BELLTOWN
Spine & Wellness

Date: _____

About You

Name: _____ Home Phone: _____ Work/Cell Phone: _____
Address: _____ Apt #_____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Age: _____ Gender: ☐ Female ☐Male Marital Status: _____
Occupation:_____ Email_____ Height:_____ Weight:_____
Emergency Contact: _____ Phone #: _____ Relationship: _____

Experience with Chiropractic

Who referred you to this office? _____ Have you been adjusted by a Chiropractor before? _____
If Yes, reason for the visit? _____
Doctor's Name: _____ Approximate Date of last visit: _____

Health History

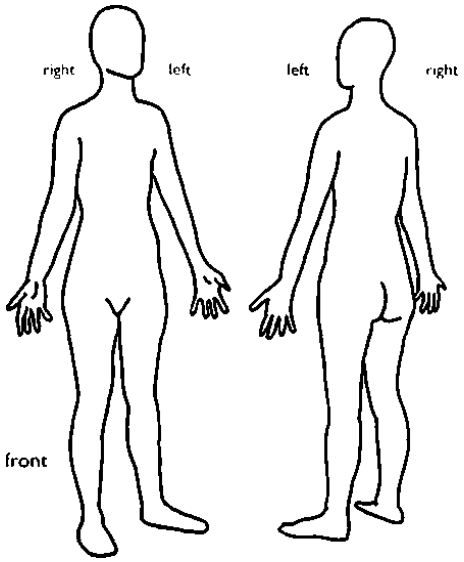
Have you ever had surgery or have been hospitalized? ☐ Yes ☐No If yes, please explain: _____
Have you had any sports injuries? ☐Yes ☐No If yes, please explain: _____
When was the last time you had a spinal X-ray? _____ What medications and/or supplements are you currently taking?
_____
How many glasses of water do you drink per day? _____ How do you sleep? (ie: left side, right side, back, stomach): _____
Do you smoke? _____ If yes, how many per day? _____ Do you drink alcohol? _____ If yes, how many per day? _____
Do you drink coffee? _____ If yes, how many per day? _____ Do you exercise? _____ If yes, how often? _____
Are you aware of any poor postural habits? _____

Reason for this visit

Describe the purpose of this visit: _____
When did this condition begin? _____Has the condition: ☐ gotten worse ☐ stayed constant ☐ comes & goes
Does this condition interfere with your work, sleep, daily routine, or other activities? ☐ Yes ☐No Please explain: _____
_____
Has this condition occurred before? ☐ Yes ☐No If yes, please explain: _____

Where do you feel pain?

Please mark the areas on the body forms to the right



What Kind of Pain?

KEY

Stabbing Pain	↗↗↗
Burning	^^^^
Numbness	••••
Pins & Needles	»»»»
Aching	++++

Doctors notes:

Overall intensity of complaint: ☐ minimal ☐ slight ☐ moderate ☐ severe
What aggravates the problem? _____
What relieves the pain? _____

Survey of Overall Health

Abnormal postural habits are the result of trauma or stress to the body that have misaligned the vertebrae in our spine, when these vertebrae are misaligned from their normal position they will cause stress to the spinal cord and delicate nerves that pass between the vertebrae, these misalignments are called **subluxations (sub-lux-a-shun).** It has been extensively documented that subluxations, causing stress to your nerves will weaken & distort the overall structure of your spine, which results in a weakened and distorted **posture.** Postural distortions have many serious and adverse affects on your overall health, the most common and detrimental postural distortion is called **FORWARD HEAD POSITION** ("hunched forward" posture stating in the neck & progressively weakening the entire body).

