Quam Chiropractic

Confidential Health History

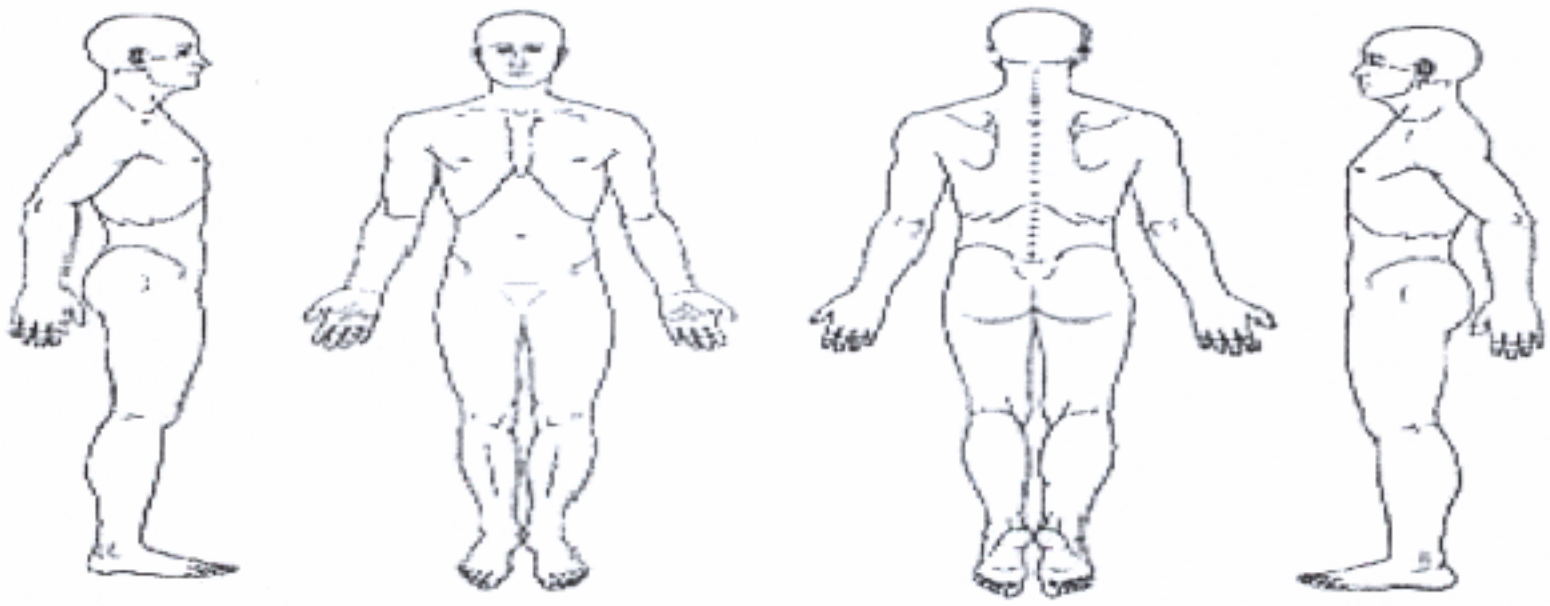
Full Legal Name_____ Gender: Male / Female
Address_____ City/State/Zip_____
Date of Birth_____ AGE_____ Marital Status: S M W D
Home Phone_____ Cell Phone_____
E-mail Address_____
Would you like email / text reminders? Yes / No Cell Phone Carrier_____
Occupation_____ Employer_____ Work Phone_____
Spouse's Name_____ Spouse's Date of Birth_____
Person responsible for this Account (if different than patient) _____
Subscriber's Name_____ Date of Birth_____ M / F
Emergency Contact_____ Phone_____
Family Physician_____ Do you have children? Yes / No If yes, how many? _____

Is this a work-related injury? Yes / No If yes, Employer at time of injury_____

Chief Complaint

Primary reason for seeking care? _____ Date of onset: _____
What caused the onset? _____
Duration & Timing: How often do you experience this pain? Occasional Intermittent Frequent Constant
Severity: 0 = No Pain 1 2 3 4 5 6 7 8 9 10 = Excruciating Pain
Quality of Symptoms: Dull Ache Stiff Tight Sore Sharp Shooting Stabbing Burning Radiating Throbbing Numb/Tingling Weak
Do the symptoms radiate to other areas? Yes / No If yes, where to? _____
How is your condition changing? Improving Getting Worse Not Changing
What relieves the pain / symptom(s)? _____
What aggravates the pain / symptom(s)? _____
Have you seen anyone else for this condition? Yes / No Whom? _____

Please mark the areas of pain or injury on the diagram with an X:



Quam Chiropractic Patient name: _____ DOI: _____ Claim#_____

Doctors Notes:

Patient: Denies / Has: pain, numbness, tingling, weakness in the: upper ext. / lower ext., on R L B/L
Sleep changes: Denied / Positive:
Energy levels: no change / decreased
Stress levels: no change / Increased

Review of Systems (please circle all of the following you have now or have had in the past)

