Back On Track Chiropractic & Massage

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8621 Martin Way East, Suite A102
Lacey, WA. 98516
Telephone: (360) 456-4954
Fax: (360) 412-1227

Welcome

Please fill out this form as complete as possible.
The better you communicate the better we can help.

Personal Information:

Name:_____ Home phone: _____ Cell:_____
Address: _____City: _____ St: ____ Zip: _____
Birth date: ____/____/____ Age: _____ Weight: _____ Height: _____
Marital Status (circle one) M S D W Sex (circle one) F M
Social security #: _____-_____-_____
Occupation:_____ Employer: _____
Work Address: _____ City: _____ State: ____ Zip: _____
Work number: _____
Spouses Name_____
In the event of an emergency, is there someone that we should contact?
Name:_____Relation:_____Number: _____
Who may we thank for referring you? _____
Have you seen a chiropractor before? Yes/No Date: _____
If so, for what condition? _____
Any X-rays taken? Y / N Date taken _____

Insurance Information:

Do you have health insurance? Yes/No Subscriber's ID #: _____
Primary Insurance Company _____ Phone #_____
Any changes to your health insurance is your responsibility to notify the office staff.
Is this injury or illness related to (circle one):
Employment, Auto Accident, Other _____

Your Current Complaints:

What is your main complaint for visiting our office? : _____
_____

Please use the following numbers to demonstrate on this diagram the areas of your body where you have been experiencing symptoms:

1 = stabbing or sharp pain

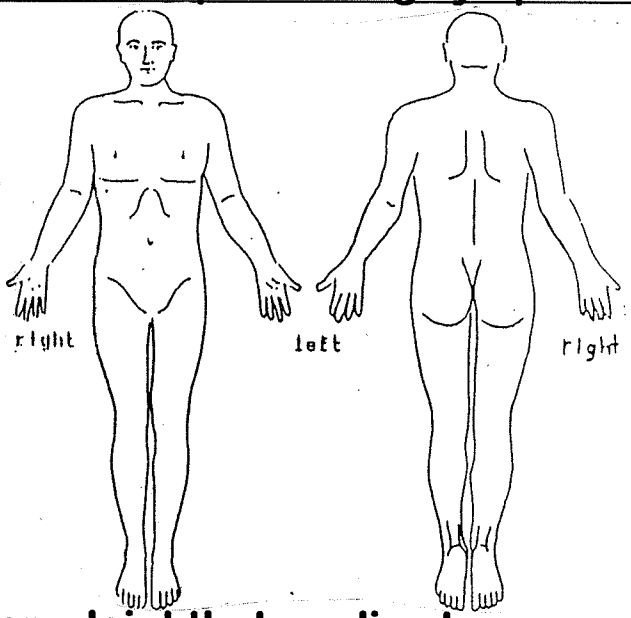
2 = aching pain (deep and dull)

3 = Numbness

4 = pins and needles

5 = stiffness

6 = muscle weakness



Please circle "each" current complaint that applies to you.

Neck:
Sharp pain Dull pain Stiffness Aching Numbness Constant or Intermittent:
Frequency: Daily Once/Week Once/Month Other: _____
When did this condition begin? _____
What caused this condition? Unsure or Explain _____

Middle Back:
Sharp pain Dull pain Stiffness Aching Numbness Constant or Intermittent:
Frequency: Daily Once/Week Once/Month Other: _____
When did this condition begin? _____
What caused this condition? Unsure or Explain _____

Lower Back:
Sharp pain Dull pain Stiffness Aching Numbness Constant or Intermittent:
Frequency: Daily Once/Week Once/Month Other: _____
When did this condition begin? _____
What caused this condition? Unsure or Explain _____

Headaches:
Sensitive to light Sensitive to sound Dizziness Nausea Vomiting
Sharp pain Dull pain Stiffness Aching Numbness Constant or Intermittent:
Frequency: Daily Once/Week Once/Month Other: _____
When did this condition begin? _____
What caused this condition? Unsure or Explain _____

Numbness & Tingling
Hands Arms Legs Feet
How often do you experience numbness and tingling? Daily Once/Day Once/Week Once/Month
When did this condition first begin?
What caused this condition? Unsure or Explain. _____

Circle any of the following you have had in the last six months:

Headaches
Sinus congestion/Allergies
Vision problems
Ear Aches
Dizziness
Heart problems
Lung problems
Blood pressure problems
Ankle swelling
Prostate/Sexual dysfunction
Menstrual

Frequent Nausea/Vomiting
Abdominal cramps
Constipation
Diarrhea
Poor/excessive Appetite
Excessive thirst
Excessive/Pain Urination
Discolored Urine
Diabetes
Cancer
Difficulty Swallowing

Please circle:
Are you pregnant? Y N

Do you? Smoke cigarettes, Drink Alcohol or use street drugs?

Have you ever been hospitalized for any reason in the last 7 years? Y N

If yes, please explain_____

Are you currently taking prescription medications? Y N
If so please list _____
Physician's name: _____

The above information is true to the best of my knowledge; I agree and acknowledge responsibility for all charges I incur at this office. All fees are payable at the time services are rendered. I hereby authorize Back on Track Chiropractic Center to release any information related to this claim to insurances, attorneys or collection agency, if necessary.

