

WORKER'S COMPENSATION AUTHORIZATION

Patient Name _____

Date of Accident _____

Disability: Date Last Worked _____ Date Returned to Work _____

Employer Name _____

Address _____

Phone _____

Person to Contact _____

Worker's Compensation Carrier

Name _____

Address _____

Phone _____

Person to Contact _____

Do you wish billing to be forwarded to employer or insurance carrier?

Employer

Insurance Carrier

Claim# _____

The above patient has advised me of his work-related injury and that he/she is being treated by:

Provider Name _____

Address _____

Phone _____

Person to Contact _____

Signature Authorized Representative

Date

Please Print Name

CONFIDENTIAL HEALTH INFORMATION

Fairwood Chiropractic Clinic
14410 SE Petrovitsky Rd #109
Renton, WA 98058
(425) 226-1856

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

No Yes When? _____

Whom may we thank for referring you? _____

If so, whom? _____

Gender

Male Female

Your Last Name _____

Your Social Security Number _____

Your First Name _____

Your Middle Name (or Initial) _____

Birth Date (MM/DD/YYYY) _____

Age _____

Marital Status

Single Married Divorced
 Widowed Separated

Address _____

City _____

State/Province _____

ZIP/Postal Code _____

Home Phone _____

Spouse's Name _____

Email Address _____

Cell Phone _____

Child's Name and Age _____

Emergency Contact _____

Phone _____

Child's Name and Age _____

Your Occupation _____

Child's Name and Age _____

Your Employer _____

May we contact you at work?

Yes No

Preferred method of contact?

Home Phone Cell Phone
 Work Phone Email

Address _____

City _____

State/Province _____

ZIP/Postal Code _____

Work Phone _____

Insurance Carrier _____

Policy Number _____

Primary Care Provider's Name _____

Insured's Last Name _____

Birth Date (MM/DD/YYYY) _____

Who carries this policy?

Self Spouse Parent

First Name _____

Middle Name (or Initial) _____

Insured's Employer _____

Address _____

City _____

State/Province _____

ZIP/Postal Code _____

Employer's Phone _____

CONFIDENTIAL HEALTH INFORMATION

PAGE
1/4

1. The symptom(s) that have prompted me to seek care today include: _____

Patient name _____

2. And are the result of (darken circle): An accident or injury
 Work Auto Other _____
 A worsening long-term problem
 An interest in: Wellness Other _____

3. Onset (When did you first notice your current symptoms?) _____

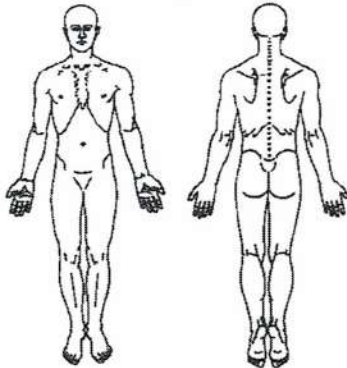
4. Intensity (How extreme are your current symptoms?)
0 10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
 Constant Comes and goes. How Often? _____

6. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.) _____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Surgery Ice
- Over-the-counter drugs Acupuncture Heat
- Homeopathic remedies Chiropractic Other _____
- Physical therapy Massage _____

11. What else should Fairwood Chiropractic Clinic know about your current condition? _____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

Had Have Osteoporosis Arthritis Scoliosis Neck pain Back problems Hip disorders NONE
 Knee injuries Foot/ankle pain Shoulder problems Elbow/wrist pain TMJ issues Poor posture Initials _____

b. Neurological

Had Have Anxiety Depression Headache Dizziness Pins and needles Numbness NONE
Initials _____

c. Cardiovascular

Had Have High blood pressure Low blood pressure High cholesterol Poor circulation Angina Excessive bruising NONE
Initials _____

d. Respiratory

Had Have Asthma Apnea Emphysema Hay fever Shortness of breath Pneumonia NONE
Initials _____

