SKAMANIA CHIROPRACTIC & REHABILITATION
27 Russell Ave, Lower Suite / P.O. Box 1498 / Stevenson, WA 98648
P: 509-427-3600 / F: 509-427-3601

New Patient Registration

Please note that all information is strictly confidential.

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. If we believe that we cannot assist you with your health care needs, we will be more than happy to refer you to the appropriate health care professional.
If you have any questions, please ask. Thank you.

First Name: Middle Initial:

Last Name:

Date of Birth: / / Age:

Gender: [ ] Male [ ] Female Height: Weight:

Marital Status: [ ] Married [ ] Single [ ] Life Partner [ ] Widowed Number of Children:_____ No Children:_____

Address: **City/State/Zip:**

Home Phone: **Work Phone:** **Cell Phone:**

Email:

As a courtesy, we utilize EMAIL or TEXT MESSAGE for appointment reminders for our patients. Please choose ONE.

☐ **Text message or** ☐ **Call** **(phone number):**

☐ **E-mail address**:

Occupation: **Employer:**

In Case of Emergency Contact: Relationship & Phone:

Financially Responsible Party: [ ] Self [ ] Other-Name, Address, Phone:

Family Physician: Phone:

How did you hear about us?

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Health History Questionnaire

Reason #1 for contacting our office: _____

□mild □moderate □severe ~ Please rate your pain on a scale of 0-10 (0 being no pain) __/10

□constant □intermittent

□symptoms ↑ with activity □symptoms ↓ with activity

□getting worse □getting better □no change

Date of Injury: _____

If no injury, when did the problem begin? _____

Reason #2 for contacting our office: _____

□mild □moderate □severe ~ Please rate your pain on a scale of 0-10 (0 being no pain) __/10

□constant □intermittent

□symptoms ↑ with activity □symptoms ↓ with activity

□getting worse □getting better □no change

Date of Injury: _____

If no injury, when did the problem begin? _____

Reason #3 for contacting our office: _____

□mild □moderate □severe ~ Please rate your pain on a scale of 0-10 (0 being no pain) __/10

□constant □intermittent

□symptoms ↑ with activity □symptoms ↓ with activity

□getting worse □getting better □no change

Date of Injury: _____

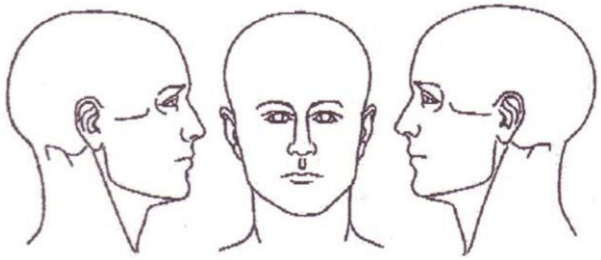
If no injury, when did the problem begin? _____ Have you been given a diagnosis for any of these conditions? If so, what?

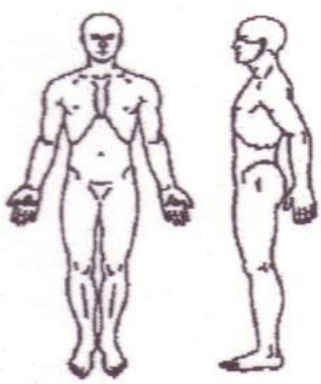
_____

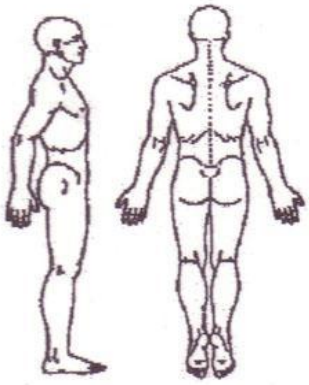
To what extent does the condition(s) interfere with your daily activity (work, exercise, sleep, sex etc.)?_____ What kind of treatments have you tried?

_____

Please indicate any areas causing pain or distress:







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Past Medical History:
Please note dates of each:

☐ Mental Illness	☐ Diabetes	☐ Hepatitis	☐ HIV+	☐ AIDS	☐ Herpes
☐ High Blood Pressure	☐ Heart Disease	☐ Asthma	☐ Allergies	☐ Stroke	☐ Arthritis
☐ Chronic Fatigue	☐ Gall Stones	☐ Venereal Disease	☐ Osteoporosis	☐ Seizures	☐ Parasites
☐ Mononucleosis	☐ Rheumatic Fever	☐ Thyroid Problems	☐ Kidney Stones	☐ Ulcers	☐ Cancer

☐ Other _____

Surgeries (types & dates): _____

_____

Significant Traumas: _____

_____

Significant Dental Work: _____

Other: _____

Allergies (drugs, chemicals, foods, etc.) _____

_____

Occupational Stress (chemical, physical, psychological) _____

_____

Birth History (prolonged labor, forceps, premature, etc.) _____

_____

Family Medical History:

☐ Cancer	☐ Heart Disease	☐ Asthma	☐ Diabetes	☐ Stroke
☐ Allergies	☐ High Blood Pressure	☐ Seizures	☐ Other _____	

Medications:
What medications and/or supplements are you currently taking? _____

Have you had any courses of antibiotics recently? ☐ Yes ☐ No

Habits:
Do you have a regular exercise program? Please describe: _____
Usage of:

Cigarettes	_____per ____	Tea	_____per ____	Alcohol	_____per ____
Soft Drinks	_____per ____	Drugs	_____per ____	Coffee	_____per ____

Check all that apply, and for each note if it is current or past.
General

☐ Night Sweats	☐ Recurrent Infections	☐ Strong thirst (prefer hot or cold?)	☐ Fatigue
☐ Sweat easily	☐ Bleed or bruise easily	☐ Thirst with no desire to drink?	☐ Poor Sleep
☐ Overweight	☐ Poor Balance	☐ Tremors	☐ Edema
☐ Underweight	☐ Sudden energy drops Time of day _____		

