VOSS CHIROPRACTIC CONFIDENTIAL HEALTH REPORT

Name:_____ Date: _____ Sex: _____
(Last) (First) (Middle)

DOB: _____ Height: _____ Weight:_____ Occupation: _____ Date of onset:_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:
O- CIRCLE ALL ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS:

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Foot Problems
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Malaria
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Pollo
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease

Please list any prescription drugs now taking: _____

_____

Past Surgeries: _____

_____

Allergies: _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case.
THIS IS A CONFIDENTIAL HEALTH REPORT.

GENERAL

- ☐ Allergy
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Neuralgia
- ☐ Numbness

EYES, EARS, NOSE & THROAT

- ☐ Asthma
- ☐ Colds
- ☐ Deafness
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Eye pain
- ☐ Nasal Obstruction
- ☐ Nose bleeds
- ☐ Sinus infection

CARDIO-VASCULAR

- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Slow heartbeat
- ☐ Swelling of ankles

GASTRO-INTESTINAL

- ☐ Colon issues
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Distension of abdomen
- ☐ Gallbladder issues
- ☐ Hemorrhoids
- ☐ Liver Issues
- ☐ Pain over stomach

NONE	LIGHT	MODERATE	HEAVY	
☐	☐	☐	☐	Alcohol
☐	☐	☐	☐	Coffee
☐	☐	☐	☐	Drug
☐	☐	☐	☐	Exercise
☐	☐	☐	☐	Soft Drinks
☐	☐	☐	☐	Tobacco

MUSCLE & JOINT

- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Low back pain
- ☐ Neck pain or stiffness
- ☐ Pain between shoulders
- ☐ Sciatica
- ☐ Swollen joints
- ☐ Pain, Numbness or cramps
- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet

GENITO-URINARY

- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ In ability to control kidneys
- ☐ Kidney infection or stones
- ☐ Painful urination
- ☐ Prostate Issues
- ☐ Pus in urine

SKIN

- ☐ Bruise easily
- ☐ Dryness
- ☐ Skin eruptions (rash)
- ☐ Varicose veins

RESPIRATORY

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing

Signature:_____

PRIMARY INFORMATION

NAME: _____

PHONE: _____

MAILING ADDRESS: _____CITY/STATE: _____ZIP CODE: _____

Who may we thank for referring you? _____

Emergency Contact Information (Please fill out)

NAME: _____ NAME: _____

PHONE #: _____ PHONE: _____

RELATION TO PATIENT: _____ RELATION TO PATIENT: _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

As in all health care, there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks or complications; however the doctor will do his/her best to explain the problem. Based on the facts and findings as presented to the doctor at the time of treatment, I agree to rely on the doctor to exercise judgment which is based on my best interest and well being during the course of the procedures.

I have read the above consent with the doctor and/or staff as indicated by my signature. I have had the opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

For more information, please refer to following Revised Codes of Washington:

RCW 18.25.005 "Chiropractic" defined

(1)Chiropractic is the practice of health care that deals with the diagnosis or analysis and care of treatment of the vertebral subluxation complex and its effects, articular dysfunction and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.

(3) As part of chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which may include diagnostic x-rays. To determine the appropriateness of chiropractic care or the need for referral to other health care providers. The chiropractic equality assurance commission shall provide by rule for the type and use of diagnostic analytical devices and procedures and procedures consistent with this chapter.

RCW 18.25.006 Definitions

(5) "Vertebral Subluxation Complex" means a functional defect or alteration of the biomechanical physiological dynamics in a joint that may cause neuronal disturbances. With or without displacement detectable by x-ray. The effects of the vertebral subluxation complex may include, but are not limited to, any of the following: Fixation, hypomobility, periarticular muscle spasm, edema or inflammation.

(9) "Chiropractic Adjustment" means chiropractic care of a vertebral subluxation complex, articular dysfunction, or musculoskeletal disorder. Such care includes manual or mechanical adjustment of any vertebral articulation and contiguous articulations beyond the normal passive physiological range of motion.

PATIENT SIGNATURE: _____ DATE: _____

(Patient, Guardian* or Authorized Representative*)

PERSONNEL SIGNATURE: _____ DATE: _____

HIPAA Disclosure Authorization Form

I, _____, hereby authorize Voss Chiropractic P.S., to release my medical information and/or account information to the following person/persons listed below:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP:_____

FULL DISCLOSURE: YES/NO LIMITED DISCLOSURE: YES/NO

By signing this form, I understand that:

*Protected health information may be disclosed or used for treatment, payment, claims processing or healthcare operations.

*The practice reserves the right to change the privacy policy as allowed by law.

*The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

*I have been presented/offered a copy of the County Health Department's Notice of Privacy Policies Detailing how my information may be used and disclosed as permitted under Federal and State Law.

VOSS CHIROPRACTIC FEE POLICY
WORKERS COMPENSATION

It is our goal at Voss Chiropractic to make chiropractic care available to everyone.

- **Workers Compensation Claim -** We will gladly bill your workers compensation insurance company directly. In the event of a rejected or closed claim, you will be responsible for all unpaid charges.

