509.427.3600 • 138 NW 2nd Street • PO Box 1498 • Stevenson, WA 98648

PATIENT INFORMATION Today's Date: ___/___/____

Full Name: ____ Jr/Sr Date of Birth: ________/________/_________

Mailing Address: ____

Email Address: ____

Primary Phone: _____________________________________ Alternate Phone: ___________________________________

Emergency Contact: ______________________ Relationship: ________________________ Phone: ____________________

Gender: _________________ Marital Status: ________________________ # of Children: ___________ Student: Yes or No

Preferred Language: ____________________________ Race: ___________________ Ethnicity: ______________________

Occupation: _________________________________ Employer: ____

Financially Responsible Party: Self or Other: ______________________ Referred by: _______________________________

HEALTH HISTORY

Height: __________ Weight: __________ Dominant Hand: Right or Left or Both

Primary Care Physician: ______________________________________ Phone Number: ____________________________

YES NO I have seen a chiropractor before. If yes, please specify: ____

YES NO I have had significant traumas/accidents/surgeries in the past: ____

____

YES NO I am currently on medications. If yes, please specify name and dosage: ________________________________

____

YES NO I have a known allergy to: ____

YES NO I have been diagnosed with the following disease(s) *(i.e. heart disease, cancer, diabetes…)* ________________

____

YES NO I have a family history of the following disease(s) *(i.e. heart disease, cancer, diabetes…)* Please list most relevant and family member ____

____

YES NO I use/have used tobacco products. Started in: ______________ Quit in: ____________ or Current __________

Please circle any of the following habits that apply to you: Alcohol, Marijuana, Tea, Coffee, Energy Drinks, Water, Regular exercise program. Please specify how much and how often: ____

____

Mitzi B. Ferrill, D.C. A. Scott Yerrick, D.C.

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NAME: _____________________________ DOB: _____/_____/______ TODAY'S DATE: _____/_____/______

REVIEW OF SYSTEMS

Please circle or fill in all that apply…

YES NO Musculoskeletal issue/problem with: Head, Neck, Upper/Mid Back, Low Back, Ribs, Chest/Abdomen, Shoulder/Arm, Elbow/Forearm, Wrist/Hand, Buttocks/Hip/Thigh, Knee/Lower Leg, Ankle/Foot, Joint/Bone/Muscle, Other: ____

YES NO Head/ENT issue/problem with: Headaches, Migraines, Dizziness, Jaw Pain, Facial Pain, Grinding Teeth, Recurrent Sore Throat, Poor Hearing, Swollen Glands, Ringing in Ears, Tonsillitis, Blurry Vision, Other:

____

YES NO Neurological issue/problem with: Poor Balance, Tremors, Seizures, Concussion, Nerve Damage, Paralysis, Vertigo, Trouble Concentrating, Lack of Coordination, Poor Memory, Other: ____________________________________

____

YES NO Cardiovascular issue/problem with: Pacemaker, High Blood Pressure, Low Blood Pressure, Chest Discomfort/Pain, Heart Palpitations, Cold Hands or Feet, Swelling of Hands or Feet, Edema, Blood Clots, Fainting, Other:

____

YES NO Respiratory issue/problem with: Difficulty Breathing, Pain with Breathing, Shortness of Breath, Other:

____

YES NO Genital-Urinary issue/problem with: Pain on Urination, Urgency with Urination, Frequent Urination, Blood in Urine, Prostate Problems, Decrease in Urinary, Unable to Hold Urine, Other: ____________________________________

____

YES NO Digestion issue/problem with: Heartburn, Nausea, Vomiting, Constipation, Other: _______________________

YES NO Endocrine issue/problem with: Thyroid problems, Strong Thirst, Numbness/Tingling in Hands or Feet, Other:

____

YES NO Behavioral issue/problems: ____

YES NO Skin issue/problem with: ____

YES NO Gynecological: Pregnant? YES or NO. Endometriosis? YES or NO. Age of first menses: ____________

Age of menopause: ___________ Number of Pregnancies: ______________ Number of Births: ____________

SKAMANIA
CHIROPRACTIC
& Rehabilitation

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NAME: ____________________________________ DOB: _____/_____/______ TODAY'S DATE: _____/_____/_______

⇒**Main Concern #1**: Headaches, Neck, Mid back, Low back, Shoulder, Elbow, Hip, Knee, Other: ___________________________