Head/Eyes/Ears/Nose/Throat

☐ Sore eyes	☐ Facial Pain	☐ Nasal discharge	☐ Headaches Where _____When _____	
☐ Blocked nose	☐ Nose bleeds	☐ Discharge from ear	☐ Migraines	☐ Ringing in ears
☐ Hoarseness	☐ Snoring	☐ Sores on lips/mouth	☐ Poor hearing	☐ Tonsillitis
☐ Dizziness	☐ Grinding teeth	☐ Recurrent sore throat	☐ Swollen glands	☐ Blurry vision
☐ Eye Pain	☐ Color blindness	☐ Night blindness	☐ Excessive Tearing	☐ Squint
☐ Glasses	☐ Teeth problems	☐ Spots in front of eyes	☐ Other _____	

Skin
☐ Rashes ☐ Itching ☐ Eczema ☐ Oozing ☐ Pimples ☐ Dry skin / scalp ☐ Recent moles ☐ Changes in hair/skin
☐ Other _____

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Genital-urinary
□ Pain on urination □ Urgency with urination □ Frequent urination □ Blood in urine □ Prostate problems
□ Decrease in urinary □ Unable to hold urine □ Incontinence at night □ Dribbling urination □ Kidney stones
□ Changes in sexual drive □ Rashes □ Impotency □ Other _____
□ Do you wake at night to urinate? How many times? _____

Respiratory
□ Difficulty breathing □ Pain with breathing □ Shallow breathing □ Shortness of breath □ Bronchitis
□ Production of phlegm □ Pneumonia □ Asthma/Wheezing □ Status asthmatics □ Recurrent cough
□ Other _____

Cardiovascular
□ Pacemaker □ High Blood Pressure □ Low Blood Pressure □ Chest discomfort/pain
□ Heart Palpitations □ Cold hands or feet □ Swelling of hands or feet □ Blood Clots
□ Spider veins □ Fainting □ Other _____

Musculoskeletal
□ Neck ache/pain □ Back ache/pain □ Knee ache/pain □ Shoulder pain □ Elbow/Forearm pain
□ Hand/Wrist pain □ Foot/Ankle pain □ Joint/Bone problems □ Torn tissues □ Muscle pain/weakness
□ Prostheses □ Hernia □ Other _____

Neurological
□ Seizures □ Nerve damage □ Paralysis □ Difficulty in concentrating □ Sleep disorder □ Stroke
□ Concussion □ Loss of balance □ Vertigo □ Lack of coordination □ Poor memory □ Other _____

Gynecological
# of pregnancies_____# births_____# premature births_____
Age of 1st menses_____# days between menses_____Duration of menses _____ 1st day of last menses_____
Age of menopause_____Date of last PAP_____
□ PMS □ Irregular periods □ Painful periods □ Light periods □ Heavy periods □ Clots
□ Fibroids □ Endometriosis □ Infertility □ Breast lumps □ Vaginal discharge
□ Vaginal sores □ Nipple discharge □ Postcoital bleeding □ Other _____
Do you practice birth control? □ yes □ no What type and for how long? _____
Are you pregnant now? □ yes □ no Due Date: _____

Digestion
□ Bad breath □ Change in appetite □ Loose stools / Diarrhea □ Heartburn □ Indigestion
□ Weight gain □ Weight loss □ Bloody stools □ Belching
□ Nausea □ Pale stools □ Abdominal pain or cramps □ Black stools □ Hemorrhoids
□ Vomiting □ Green stool □ Pain with passing stools □ Gas □ Rectal pain
□ Bulimia □ Anorexia nervosa □ Strong smelling stools □ Constipation (not daily, or difficult)
□ Other _____

Behavioral
□ Vacant □ Easily susceptible to stress □ Panic Attacks □ Anxiety □ Fear □ Depression
□ Moody □ Aggressive/Bad temper □ Lose control of emotions □ Substance abuse □ Other _____
Have you ever been treated for emotional problems? □ yes □ no

Comments: _____

_____

Thank you for taking the time to fill out this form thoroughly. It will help us serve you better.

Patient/Guardian Signature:_____**Date:** _____

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CONSENT TO TREATMENT

To Skamania Chiropractic and Rehabilitation Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat or ice application, manual muscle therapy, and therapeutic exercises) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, skin irritations and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side-effects. I give my permission and consent to the procedure or treatment. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient/Guardian Signature_____**Date**_____

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided for you.

Skamania Chiropractic & Rehabilitation, LLC uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Skamania Chiropractic & Rehabilitation, LLC will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Skamania Chiropractic & Rehabilitation, LLC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Skamania Chiropractic & Rehabilitation, LLC may disclose your information for public health activities, to funeral directors in order to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have the right to request restrictions, report and obtain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

Skamania Chiropractic & Rehabilitation, LLC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative reasons other than those listed above and permitted under law.

Patient/Guardian Signature_____**Date**_____

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FINANCIAL AGREEMENT

We are committed providing you with the best possible care. If you have medical insurance, we are anxious to help you receive maximum allowable benefits. In order to achieve the goals, we need your assistance and your understanding of your payment policy.

Payment for services are due at the time of your visit unless payment arrangements have been made in advance. We accept cash, checks, Visa, MasterCard, Discover, and AMEX. We will be happy to process your insurance claim.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1% per month.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary and reasonable fees for this region.
3. Not all services are a covered benefit in all contracts. Some insurance companies' arbitrarily select certain services they will not cover.

We must emphasize that as chiropractic care provider, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

Release of Benefits: I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim.

Patient/Guardian Signature_____**Date**_____