HALEY CHIROPRACTIC CLINIC
1919 NO. PEARL ST. #A4
TACOMA, WA 98406

CONFIDENTIAL PATIENT HISTORY

Name_____ Today's Date: _____

Home #_____ Cell #_____ Cell phone provider:_____

Email Address: _____ Text Message Reminder ☐ OR Email Reminder ☐

Address_____ City_____ State _____ Zip_____

Marital Status: S M W D SSN#_____ Date of Birth _____

Employer_____ Work # _____ Ext: _____

Have you received chiropractic care in the past? ☐ Yes ☐ No

Are you currently under chiropractic care? ☐ Yes ☐ No

The reason for this visit: ☐ PI (automobile accident) ☐ L&I (injury on the job)

☐ Other_____

How did you hear about our office? ☐ Website ☐ Phonebook ☐ Other _____

INSURANCE COVERAGE

We can bill your insurance as a courtesy to you.

Will we be billing insurance for you? ☐ Yes ☐ No

☐ Private Insurance ☐ Medicare Coverage (also provide your supplemental insurance info)

Name of Insurance_____ Phone_____

Policy Number_____ Group # _____

Policy Holders Name_____ Employer_____

SS# of policy holder_____ Date of birth _____

***Secondary Insurance or Supplemental Insurance if applies:**

Name of Insurance_____ Phone_____

Policy Number_____ Group # _____

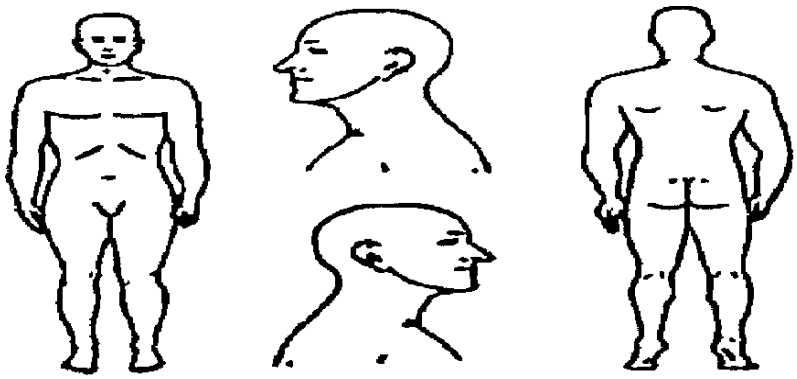
Policy Holders Name_____ Employer_____

SS# of policy holder_____ Date of birth _____

Haley CHIROPRACTIC Clinic

1919 N Pearl St. Suite A4 Tacoma WA 98406 ph: 253-761-0930

PLEASE CIRCLE YOUR AREA(S) OF COMPLAINT



What is your **PRIMARY** complaint? _____ When did your symptoms start? _____

Describe how your symptoms began: _____

_____

How often do you experience your symptoms throughout the day?

☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

What is the severity of your pain? ☐ Mild ☐ Moderate ☐ Severe

What **TYPE** of pain and/or discomfort do you have? (Check all that apply)

☐ Sharp ☐ Dull ☐ Ache ☐ Numb ☐ Tingling ☐ Shooting ☐ Stabbing ☐ Burning

☐ "Tight" ☐ "Stiff" ☐ Pulling ☐ Throbbing ☐ Annoying ☐ Uncomfortable ☐ Other:

Do your symptoms radiate anywhere? ☐ NO ☐ YES If yes, where? _____

Since the onset how are your symptoms changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

How would you rate your pain? (Circle one)

Currently: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

At its worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

What helps relieve your symptoms (ice, heat, massage, etc)? _____

What activities make your symptoms worse (working, exercise, etc)? _____

Have you experienced this type of pain before? ☐ NO ☐ YES If so, what helped relieve pain? _____

How do your symptoms affect your ability to perform activities of daily living (ADL's)? (Check one)

☐ Not at all ☐ Mildly (forgotten with activity) ☐ Moderately (interferes with activity)

☐ Limiting (prevents full activity) ☐ Severe (no activity is possible)

What activities of daily living are **painful and/or difficult** to perform due to symptoms? (Check all that apply)

☐ Sitting for more than 10 minutes	☐ Putting on shoes	☐ Looking over shoulder
☐ Sitting for more than 60 minutes	☐ Changing positions (sit to stand)	☐ Reaching overhead
☐ Standing for more than 10 minutes	☐ Sleeping	☐ Gripping
☐ Standing for more than 60 minutes	☐ Turning over in bed	☐ Pushing
☐ Walking short distances	☐ Lying on stomach	☐ Pulling
☐ Getting in and/or out of the car	☐ Lying on back	☐ Kneeling
☐ Bending over forward	☐ Coughing and/or Sneezing	☐ Balancing
☐ Putting on and/or taking off clothes	☐ Sexual activities	☐ Squatting
☐ Picking something off the floor	☐ Driving	☐ Going up and/or down stairs
☐ Computer work	☐ House/Yard work	☐ Exercise/Running/Biking

Who have you seen for your current symptoms? (Check all that apply)

☐ No one ☐ Chiropractor ☐ Primary Care Physician ☐ Physical Therapist ☐ Massage Therapist

If so, what treatment was given and/or what medication(s) were prescribed to you? _____

What tests/imaging have been performed for your current symptoms? (Check all that apply):

☐ None ☐ X-RAY *date:* _____ ☐ MRI *date:* _____ ☐ CT Scan *date:* _____ Other *date:* _____

Are there any *ADDITIONAL* areas of complaint? ☐ NO ☐ YES If yes where? _____

Describe how symptoms began: _____

When did your symptoms start? _____ What is the severity of your pain? ☐ Mild ☐ Moderate ☐ Severe

How often do you experience your symptoms?

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☐ "Tight" ☐ "Stiff" ☐ Pulling ☐ Throbbing ☐ Annoying ☐ Uncomfortable ☐ Other:

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General Patient Health, Social and Past Health History

Height: _____ Weight: _____ Occupation: _____

Do you smoke? ☐ NO ☐ YES If yes, how many cigarettes per day? _____

Do you exercise? ☐ NO ☐ YES If yes, how many times per week? _____

In the space provided please enter **"C"** if you **CURRENTLY** or **"P"** if you have had this problem in the **PAST**.

Musculoskeletal
_____Spinal Surgery
_____Screws, Pins and/or Plates
_____Muscle Spasms/Cramping
_____Scoliosis
_____Arthritis
_____Osteoporosis
_____Slipped/Herniated Disc
_____Spinal/Extremity Fractures
_____TMJ Issues
_____Hip Disorders

Neurologic
_____Tremors
_____Dizziness/Vertigo
_____Fainting
_____Epilepsy and/or Seizures
_____Numbness/Tingling/Weakness
_____Partial or Complete Paralysis
_____Stroke
_____Loss of Vision, Taste or Smell

Eye, Ear Nose & Throat
_____Blurred or Double Vision
_____Eye Pain or Vision Change
_____Chronic Ear Infections
_____Ringing in Ears
_____Sinus Problems
_____Difficulty Swallowing

Cardiovascular
_____Blood Clots
_____Chest Pain or Tightness
_____Heart Attack
_____Coronary Artery Disease
_____High Blood Pressure
_____Low Blood Pressure
_____Excessive Bruising
_____Swollen Legs or Feet
_____Varicose Veins
_____Leg Pain with Walking

Respiratory
_____Snoring Issues
_____Difficulty Breathing
_____Chronic Cough
_____Emphysema
_____Spitting Blood
_____Wheezing/Asthma
_____Shortness of Breath

Gastrointestinal
_____Abdominal Pain
_____Irritable Bowel
_____Food Sensitivities
_____Constipation
_____Hernia
_____Loss of Bowel Control
_____Appendicitis

General
_____Unexplained Weight Loss/Gain
_____Anemia
_____Diabetes
_____Gout
_____Cancer
_____Thyroid Disease
_____Migraines with Aura
_____Migraines without Aura
_____Changes in Bowel or Bladder Habits

Allergies:_____
_____
_____

Women ONLY:
Currently pregnant: ☐ NO ☐ YES
Currently nursing: ☐ NO ☐ YES
Birth Control: ☐ NO ☐ YES
Breast implants: ☐ NO ☐ YES
Hormone Replacement: ☐ NO ☐ YES
Menopause Symptoms: ☐ NO ☐ YES

List all the surgical procedures you have had and the dates they were performed:
_____
_____
_____

List all the prescriptions, over-the counter medications and nutritional supplements you are taking:
_____
_____
_____

Have you been involved in previous auto/work/fall accidents? ☐ NO ☐ YES If yes; explain: _____
_____

Have you been hospitalized for any previous illnesses? ☐ NO ☐ YES If yes; explain: _____

Is there anything else that is causing you concern, worry or stress? ☐ NO ☐ YES If yes; explain: _____
_____

_____

HALEY CHIROPRACTIC CLINIC PAYMENT POLICY

PATIENTS WITHOUT INSURANCE COVERAGE FOR CHIROPRACTIC CARE are expected to pay for services in full at the time services are rendered. If payment arrangements need to be made please consult with the office manager before making an appointment. A billing fee may be applied to your account if your estimated portion due is not received at the time of service. You will also be charged the full billing rate instead of the discounted rate.

