Avise Chiropractic

Dr. Darren Avise

4017 A St SE, B101 Auburn, WA 98002

253-939-8144

Confidential Health History 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 to the office? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Your Employer: _____Phone: _____ Job Title: _____

Thank you for consulting our office. We consider it an honor to have a chance to be part of your health care team.

Please answer the following questions completely to help me understand the reason for your visit today.

Please answer the following questions regarding your Primary reason for today's visit:

When did your condition start (please give a date if possible)? _____

What event or action aggravated your complaint? _____

Is your pain(please circle): Constant or Off & On Is your pain(please circle) worse at: Night/ Mid day/ Morning

Is your condition (please circle) getting worse/ getting better/ staying the same

What aggravates your condition? Sitting/ Bending/ Standing/ Walking/ Sleeping/ Movement/Other_____

How would you describe your pain? Stabbing/ Achy/ Tingling/ Shooting/ Dull/ Burning/ Other _____

List any other healthcare providers you have seen regarding this complaint?

_____

Please illustrate areas of complaint on the picture below. Please mark using the symbols listed in the key.

Key

Stabbing ↗↗↗↗

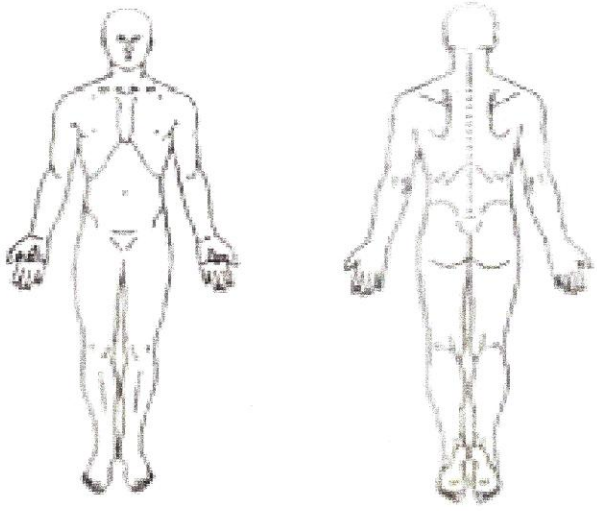
Burning ^^^^

Numbness ●●●●

Pins & Needles >>>>

Aching ++++

Just Hurts XXXX



Notice to all new patients: Payments in full for chiropractic services is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the Doctor. We value and protect your privacy. We invite you to discuss any questions with us regarding any of our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Signature: _____ Date: _____

Name: _____

Health History

List any surgeries (include reason & 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 (cancer, diabetes, heart disease, arthritis, etc.)

_____

Have you ever been in an Auto Accident? Y/ N When? _____ How many? _____

When was your last Physical? _____ With Dr. _____

Have you ever been under Chiropractic care? Y / N with Dr. _____ City: _____

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)	_____
___	___	Sinus/Immune	(e.g. Congestion, Freq. Cold/Flu)	_____
___	___	Musculoskeletal	(e.g. Neck, Mid, Low Back Pain)	_____

Have you had any of the following (please mark with an X):

___ Pain worse at night ___ Loss of bowel or bladder control ___ Recent surgery (30 days)

___ Constant pain ___ Unexplained weight loss ___ Dizzy/ Lightheaded

Do you take vitamins or supplements? _____

What other symptoms / health concerns do you currently have? _____

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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 findings, we will advise you. If you desire advice for those findings 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 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 an unborn child.

I _____ certify that there 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 misunderstandings 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 you 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 has been requested by Darren J. Avise, Avise Chiropractic, PLLC. The purpose of 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 regulation guide.

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

Signature:_____ Date:_____

☐ Please check this box if you are signing for a minor and tell us your relation to the minor below.

_____