e. Digestive

Had Have Anorexia/bulimia Ulcer Food sensitivities Heartburn Constipation Diarrhea NONE
Initials _____

f. Sensory

Had Have Blurred vision Ringing in ears Hearing loss Chronic ear infection Loss of smell Loss of taste NONE
Initials _____

g. Skin

Had Have Skin cancer Psoriasis Eczema Acne Hair loss Rash NONE
Initials _____

Consultation Notes

Doctor's Initials _____

Fairwood Chiropractic Clinic

(Continued from previous page)

h. Endocrine

- Had Have Thyroid issues
- Had Have Immune disorders
- Had Have Hypoglycemia
- Had Have Frequent infection
- Had Have Swollen glands
- Had Have Low energy

NONE

Initials _____

i. Genitourinary

- Had Have Kidney stones
- Had Have Infertility
- Had Have Bedwetting
- Had Have Prostate issues
- Had Have Erectile dysfunction
- Had Have PMS symptoms

NONE

Initials _____

j. Constitutional

- Had Have Fainting
- Had Have Low libido
- Had Have Poor appetite
- Had Have Fatigue
- Had Have Sudden weight gain/loss (circle one)
- Had Have Weakness

NONE

Initials _____

Patient name _____

All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

- | | | | | | |
|---------------------------|----------------------------|------------------------------|---------------------------|----------------------------|---------------|
| Had <input type="radio"/> | Have <input type="radio"/> | AIDS | Had <input type="radio"/> | Have <input type="radio"/> | Tuberculosis |
| <input type="radio"/> | <input type="radio"/> | Alcoholism | <input type="radio"/> | <input type="radio"/> | Typhoid fever |
| <input type="radio"/> | <input type="radio"/> | Allergies | <input type="radio"/> | <input type="radio"/> | Ulcer |
| <input type="radio"/> | <input type="radio"/> | Arteriosclerosis | <input type="radio"/> | <input type="radio"/> | Other: _____ |
| <input type="radio"/> | <input type="radio"/> | Cancer | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Chicken pox | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Diabetes | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Epilepsy | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Glaucoma | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Goiter | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Gout | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Heart disease | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Hepatitis | _____ | | |
| <input type="radio"/> | <input type="radio"/> | HIV Positive | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Malaria | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Measles | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Multiple Sclerosis | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Mumps | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Polio | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Rheumatic fever | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Scarlet fever | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Sexually transmitted disease | _____ | | |
| <input type="radio"/> | <input type="radio"/> | Stroke | _____ | | |

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- Appendix removal
- Bypass surgery
- Cancer
- Cosmetic surgery
- Elective surgery: _____
- _____
- Eye surgery
- Hysterectomy
- Pacemaker
- Spine _____
- _____
- Tonsillectomy
- Vasectomy
- Other: _____
- _____
- _____

16. Treatments

Check the ones you've received in the Past or are receiving **Currently**.

- | | | |
|----------------------------|---------------------------------|--------------------------|
| Past <input type="radio"/> | Currently <input type="radio"/> | Acupuncture |
| <input type="radio"/> | <input type="radio"/> | Antibiotics |
| <input type="radio"/> | <input type="radio"/> | Birth control pills |
| <input type="radio"/> | <input type="radio"/> | Blood transfusions |
| <input type="radio"/> | <input type="radio"/> | Chemotherapy |
| <input type="radio"/> | <input type="radio"/> | Chiropractic care |
| <input type="radio"/> | <input type="radio"/> | Dialysis |
| <input type="radio"/> | <input type="radio"/> | Herbs |
| <input type="radio"/> | <input type="radio"/> | Homeopathy |
| <input type="radio"/> | <input type="radio"/> | Hormone replacement |
| <input type="radio"/> | <input type="radio"/> | Inhaler |
| <input type="radio"/> | <input type="radio"/> | Massage therapy |
| <input type="radio"/> | <input type="radio"/> | Physical therapy |
| <input type="radio"/> | <input type="radio"/> | Nutritional supplements: |

List: _____

Medications (prescription and over-the-counter):

PERSONAL

Consultation Notes

17. Injuries

Have you ever...