Patient Signature _____ Date_____

Thank you for allowing us to serve you!

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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8621 Martin Way E. #A102
Lacey, WA 98516

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____ **Date:**_____

Relationship to Patient: _____ **Authorized persons?** _____

Signature: _____

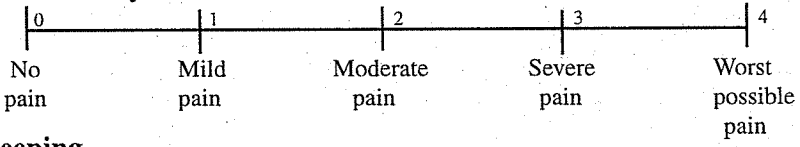
If for some reason we are not able to contact you, can we leave a message in regards to your appointment? Y / N
If so, at what number and with whom? _____

Functional Rating Index

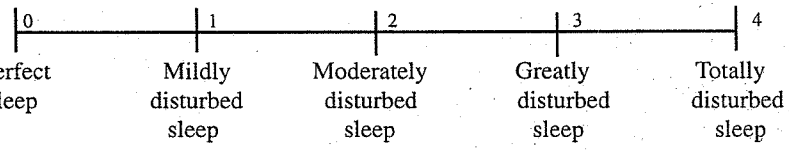
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

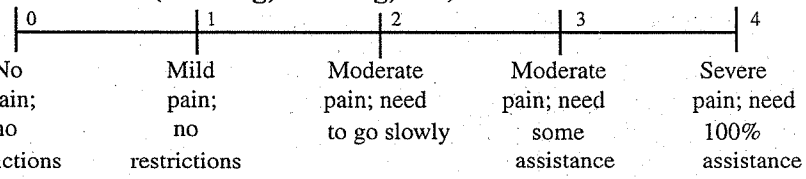
1. Pain Intensity



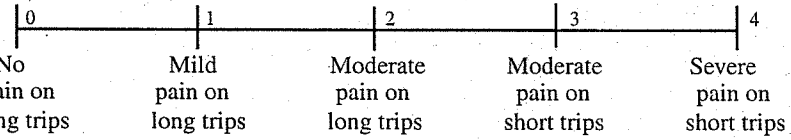
2. Sleeping



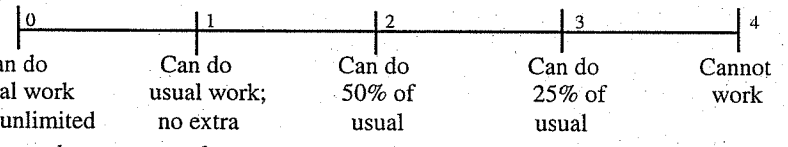
3. Personal Care (washing, dressing, etc.)



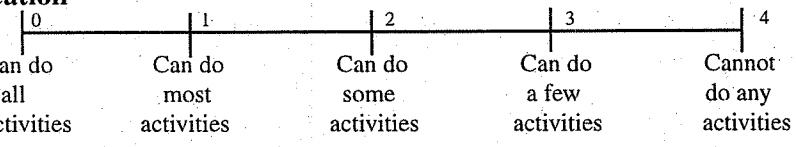
4. Travel (driving, etc.)



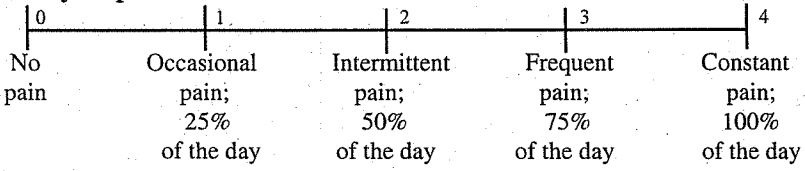
5. Work



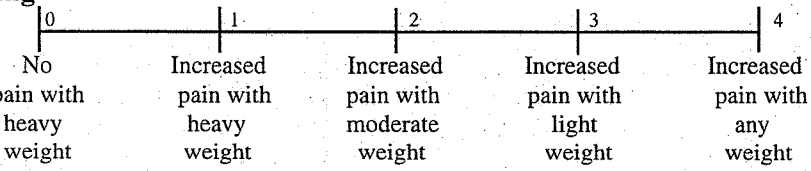
6. Recreation



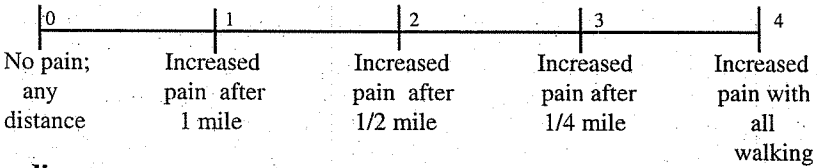
7. Frequency of pain



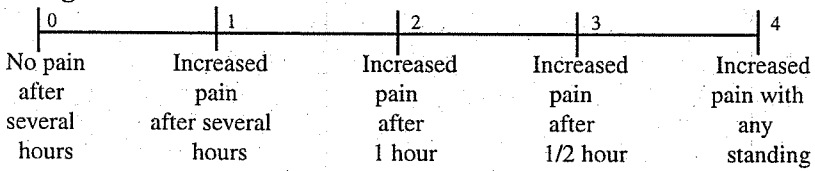
8. Lifting



9. Walking



10. Standing



Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date: