FULL SPECTRUM
CHIROPRACTIC PLLC

CONFIDENTIAL HEALTH INFORMATION

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?

Your Last Name

Gender
○ Male ○ Female

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status
○ Single ○ Married ○ Divorced ○ Widowed
○ Separated ○ Domestic ○ Partners

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

Address

Preferred method of contact?
○ Home Phone ○ Text
○ Work Phone ○ Email

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

101 Rogers Street NW, Olympia WA 98502 • Tel: (360) 269-3448 • Fax: (360) 705-0421 • Email: infofullspectrumchiro@gmail.com

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

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 _____

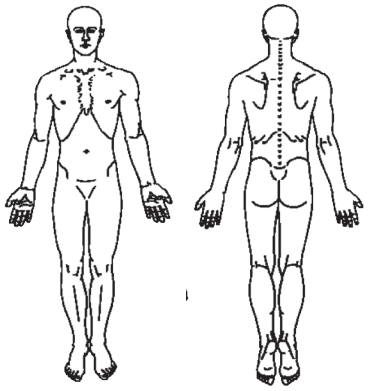
3. Onset (When did you first notice your current symptoms?)
_____

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. Do you have any chronic infectious diseases? ◯ Yes ◯ No If yes, please explain: _____

12. Are you currently suffering from any chronic illness? ◯ Yes ◯ No If yes, please explain: _____

13. What else should Full Spectrum Chiropractic, PLLC know about your current condition? _____

14. How does your current condition interfere with your:
Work or career: _____
Recreational activities: _____
Household responsibilities: _____
Personal relationships: _____

15. Review of Systems: Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture

NONE ◯ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness
◯	◯	Seizures/Epilepsy	◯	◯	Paralysis	◯	◯	Loss of Balance									

NONE ◯ Initials ____

c. Head, Eye, Ear, Nose and Throat

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Teeth Grinding	◯	◯	Eye Pain/Strain	◯	◯	Glaucoma	◯	◯	Impaired Hearing	◯	◯	Tearing/Dryness	◯	◯	Glasses/Contacts
◯	◯	Headaches	◯	◯	Nose Bleeds	◯	◯	Hay Fever	◯	◯	Sinus Problems	◯	◯	Frequent Sore Throats	◯	◯	Earaches

NONE ◯ Initials ____

d. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising

NONE ◯ Initials ____

e. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia
◯	◯	Persistent Cough	◯	◯	Frequent Common Colds	◯	◯	Difficuty Breathing									

NONE ◯ Initials ____

f. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea

NONE ◯ Initials ____

g. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste

NONE ◯ Initials ____

h. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash

NONE ◯ Initials ____

i. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Thyroid issues	◯	◯	Immune disease	◯	◯	Hypoglycemia	◯	◯	Frequent infection	◯	◯	Swollen glands	◯	◯	Low energy
◯	◯	Night Sweats	◯	◯	Feeling Hot/Cold	◯	◯	Diabetes Mellitus									

NONE ◯ Initials ____

Patient name _____

Consultation Notes

Doctor's Initials _____

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j. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Kidney stones	◯	◯	Infertility	◯	◯	Bedwetting	◯	◯	Prostate issues	◯	◯	Erectile dysfunction	◯	◯	PMS symptoms	NONE ◯
◯	◯	Painful Urination	◯	◯	Venereal Disease	◯	◯	Frequent Urinary Tract Infection	◯	◯	Impaired Urination	◯	◯	Penile Discharge	◯	◯	Testicular Pain/Swelling	Initials____

k. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Fainting	◯	◯	Low libido	◯	◯	Poor appetite	◯	◯	Fatigue	◯	◯	Sudden weight gain/loss (circle one)	◯	◯	Weakness	NONE ◯
◯	◯	Anemia	◯	◯	Cancer	◯	◯	Cold Hands/Feet										Initials____

l. Female Reproductive/Breasts

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Irregular Cycles	◯	◯	Breast Lumps/ Tenderness	◯	◯	Menopausal Symptoms	◯	◯	Vaginal Discharge	◯	◯	Bleeding Between Cycles	◯	◯	Difficulty Conceiving	NONE ◯
◯	◯	Nipple Discharge	◯	◯	Heavy Flow	◯	◯	Clotting										Initials____

A. Age of First Menses: _____ B. # of Days of Menses: _____ C. Length of Cycle: _____ D. # of Pregnancies: _____ E. # of Miscarriages: _____

F. Birth Control: _____ G. # of Abortions: _____ H. # of Live Births: _____

PERSONAL

16. Illnesses

Check the illnesses you have HAD in the past or HAVE now

Had	Have		Had	Have	
◯	◯	AIDS	◯	◯	Tuberculosis
◯	◯	Alcoholism	◯	◯	Typhoid fever
◯	◯	Allergies	◯	◯	Ulcer
◯	◯	Arteriosclerosis	◯	◯	Scarlet Fever
◯	◯	Cancer	◯	◯	German Measles
◯	◯	Chicken pox	◯	◯	Diphtheria
◯	◯	Diabetes	◯	◯	Streptococcus
◯	◯	Epilepsy	◯	◯	Staphylococcus
◯	◯	Glaucoma	◯	◯	Rheumatic Fever
◯	◯	Goiter	◯	◯	Mumps
◯	◯	Gout	◯	◯	Chicken Pox
◯	◯	Heart disease	◯	◯	Measles
◯	◯	Hepatitis	◯	◯	MRSA
◯	◯	HIV Positive	◯	◯	Other:_____
◯	◯	Malaria			
◯	◯	Measles			
◯	◯	Multiple Sclerosis			
◯	◯	Mumps			
◯	◯	Polio			
◯	◯	Rheumatic fever			
◯	◯	Scarlet fever			
◯	◯	Stroke			
◯	◯	Sexually transmitted disease			

