MVA DOI: _____

Avise Chiropractic
4017 S Street SE B101 Auburn WA 98002
253-939-8144

Confidential Health Questionnaire

Today's Date: _____
Full Legal Name: _____ Name you prefer: _____
Address: _____ City/State/Zip: _____
Phone: (home) _____ (cell) _____ (work) _____ Preferred H/C/W
Birth Date: _____ SSN: _____ Age: ____ Sex: __
Marital Status S/M/W/D Spouses Name: _____ # of children: _____
Email Address: _____ Do you want to receive our monthly health letter? Y/N
Who may we thank for referring you into our office? _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Your Employer: _____ Phone: _____ Job Title: _____

Health History

List any surgeries (include reason and date) _____
List any hospitalizations (include reason and date) _____
List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.)
_____
List any health conditions that run in your family: _____
Have you ever been in an Auto Accident? Y/N When? _____ How many? _____
Have you ever been under Chiropractic care? Y/N with Dr. _____
Do you exercise? Never / occasionally / frequently Do you smoke/use tobacco? Y/N
Do you have any allergies (food, medication, seasonal, etc.) Y/N list: _____
If female, is there any possibility that you are pregnant? Y/N Date of last menstrual cycle? _____

REVIEW OF SYSTEMS: Please mark either past or now for anything you have experienced.

Past	Now			Doctor's comments
___	___	General Health	(e.g. Fatigue, Stressed)	_____
___	___	Mind	(e.g. Depression, Anxiety)	_____
___	___	Neurologic	(e.g. Stroke, Seizure, H.A)	_____
___	___	Visual	(e.g. Blurred vision, Double)	_____
___	___	ENT/Mouth	(e.g. Ringing in ears, Jaw pain)	_____
___	___	Heart	(e.g. Heart attack, pacemaker)	_____
___	___	Breathing	(e.g. Asthma, short of breath)	_____
___	___	GI	(e.g. Vomiting, Diarrhea, Ulcer)	_____
___	___	GU	(e.g. Incontinence, Sexual Dis.)	_____
___	___	Endocrine	(e.g. Diabetes, Thyroid Disease)	_____
___	___	Hem/Lymph	(e.g. Bleeding disorder, Cancer)	_____
___	___	Sinus/Immune	(e.g. Congestion, Freq. Cold/Flu)	_____
___	___	Musculoskeletal	(e.g. Neck, Mid, Low back pain)	_____

Automobile Accident History

What bleeding cuts and/or bruises did you receive during the accident?
_____
Did any part of your body hit any part of the automobile? Y/N if yes, please describe:
_____
What is the estimated cost of damage to the vehicle you were in?
_____

MVA DOI: _____

Which of the following car parts were damaged in the accident?

___Windshield ___Steering Wheel ___Front Seat ___R or L side window ___Rear view mirror

Other: _____

Was the trunk of your body pointing straight forward at the time of the collision? Y/N

If no, in which direction was it turned? _____

Was your head pointing straight forward at the time of the collision? Y/N

If no, in which direction was it turned? _____

Since the accident, have you noticed?

___Reduced energy ___Suicidal thoughts ___Indecisive ___Loss of interest in activities or hobbies

___Change in sex drive ___Difficulty concentrating ___Appetite changes (Increased / Decreased)

___Weight changes (Increased / Decreased) # of pounds ___Waking in the middle of the night (# of times ___)

What is causing you to wake up in the middle of the night? _____

Circle the number below to indicate you level of pain (1 no pain – 10 extreme pain)

Right now / Today 1 2 3 4 5 6 7 8 9 10

At the time of the Accident 1 2 3 4 5 6 7 8 9 10

The following questions pertain to the other vehicle involved in the accident:

Was the other car stopped at the time of the impact? Y/N if no, estimate the speed ___ M.P.H

If moving, was the vehicle: _____ slowing down _____ gaining speed _____ traveling at a steady rate of speed

DID ANY PART OF YOUR HEAD HIT ANY PART OF THE CAR? Y/N

WHAT AREA OF THE HEAD WAS HIT? _____

YES NO Did you lose consciousness or black out for any amount of time after the head injury? How Long? _____

YES NO Had you lost any memory before the head injury?

YES NO Have you lost any memory or has your memory been different since the head injury?

YES NO Did you have a lump or bruise after the head injury? Where? _____

YES NO Have you had any head injuries in your past? (include childhood)

YES NO Have your seen other doctors for this head injury?

YES NO Have you had any x-rays taken?

YES NO Have you had a CT or MRI scan taken of your head?

Please circle the following symptoms that you have had recently since your neck or head injury:

Headaches	Blurry vision
Loss of coordination	Loss of balance
Reduced drive/motivation	Difficulty handling multiple tasks
Poor memory	Dizziness/lightheadedness
Difficulty finishing tasks	Irritability
Sleep disorder	Personality change
Abnormal levels of anxiety	Hand tremors
Reduced tolerance of alcohol	Ringing in ears
More assertive	Less diplomatic than normal
Forgetful	Mood swings
Anger outbursts	Reduced attention span
Depression	Black outs
Fatigue	Indifference to other people
Absence of ability to anticipate	More shallow relationships
Inflexibility	Difficulty with problem solving
Impaired sexual function	Less mental stamina
Language difficulty	Performance inconsistencies
Impaired judgment	Verbal learning problems
Slower reaction times	Need day times to remember home/work activities

Avise Chiropractic

Personal Injury Questionnaire

PATIENT INFORMATION

Name:_____

Accident date:_____

Accident location:_____

In which direction were you headed?_____

Was there a police report filed? Y/N

If yes, please provide a copy of the police report that was filed.