- Had a fractured or broken bone
- Had a spine or nerve disorder
- Been knocked unconscious
- Been injured in an accident
- Used a crutch or other support
- Used neck or back bracing
- Received a tattoo
- Had a body piercing

18. Family History

Some health issues are hereditary. Tell Fairwood Chiropractic Clinic about the health of your immediate family members.

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

19. Are there any other hereditary health issues that you know about? _____

20. Social History

Tell Fairwood Chiropractic Clinic about your health habits and stress levels.

- | | | | | |
|----------------|--|-----------------|-----------------------|--|
| Alcohol use | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Prayer or meditation? | <input type="radio"/> Yes <input type="radio"/> No |
| Coffee use | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Job pressure/stress? | <input type="radio"/> Yes <input type="radio"/> No |
| Tobacco use | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Financial peace? | <input type="radio"/> Yes <input type="radio"/> No |
| Exercising | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Vaccinated? | <input type="radio"/> Yes <input type="radio"/> No |
| Pain relievers | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Mercury fillings? | <input type="radio"/> Yes <input type="radio"/> No |
| Soft drinks | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Recreational drugs? | <input type="radio"/> Yes <input type="radio"/> No |
| Water intake | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | | |
| Hobbies: | _____ | | | |

SOCIAL

Doctor's Initials _____

Fairwood Chiropractic Clinic

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

Patient name _____

22. What is the major stressor in your life? _____ 23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____ 25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Consultation Notes

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

Doctor's Initials _____

Fairwood Chiropractic Clinic

Signature _____

Date (MM/DD/YYYY) _____

Fairwood Chiropractic Clinic
14410 SE Petrovitsky Rd #109
Renton, WA 98058
(425)226-1856

FINANCIAL AND INSURANCE INFORMATION POLICY

As a complimentary service, our office will submit insurance and billing claims for you, easing your paperwork burden as well as saving you time and frustration. Although we make every effort to confirm eligibility and benefits before a procedure, it is your responsibility to be familiar with your insurance plan, and to know your deductible and co-insurance. These are all to be paid in full upon receipt of our billing statement. In order for us to provide you with this service, please review this document for those items that pertain to your individual situation.

INSURANCE

We are happy to help you claim your insurance benefits. We will bill your insurance company for you if you will provide us with the following:

- Proof of Insurance
- Insurance Company name & phone number
- Policy and group number
- Address of the insurance company
- Name of employer
- Social Security number and birth date of policy holder

ASSIGNMENT OF BENEFITS

Please provide us with a signed "assignment of benefits", located on our office registration sheet, prior to the start of treatment so that we can bill your insurance company for you. (Without an "assignment", you will need to pay at the time of service)

*** It is important to note that if for any reason the insurance company declines to pay for services, the balance then becomes the responsibility of the patient. ***

BILLING

All payments must be paid in full upon receipt of our billing statement unless prior arrangements have been authorized.

All co-payments must be made at time of service, or your appointment will be rescheduled for a later date.

In an effort to assist our patients with ever increasing health care costs we have elected to eliminate billing fees and interest fees on our patient accounts for those patients who maintain current account status.

For those patients without insurance, the office visits and procedures are to be paid in full at time of service, unless prior arrangements have been authorized.

We gladly accept cash, personal checks, and major credit cards. *Please inquire at the front desk for payment arrangements*

DIVORCE/SEPARATION

The guardian accompanying the child to the medical facility is responsible for the child's account. Any agreement between divorced or separated parents is solely between them, and does not nullify your obligation to the physician or the facility.

Thank you for filling out your forms completely. The information you have provided will help us serve your chiropractic and massage needs more effectively and efficiently. If you have any questions at any time, please ask- we are always happy to help!

Thank You

Signature of responsible party

Date

Minor patient name

I have received a copy of this signed "financial and insurance information policy"
initials _____