 minutes ☐ Pain prevents me from standing at all

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Name:____ Date: ____________

Section 7: **Sleeping**	Section 8: **Sex Life (if applicable)**	Section 9: **Social Life**
☐ My sleep is never disturbed by pain ☐ My sleep is occasionally disturbed by pain ☐ Because of pain I have less than 6 hours of sleep ☐ Because of pain I have less than 4 hours of sleep ☐ Because of pain I have less than 2 hours of sleep ☐ Pain prevents me from sleeping at all	☐ My sex life is normal and causes no extra pain ☐ My sex life is normal but causes some extra pain ☐ My sex life is nearly normal but is very painful ☐ My sex life is severely restricted by pain ☐ My sex life is nearly absent because of pain ☐ Pain prevents any sex life at all	☐ My social life is normal and gives me no extra pain ☐ My social life is normal but increases the degree of pain ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, eg. sports ☐ Pain has restricted my social life and I do not out as often ☐ Pain has restricted my social life to my home ☐ I have no social life because of pain

Section 10: **Travelling**

☐ I can travel anywhere without pain
☐ I can travel anywhere but it gives me extra pain
☐ Pain is bad but I manage journeys over two hours
☐ Pain restricts me to journeys of less than one hour
☐ Pain restricts me to short necessary journeys under 30 minutes
☐ Pain prevents me from travelling except to receive treatment

Score: ____/ 50 = %

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5 if all ten sections are completed the score is calculated as follows:

Example: 16 (total scored) / 50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

Example: 16 (total scored) / 45 (total possible score) x 100 = 35.5%

Minimum Detectable change (90% confidence): 5 points or 10% points

Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.

Northwest Family
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Name:____ **Date:**____________________

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realize you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: **Pain Intensity** ☐ I have no pain at the moment ☐ The pain is very mild at the moment ☐ The pain is mild at the moment ☐ The pain is fairly severe at the moment ☐ The pain is very severe at the moment ☐ The pain is the worst imaginable at the moment	Section 2: **Personal Care (Washing, Dressing, etc)** ☐ I can look after myself normally without causing extra pain ☐ I can look after myself normally, but it causes extra pain ☐ It is painful to look after myself and I am slow and careful ☐ I need some help but can manage most of my personal care ☐ I need help everyday in most aspects of self-care ☐ I do not get dressed, I wash with difficulty and stay in bed	Section 3: **Lifting** ☐ I can lift heavy weights without extra pain ☐ I can lift heavy weights, but it gives extra pain ☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned ☐ I can only lift very light weights ☐ I cannot lift or carry anything
Section 4: **Reading** ☐ I can read as much as I want to with no pain in my neck ☐ I can read as much as I want to with slight pain in my neck ☐ I can read as much as I want to with moderate pain in my neck ☐ I can't read as much as I want because of moderate pain in my neck ☐ I can hardly read at all because of severe pain in my neck ☐ I cannot read at all	Section 5: **Headaches** ☐ I have no headaches at all ☐ I have slight headaches, which come infrequently ☐ I have moderate headaches, which come infrequently ☐ I have moderate headaches which come frequently ☐ I have severe headaches, which come frequently ☐ I have headaches all the time	Section 6: **Concentration** ☐ I can concentrate fully when I want to with no difficulty ☐ I can concentrate fully when I want to with slight difficulty ☐ I have a fair degree of difficulty in concentrating when I want to ☐ I have a lot of difficulty in concentrating when I want to ☐ I have a great deal of difficulty in concentrating when I want to ☐ I cannot concentrate at all

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Name:____ **Date:**__________________

Section 7: **Work**	Section 8: **Driving**	Section 9: **Sleeping**
☐ I can do as much work as I want to ☐ I can only do my usual work, but no more ☐ I can do most of my usual work, but no more ☐ I cannot do my usual work ☐ I can hardly do any work at all ☐ I can't do any work at all	☐ I can drive my car without any neck pain ☐ I can drive my car as long as I want with slight pain in my neck ☐ I can drive my car as long as I want with moderate pain in my neck ☐ I can't drive my car as long as I want because of moderate pain in my neck ☐ I can hardly drive at all because of severe neck pain ☐ I can't drive my car at all	☐ I have no trouble sleeping ☐ My sleep is slightly disturbed (less than 1 hr sleepless) ☐ My sleep is mildly disturbed (1-2 hrs. sleepless) ☐ My sleep is moderately disturbed (2-3 hrs sleepless) ☐ My sleep is greatly disturbed (3-5 hrs sleepless) ☐ My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: **Recreation**
☐ I am able to engage in all my recreation activities with no neck pain at all
☐ I am able to engage in all my recreation activities with some pain in my neck
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck
☐ I can hardly do any recreation activities because of pain in my neck
☐ I can't do any recreation activities at all

Score: ____/ 50 = %

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5 if all ten sections are completed the score is calculated as follows:

Example: 16 (total scored) / 50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

Example: 16 (total scored) / 45 (total possible score) x 100 = 35.5%

Minimum Detectable change (90% confidence): 5 points or 10% points

NDI Developed by: Vernon, H & Mior, S. (1991). The Neck Disability Index: A study of reliability and validity. Journal of Manipulative and Physiological Therapeutics. 14, 409-415