- As a courtesy, Voss Chiropractic may verify claims and authorization for chiropractic services. This does not guarantee payment. **It is ultimately the patients' responsibility to know the status of their claim.**

Your Workers Compensation Insurance Carrier may require supporting medical documentation in order to process your claims. **Your signature below represents authorization for Voss Chiropractic to release any information requested by insurance in regards to the patients' treatment at Voss Chiropractic.** I also authorize and direct my Workers Compensation Insurance Company to pay Voss Chiropractic directly. I understand if my insurance denies payment for my treatment that I am fully responsible for any and all unpaid balances.

Patients Signature _____ Date _____

Print Name _____

If patient is a minor, relationship to patient _____

24 HOUR CANCELLATION & NO SHOW FEE

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, **Voss Chiropractic P.S** reserves the right to charge a **Cancellation/No Show fee** for all missed office visits, rehab visits and massage visits.

No Show fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows", may result in termination from our practice.

Thank you for understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Signature:_____ **Print Name**: _____

WORKER'S COMPENSATION PATIENT HISTORY

PLEASE WRITE LEGIBLY:

NAME: _____DATE:_____

HISTORY OF OCCURANCE:

Employer's Business Name (at time of accident):_____
Employer's Phone: _____ Employer's Address:_____
City: _____State:_____ZIP:_____
Occupation: _____ Describe your job: _____
Date of Injury: _____ Time of Injury: _____ AM or PM Last date worked: _____
What were you doing at the time you were injured? How did the accident/injury happen (lifting/bending/carrying)?
_____
_____
When did pain begin? Where in your body did you first feel it? Was pain intense at first or did you feel pain gradually worsened? PLEASE BE SPECIFIC:_____
_____
_____
Describe the environmental conditions, which may have contributed to your present injury: Darkness, faulty equipment, slippery floor, limited space. (Distinguish natural hazards from hazards created by other employees:
_____
_____

FIRST DOCTOR/HOSPITAL SEEN:

Were you hospitalized as a result of this accident: **YES/NO**
If YES, where? _____
Doctor's Name: _____Date of FIRST visit: _____
Were you examined? **YES/NO** Were X-rays taken? **YES/NO**
Did you receive treatment? **YES/NO**
If YES, what kind of treatment did you receive? _____
What benefits did you receive from the treatment? _____
Date of LAST treatment? _____

SECOND DOCTOR/HOSPITAL SEEN:

Doctor #2: Name: _____ Date of first visit:_____
Were you examined? **YES/NO** Were X-rays taken? **YES/NO**
Did you receive treatment? **YES/NO**
If YES, what kind of treatment did you receive? _____
What benefits did you receive from the treatment? _____
Date of LAST treatment? _____

THIRD DOCTOR/HOSPITAL SEEN:

Doctor #3: Name:_____ Date of first visit?_____
Were you examined? **YES/NO** Were X-rays taken? **YES/NO**
Did you receive treatment? **YES/NO**
If YES, what kind of treatment did you receive? _____
What benefits did you receive from the treatment? _____
Date of last treatment?_____

REPORT ACCIDENT TO/ACCIDENT WITNESS

What date did you report this injury? _____

Whom did you report this to? _____

What is their position? _____

Was there a witness to your injury? **YES/NO**

If YES, what was their name? _____

What is their position? _____

PRIOR SIMILAR SYMPTOMS:

Did you have any physical complaints just before this accident? **YES/NO**

If YES, please describe in detail: _____

Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected?

YES/NO If YES, state what part of your body was previously injured: _____

Date hurt: _____Describe the injury: _____

_____

_____

Were you treated? **YES/NO**

If YES, who treated you? _____

What date did treatment begin? _____ And end? _____

When was the last time you felt pain or problems from that injury? _____

WORK STATUS HISTORY:

Have you lost any time form work as a result of this new injury? **YES/NO**

If YES, give dates: _____

If you are currently on disability, (time loss), do you want to go back to work doing your regular work duties?

YES **NO** If NO, state why: _____

Have you gone back to work? **YES/NO**

If YES, what status of work? __Modified __Regular When? _____

Please list what restrictions you have been placed on: _____

_____

If you have gone back to work, please list the activities as:

Those that are painful: _____

Those that are difficult: _____

Are there any problems you have with a fellow employee, supervisor or management that need to be discussed?

YES **NO** If YES, please discuss: _____

_____

_____

ACTIVITIES OF DAILY LIVING:

Do you find any activities that you perform at home painful or difficult? **YES/NO**

If YES, those home activities that you are unable to do (be specific): _____

_____

Those home activities that are painful are (be specific): _____

_____

Are you performing exercises at home at this time? **YES/NO**

If YES, what exercises are they? _____

How frequently do you perform them? _____

Who prescribed these exercises to you? _____

What exercises or activities could you do before the work-related injury that you no longer do because of pain or loss?

_____

_____

PAIN LEVEL/SCALE OF RECOVERY:

On a scale of 0-10, with 0 being (examiner's quote), "You're pain free and can functions quite well," and 10 being, "You're in pain all the time and cannot function at all," where would you rate yourself?

NORMAL	LOW PAIN	MODERATE PAIN	INTENSE PAIN	EMERGENCY
0	1-2-3	4-5-6	7-8-9	10

Please explain **WHY?** _____

_____

_____

Relative to where you were before this injury, how would you rate how much you have recovered so far: _____%

Do you have an attorney on this case? **YES/NO**

If YES, who? Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____