*Please **CHECK** any health conditions you may be experiencing.*

Cervical Spine

- ☐ neck pain
- ☐ headaches
- ☐ allergies
- ☐ thyroid condition
- ☐ recurrent cold
- ☐ pain in to your shoulders/arms/hand
- ☐ visual disturbances
- ☐ dizziness
- ☐ sinusitis
- ☐ jaw pain/clicking
- ☐ numbness/tingling in arms
- ☐ hearing disturbances
- ☐ weakness in grip
- ☐ coldness in feet

Thoracic Spine (upper back)

- ☐ upper back pain
- ☐ heart palpitations
- ☐ heart murmurs
- ☐ tachycardia
- ☐ heart attacks
- ☐ recurrent lung infections
- ☐ asthma/wheezing
- ☐ shortness of breath
- ☐ pain on deep inspiration/expiration

Thoracic Spine (mid back)

- ☐ mid back pain
- ☐ pain in to ribs/chest
- ☐ indigestion
- ☐ heartburn
- ☐ nausea
- ☐ ulcers/gastritis
- ☐ hypoglycemia
- ☐ tired/irritable after eating or when you haven't eaten for a while

Lumbar Spine (Low back)

- ☐ low back pain
- ☐ pain in to hips/legs/feet
- ☐ muscle cramps in to hips/legs/feet
- ☐ sexual dysfunction
- ☐ recurrent bladder infections
- ☐ numbness in to hips/legs/feet
- ☐ constipation/diarrhea
- ☐ coldness in legs/feet
- ☐ frequent/difficulty urinating
- ☐ females- menstrual irregularities/cramping

Please list any health conditions not mentioned: _____

About my Insurance *Please reference and sign Financial Policy for additional information regarding your health insurance.*

Insurance Company: _____ Policy/Member Number: _____
Address: _____ Phone Number: _____

About the insured person, if other than patient

Name: _____ Date of Birth: _____ Relationship to patient: _____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of infirmity.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the series of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Patient Signature: _____ Date: _____

CONSENT TO EVALUATE & ADJUST A MINOR CHILD

I, _____, being the parent and/or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Guardian signature: _____ Date: _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge **I am not pregnant** and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Patient Signature: _____ Date: _____

HIPPA Patient Privacy Practice Summary

We are committed to preserving the privacy of your personal health information. We are required by law to protect the privacy of your medical information and to provide you with notice describing the following:

We are required by law to have your written consent before we use or disclose to others your healthcare information for purpose of providing or arranging for your healthcare, the payment for, or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. However, we may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or permission.

As our patient, you have important rights relating to inspecting and copying your medical information, amending or correcting that information, obtaining an account of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health insurance and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explain your rights and our obligations under the law. We may revise this Notice from time to time.

You have the right to receive the most current copy of this Notice. If you have not yet read or received this, please ask at the front desk for a copy, and it will be provided to you.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact Dr. Scott Mindel or Dr. Julie Sutton at our office number, (206) 441-7984.

Patient Signature: _____ Date: _____

Financial Policy

We share your concerns about rising health care costs. Our fees represent usual and customary charges based on community standards. Patients are expected to pay for professional services at the time of the visit.

Your insurance policy is an agreement between you and the insurance company. It is important that you understand your health and accident benefits listed in your policy. You or your guardian is personally responsible for any charges for services which are rendered to your account. There are many variations in the HMO's and PPO's of today. We request that you call your insurance company to verify benefits within the first week of care. As a courtesy to you, our office will also call your insurance company to verify insurance coverage; however, this is not a guarantee of what the insurance company will pay. We will try, to the best of our ability, to estimate what your co-insurance/co-pay will be at each visit. Insurance companies have 90 days to respond to claims sent out; therefore, please take note that we may not know for this amount of time what is being paid and/or considered for payment by your insurance company. The claims will be sent to your insurance company, they will determine if they apply to your deductible and send an Explanation of Benefits (EOB) to you and our office. You will then receive a bill in the amount of what your insurance company applied to your deductible. Insurance deductibles that you may have with your plan are your responsibility. If notified by the insurance company that services rendered are not payable under the "medical necessity" clause in your contract, you agree to accept full responsibility for those denied services. Any balance not paid by the insurance company ultimately becomes your responsibility.

Patient Signature: _____ Date: _____