General: Unexplained Weight Loss or Gain Fever / Chills Recent Trauma Past Trauma Fatigue Irritable Nervousness Trouble Sleeping / Sleep Disorder Allergies

Skin: Rashes Itching Color Changes New / Change in Moles Lumps Dryness Hair / Nail changes

Head / Eyes / Ears / Nose / Throat: Visual Changes Sinus Problems Hearing Loss Difficulty Swallowing / Chewing Double Vision Head Injury / Trauma Ringing in Ears TMJ Headaches Concussion

Cardiovascular: Chest Pain Shortness of Breath High / Low Blood Pressure Blood Clots Palpitations Fainting Heart Disease Cold Hands / Feet Poor Clotting DO YOU HAVE A PACEMAKER? Yes / No

Respiratory: Cough Coughing up Blood TB Sputum Asthma / Wheezing Face Flushed COPD / Emphysema

Gastrointestinal: Abdominal Pain Vomiting Diarrhea Nausea Constipation Indigestion Upset Stomach

Musculoskeletal: Neck / Back Pain Joint Pain / Stiffness Hip/Knee/Ankle Pain Plantar Fasciitis Scoliosis Joint Swelling Shoulder/Elbow/Wrist Pain Muscle Pain Muscle Weakness Muscle Cramps Hot Joints

Neurologic: Dizziness Seizures Weakness Numbness Headaches Loss of Memory Loss of Taste Loss of Smell Pins & Needles Cold Sweats Difficulty of Speech Tremors Loss of Coordination Paralysis

Other: Diabetes Cancer Fibromyalgia Anxiety Depression AS Arthritis Osteoporosis Varicose Veins MS Anaphylaxis Head Seems Heavy Thyroid issues Other_____

Female Only: Painful Menstruation Irregular Cycle Breast Problems Menopause ARE YOU PREGNANT? Yes / No / Maybe

Family History

Does anyone in your family presently or in the past have any of the following: Cancer, Stroke, Heart Attack, Angina or Chest Pain, Thyroid Problems, Asthma, HIV, Arthritis, Other. If so please explain below:

_____

_____

_____

_____

_____

Quam Chiropractic Patient name: _____ DOI: _____ Claim#_____

Medication (please list all medication and supplements you are taking

_____

_____

_____

Past Injuries (slips, falls, accidents)

_____ Date_____ _____ Date_____

_____ Date_____ _____ Date_____

Past Surgeries

_____ Year_____ _____ Year_____

_____ Year_____ _____ Year_____

Date of last physical examination: _____

Do you smoke? Yes / No If yes how many per day? _____

Do you drink caffeinated beverages? Yes / No If yes how many per day? _____

Do you drink alcoholic beverages? Yes / No If yes how many per day? _____

Do you exercise? Yes / No If yes, how often and what types? _____

Do you drink water? Yes / No If yes, how much per day? _____

Have you seen a Chiropractor before? Yes / No If yes, when? _____

Patient Informed Consent

I, _____, the undersigned, consent to care at this clinic. I understand that I have the opportunity to discuss with the doctor and / or with other office personnel, the nature and purpose of chiropractic adjustments and rehab. I hereby request and consent to the performance of chiropractic procedures to the spine and extremities, including various modes of rehab therapy / therapeutic exercise, massage, diagnostic x-rays, and any other supportive therapies on me (or in the patient mentioned above, for whom I am legally responsible) by the Doctor of Chiropractic, Massage Therapist and support team and Quam Chiropractic. I also understand that as is with all healthcare treatments, results are not guaranteed, there is no promise to cure and that there are some risks. Risks include but are not limited to: aggravating and / or temporary increase in symptoms, muscle spasms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor's judgment, based upon the facts then known, and is in my best interest. I further understand that chiropractic adjustments to the spine and / or extremities and supportive treatment is designed to reduce and / or correct vertebral subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes of avoiding more invasive procedures. I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures.

Patient Signature_____ Date_____

Financial Agreement

I, _____, the undersigned understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from my insurance carrier (s). I permit this office to endorse co-issued remittances for the conveyance of credit to my account and any authorized amount will be paid directly to Quam Chiropractic. It is my understanding that if Quam Chiropractic extends credit to me that my credit may be checked. I understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me will be immediately due and paid unless other arrangements are made. I clearly understand and agree that all services rendered to me are ultimately my responsibility and I am responsible for payments not covered by my insurance carrier.

Patient Signature_____ Date_____

Acknowledgement

I, _____, 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 in any way.

Patient Signature_____ Date_____

HIPAA PATIENT CONSENT FORM

25012 104th Ave S.E., Suite E, Kent, Washington 98030 (253)854-1233 Fax (253)854-1297

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Quam Chiropractic. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Quam Chiropractic reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the Persons indicated below.

_____**Any member of my immediate family**
_____**Spouse**
_____**Other** (please specify) _____

Name of Patient or Personal Representative _____

Signature of Patient or Personal Representative _____ Date_____

Description of Person Representative's Authority _____

Witness: _____
Printed name

_____
Signature Date

OFFICE USE ONLY BELOW THIS LINE

____Patient refused to sign

____Patient unable to sign (reason)_____