Make, Year/Model of vehicle:_____

Insurance company's name:_____

Policy number:_____

Are you the insured driver on this policy? Y/N

If no, please list the name of the insured driver:_____

Claim number:_____

Adjusters name:_____

Adjusters phone number:_____

Do you have an attorney? Y/N

Attorneys name:_____

Attorneys address:_____

Attorneys phone number:_____

AT FAULT DRIVERS INFORMATION

Name:_____

Address:_____

Insurance company's name:_____

Make/Year/Model of vehicle:_____

Avise Chiropractic
4017 A Street SE, B101
Auburn WA, 98002

Assignment of benefits for personal injury or motor vehicle accident.

I hereby assign all medical benefits, to include all major medical benefits to which I am entitled to Avise Chiropractic.

I understand that I am responsible for all charges, whether or not paid by stated insurance; I hereby authorize said assignee to release any and all information necessary to secure payment. If I have personal injury protection (PIP) or Med Pay through my automobile insurance, Avise Chiropractic will bill my insurance carrier directly, as long as my PIP/MP claim application has been filed. If no application has been filed, Avise Chiropractic will bill me directly, as I am responsible for payment of all services rendered.

If I do not have PIP/MP coverage and the other party is clearly at fault, as stated on the police report, a lien will be filed to secure payment to Avise Chiropractic, PLLC for the treatment of my injuries.

Signature:_____Date:_____

Avise Chiropractic
4017 A Street SE B101
Auburn, WA 98002

Terms of Acceptance

At our office we offer Chiropractic Care to treat Vertebral Subluxations. We do not offer to diagnose or treat any disease or condition other than subluxations. However, if during the course of an examination we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice for those finding we will recommend you to a provider who specializes in that area. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference through a specific chiropractic adjustment to correct the vertebral subluxation. If you need to spend extra time discussing your health with the doctor, please let our staff know so that we may schedule your next appointment accordingly.

I _____ have read and understand the above statements. All of my questions regarding the doctor's objectives pertaining to my care have been answered to my complete satisfaction.

_____ Initial

*In order to diagnose subluxation the doctor may take x-rays. I certify to the best of my knowledge I am not pregnant and the doctor has my permission to perform an x-ray. I have been advised that an x-ray can be hazardous to and unborn child.

I _____ certify that there is NO chance of pregnancy. _____ Initial

Office Policy

Keeping your appointments is vital to getting you back on track and healthy. We do not charge for missed appointments for chiropractic but ask that you immediately call to reschedule. When arriving for your appointments please go to the front desk and sign-in. This will help us to keep you on time and to the appointed doctor or therapist.

_____ Initial

Financial Policy

To reduce confusion and misunderstanding between patients and the practice, we have adopted the following financial policies:

All copayments, deductibles and non-insurance covered charges must be paid at time of service.

_____ Initial

We will prepare and send all claims to your insurance on your behalf. _____ Initial

There will be a $25 charge for any NSF in addition to any charges from your financial institution.

_____ Initial

I have read and understand the Terms of Acceptance, Financial and Office Policies and agree to the above terms. I also understand that the practice may amend the terms from time to time.

Signature: _____ Date: _____

Treatment of a Minor

For all services rendered to a minor, we will look to an adult to accompany the patient and for payment of any fees for services.

I _____ Being the parent or legal guardian of _____ have read and fully understand the terms above and hereby grant my permission for my child to receive Chiropractic care.

Signature: _____ Date: _____

AVISE CHIROPRACTIC, PLLC
DR. DARREN AVISE
4017 A STREET SE, B101
AUBURN, WA 98002

AUTHORIZATION FOR HIPPA

Your authorization is requested for purposes of delivering your care in an open adjusting or open door adjusting environment as described in the office's privacy notice.

In the course of your care either of these environments may cause details of your condition and care to be disclosed to other patients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other patients.

This authorization is to allow for phone reminders at home/work and your signature on a sign-in sheet.

We are requesting your authorization in these regards to assure that you are fully informed and in agreement with the method and circumstances in which we deliver chiropractic care. Your care will not be conditioned on your agreement to this authorization. You have the right to not sign this authorization and you also have the right to revoke this authorization at some time in the future. Please advise us accordingly in writing.

If you agree to this authorization copy will be maintained by this office and a copy will be provided to you.

Thank you for your cooperation and understanding.

___ Yes, I would like to receive the HIPPA rules and regulations guide.

___ No, I do not wish to receive the HIPPA rules and regulations guide.

Signature: _____ Date: _____

___ Please check here if you are signing for a minor and tell us your relation to the minor below.

_____