Date concern started bothering you: ___________________ **On a scale of 0-10 how bad does the complaint hurt?** _____________

How often does your concern bother you?	**When is the concern the worst?**	**What helps with relief?**
0-25% of the time	Morning	Ice/heat
26-50% of the time	Afternoon	Medications
51-75% of the time	Evening	Other:
76-100% of the time	Does not change	_____________________

What activities are limited by this concern? Sitting, Walking, Working, Driving, Sleeping, Turning my head, Other: _______________

____

Have you tried other medical treatments? YES or NO If yes, ____

⇒**Main Concern #2**: Headaches, Neck, Mid back, Low back, Shoulder, Elbow, Hip, Knee, Other: ___________________________

Date concern started bothering you: ____________________ **On a scale of 0-10 how bad does the complaint hurt?** ____________

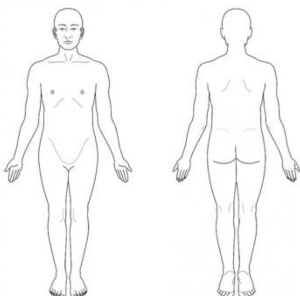
How often does your concern bother you?	**When is the concern the worst?**	**What helps with relief?**
0-25% of the time	Morning	Ice/heat
26-50% of the time	Afternoon	Medications
51-75% of the time	Evening	Other:
76-100% of the time	Does not change	_____________________

What activities are limited by this concern? Sitting, Standing, Walking, Driving, Sleeping, Turning my head, Other: _______________

____

Have you tried other medical treatments? YES or NO If yes, ____

Please circle areas of concern:



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NAME: _____________________________ DOB: _____/_____/______ TODAY'S DATE: _____/_____/______

FINANCIAL POLICY

- Please review the policies below carefully and feel free to ask questions should you have them. To ensure accurate billing and to prevent fraud, we ask each patient to provide us a photo ID along with their insurance card. When you receive a new insurance card or change to another health plan, it is your responsibility to inform us with updated policy info and provide us with a copy of the card.
- We bill your insurance as a courtesy and must have accurate health plan information. This includes primary and secondary, automobile and worker's compensation insurances. Failure to provide us with accurate and up-to-date information specific to your visit will result in patient responsibility for the balance owed.
- Your insurance plan is a contract between you and the insurance company. We will do our best to assist you in understanding your benefits.
- Most office visits require a co-pay, which is due at the time of service. If your co-pay is not printed on your card and/or we are unable to view when checking eligibility, we will bill your insurance(s) for processing and you will receive a bill from our medical billing service to determine the amount owed.
- A time of service fee is offered for those patients who pay-in-full at the time that the service is rendered.

CONSENT FOR TREATMENT

- I voluntarily consent to the rendering of safe and effective chiropractic care and/or massage therapy, including treatment and diagnostic procedures. I understand that side effects or complications may arise, which include, but are not limited to, soreness, inflammation, dizziness, burns, and skin irritations. I understand that more serious complications are extremely rare, and there is no guarantee for a specific cure or result.
- I authorize this clinic to leave brief messages to confirm appointments and other care related issues.
- I grant this clinic permission to use and disclose my protected health information for the purposes of treatment, payment and health care operations. I have a right to review this clinic's Notice of Privacy Practices, which is available at the front desk, before I sign my consent.
- I understand that the clinic's Notice of Privacy Practices is subject to change and that I may contact this clinic for the updated edition. I have the right to request how this clinic uses and discloses my protected health information for the purposes of treatment, payment or health care operations.
- I authorize my insurance benefits be paid directly to this clinic. I understand that I am financially responsible for non-covered services, any remaining deductible and co-pay. I also authorize this clinic to release any information required in the processing of this claim.
- I understand that I have the right to revoke this consent in writing, except to the extent that this clinic already has used or disclosed my protected health information according to my consent.

I authorize the following individual(s) to have access to my protected health information.

- Name: _________________________________ Name: ________________________________

We have a 24-hour cancellation policy. If you miss, cancel or change your appointment with less than a 24-hour's notice, you will be charged $20.00.

By my signature below, I voluntarily consent to the authorizations and clinic financial policies described above.

Signed __________________ by ____

(mm/dd/yyyy) Signature of patient, guardian or legal representative

Mitzi B. Ferrill, D.C. A. Scott Yerrick D.C.