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
NON-INSURED PATIENTS

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

- Voss Chiropractic offers discounted rates for cash pay patients. **If you do not pay at the time of service, this discount cannot be given.**
- **After the initial exam fee**, Voss Chiropractic can offer a payment plan beginning at $100.00 per month, per account. If the payment plan is not followed, your account will be sent to Merchant Credit Services for collections.

I have read and understand the cash pay policy for Voss Chiropractic

*Patient Signature _____ Date _____

*Printed Name _____

MONTHLY PAYMENT PLAN AGREEMENT

Credit Card Authorization Agreement for Automatic Monthly Payments

I _____ authorize Voss Chiropractic to keep my signature on file and to charge the credit card selected below for the following:

Recurring charge of **$_____** to be charged once monthly every **5th or 20th**
(Circle one)

Card Holders Name: _____

Cardholder Address: _____

City: _____State: _____ Zip: _____

Card Number: _____

Exp. Date: _____