17. Immunizations

◯ Polio ◯ Pertussis
◯ Tetanus ◯ Diphtheria

18. 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:_____

19. Energy and Immunity

◯ Frequent Common Cold
◯ Chronic Fatigue Syndrome
◯ Slow Wound Healing
◯ Chronic Infections
◯ Fatigue

20. Treatments

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

Past	Currently	
◯	◯	Acupuncture
◯	◯	Antibiotics
◯	◯	Birth control pills
◯	◯	Blood transfusions
◯	◯	Chemotherapy
◯	◯	Chiropractic care
◯	◯	Dialysis
◯	◯	Herbs
◯	◯	Homeopathy
◯	◯	Hormone replacement
◯	◯	Inhaler
◯	◯	Massage therapy
◯	◯	Physical therapy
◯	◯	Nutritional supplements

List: _____
_____

21. 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

22. Medication

Are you taking any of the following:

◯ Laxatives
◯ Antibiotics
◯ Pain Relievers
◯ Tranquilizers
◯ Antacids
◯ Thyroid Medication
◯ Cortisone
◯ Appetite Suppressants
◯ Blood Pressure Medication
◯ Sleeping Pills

23. **Medications** (prescription and over -the-counter):

_____

24. If applicable, list any foods, drugs or medications you are hypersensitive or allergic to. Please include the type of reaction:

_____

25. Height_____ Current Weight_____ Past Maximum Weight: _____ When? _____

26. Blood Pressure: What was your most recent blood pressure reading? _____/_____ When was this reading taken?_____

FAMILY

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother	_____	◯	◯	_____	_____	◯	◯
Father	_____	◯	◯	_____	_____	◯	◯
Sister 1	_____	◯	◯	_____	_____	◯	◯
Sister 2	_____	◯	◯	_____	_____	◯	◯
Brother 1	_____	◯	◯	_____	_____	◯	◯
Brother 2	_____	◯	◯	_____	_____	◯	◯
_____	_____	◯	◯	_____		◯	◯

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

SOCIAL

Alcohol use	◯ Daily	◯ Weekly	How much? _____	Prayer or meditation?	◯ Yes	◯ No
Coffee use	◯ Daily	◯ Weekly	How much? _____	Job pressure/stress?	◯ Yes	◯ No
Tobacco use	◯ Daily	◯ Weekly	How much? _____	Financial peace?	◯ Yes	◯ No
Exercising	◯ Daily	◯ Weekly	How much? _____	Vaccinated?	◯ Yes	◯ No
Pain relievers	◯ Daily	◯ Weekly	How much? _____	Mercury fillings?	◯ Yes	◯ No
Soft drinks	◯ Daily	◯ Weekly	How much? _____	Recreational drugs?	◯ Yes	◯ No
Water intake	◯ Daily	◯ Weekly	How much? _____	28. Hobbies:_____		

Consultation Notes

Patient name

◯ All other systems negative

Doctor's Initials

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30. 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	○	○	○	○

31. What is the major stressor in your life? _____ 32. How much sleep do you average per night? _____ Hours

Emotional (please circle any that you experience now and under line any that you have experienced in the past):

○ Mood Swings ○ Nervousness ○ Anxiety ○ Mental Tension

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

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

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

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

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each s tatement 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: _____

Signature _____ Date (MM/DD/YYYY) _____

Patient name _____

Consultation Notes

Doctor's Initials _____

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HIPAA Notice of Privacy Practices

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral inmates, and required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of State Law.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance o **n the use or disclosure indicated in the authorization.**

Your rights.
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will NOT retaliate against you for filing a complaint.**

This notice was published and becomes effective on/before _____

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number listed at the top of the first page of this notice.

Signature on the following page is only acknowledgement that you have received this Notice of Privacy Practices.

FULL SPECTRUM
CHIROPRACTIC PLLC

Policy for all Personal Injury Cases

_____I understand that Full Spectrum Chiropractic, PLLC will file all claims with my auto insurance. If at any time my med pay benefits are exhausted, I understand I will be responsible for all charges at the time of service.

_____I understand if I choose to file with a 3rd party insurance or attain an attorney that I am responsible for the full amount of each treatment at the time of service.

Print name_____

Signed_____ Date_____

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FULL SPECTRUM
CHIROPRACTIC PLLC

I, _____ hereby agree that the amount of (unknown at this time) can be withheld from my settlement in order to pay any services due to Full Spectrum Chiropractic, PLLC , and direct my claims adjuster to do so once care has been completed.

Patient signature _____ Date _____

I, _____, adjuster, hereby agree to accept this assignment.

Signature _____ Date_____

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FULL SPECTRUM
CHIROPRACTIC PLLC

I, _____, hereby agree that the amount of (unknown at this time) can be withheld from the proceeds of my lawsuit in order to pay Full Spectrum Chiropractic, PLLC for any services due and direct my attorney to do so at the completion of care and settlement.

Patient signature _____ Date _____

I, _____, attorney, hereby agree to accept this assignment.

Signature _____ Date _____

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