CURRENT PATOS RATES
*$50 PER ADJUSTMENT (REGIONS 1-2 OR 3-4)
*$25 FOR TRACTION (OPTIONAL TREATMENT DECIDED BY YOUR DOCTOR)
*$50 PER REHABILITATION UNIT
*$30 FOR EXTRA SPINAL MANIPULATION (EXTREMITY)

CURRENT BILLING RATES
*$53 FOR 1-2 REGION
*$75 FOR 3-4 REGION
*$30 FOR TRACTION (OPTIONAL TREATMENT DECIDED BY YOUR DOCTOR)
*$75 PER REHABILITATION UNIT
*$51 FOR EXTRA SPINAL MANIPULATIONS (EXTREMITY)

PATIENTS WITH INSURANCE COVERAGE FOR CHIROPRACTIC CARE: If your private insurance policy provides chiropractic benefits we will be happy to submit a claim to them for you. In accordance with our contracts with all insurance companies you are responsible for paying you portion at the time service.. Your estimated portion will be calculated by the benefit deductibles, co-pays, and/or a specific percentage your insurance company has established for your individual policy. A billing fee may be charged to your account if payment is not received at the time services are rendered. Please discuss any need for payment arrangements with our office manager before scheduling an appointment. Please let us know if you have new insurance since your last visit. A $10 Service Fee will apply if not informed at time of service.

BILLING SCHEDULE: Statements will be mailed at the beginning of every month to patients with balances due by them after all Explanation of Benefits are received from your insurance company(s). If patient payments are not received after the first notice is sent to you a billing fee may be charged to your account for every 30 days your account is past due (I.E. 60 days, 90 days, 120 days). If payment from you is not made within 120 days of your first notice from our office your account may be turned over to a collections agency.

WORKERS COMPENSATION AND MOTOR VEHICLE COLLISION INJURIES Please notify us if you have been injured on the job or in a motor vehicle accident. Worker's compensation does cover necessary chiropractic treatments if your claim has been approved and is currently open. A new claim will require necessary forms to be completed by the patient and the doctor before it will be considered by the worker's compensation department. If your injury claim is not allowed it is your responsibility to pay any outstanding balances. Your auto insurance company will pay for any necessary chiropractic treatment if you had "PIP" coverage (Personal Injury Protection) included in your auto insurance policy at the time of the injury. You must file a claim with your auto insurance company and complete and return a "PIP" application to them before they will issue any payment towards your account. Workers compensation/Auto insurance policies will not cover any cost incurred by retail charges (i.e. braces, ice packs, etc).

I have read the above policies of Haley Chiropractic Clinic and fully understand that I am responsible for the payment of my account. If a minor, a parent or guardian must sign this form.

PLEASE GIVE 24 HOURS NOTICE IF YOU ARE UNABLE TO MAKE YOU SCHEDULED APPOINTMENT. NO SHOW APPOINTMENTS WILL BE SUBJECT TO A $35 NO SHOW FEE. PLESE NOTIFY US OF ANY CHANGES TO INSURANCE, ADDRESS, OR PHONE NUMBERS PROMPLY.

SIGNATURE_____ DATE _____

PATIENT'S NAME_____

IF MINOR, PARENT / GUARDIAN_____

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

Patient Name_____ Date_____

I hereby authorize Haley Chiropractic Clinic to release any information deemed appropriate to my health insurance company and their affiliates, my auto insurance company and their affiliates, or my attorney and/or claims adjuster in order to process any claim for reimbursement of charges incurred.

In the event my insurance company or attorney does not pay Haley Chiropractic Clinic for services and/or product I receive. I understand that I am personally responsible to pay my account balance in full. I also understand that Haley Chiropractic Clinic will make all efforts in my favor to settle or resolve any said claim as we see fit.

In addition to the above, I waive the statute of limitations on collection in the state of WA. I agree that this authorization is irrevocable and ongoing until all monies owed are paid in full. This authorization will be in effect until revoked by both parties.

Our office is required by federal law to maintain the privacy of you Private Health Information (PHI). We will not share your PHI with other healthcare providers or persons unless you have granted us permission to do so.
I hereby give permission for Haley Chiropractic Clinic to share my PHI to the following health care providers and/or persons:

_____

_____

For a complete description of our practice's privacy notice, please ask at the reception desk. By signing below, I acknowledge I have read and understand the above terms.

SIGNATURE_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We keep a record of the care we give you. The record also contains other health information about you. We will not discuss your health information to others unless we have your permission to do so, or unless the law allows or requires us to do so. If you have questions about your health information or want to ask about your rights, contact:

Haley Chiropractic Clinic
1919 N. Pearl Street, Suite A4
Tacoma, WA 98406
(253)761-0930

By signing this form, you are letting everyone know that you received a copy of the Notice of Privacy Practices that explain your rights.

SIGNATURE_____ DATE_____

IF MINOR, PARENT/GUARDIAN_____ RELATIONSHIP_____