Spokane Chiropractic &
Sports Injury Clinic

Massage New Patient Information

OFFICE USE ONLY

- ☐ Insurance
- ☐ FFS
- ☐ L&I
- ☐ MVA

Personal Information

Date: _____

Name_____ Age_____ Birthdate_____

Address_____ City_____ State_____ Zip_____

Phone Number _____ Cell Phone_____Marital Status_____# of Children_____

Occupation_____Your Email Address_____

Employer_____ Spouse/Parent/Guardian Name_____

Emergency Contact _____Emergency Contact's Phone Number _____

Who referred you to our office?_____ Who is you Primary Care Physician_____

Have you had massage before? Yes / No

Insurance Information

Do you have Health Insurance? Yes / No

Health Insurance Company_____

Primary Insured's Name_____ Relationship _____

Primary Insured's Address_____

Primary Insured's Phone _____ Primary Insured's Date of Birth _____

Primary Insured's Employer (If different than above) _____

Motor Vehicle Accident

Are you seeking treatment for a motor vehicle accident? Yes / No If so what is the date the injury occurred? _____

Your auto insurance company name _____ Do you have an open medical claim? Yes/ No

Claim Number issued by your insurance company _____ Phone #_____

On the Job Injury

Are you seeking treatment today for an on the job injury? Yes / No If so what is the date the injury occurred? _____Have you filed a claim? Yes / No

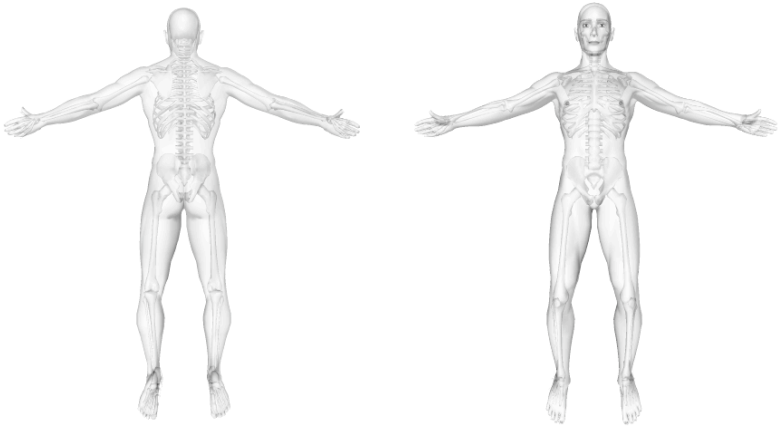
Name of Attending Physician _____ Claim Number: _____

Did your attending physician refer you to our clinic? Yes / No

Do you have an attorney? Yes / No Name of Attorney _____Attorney's Phone _____

Chief Complaints

Mark or circle the area of your symptoms on the drawing and indicate if painful, numb, tingling, weak, etc.



Please circle the number that best describes your your pain
(0 being no pain and 10 being debilitating pain)

Example: ***Neck*** ***Foot*** ***Back***

0 1 2 (3) 4 (5) 6 7 8 (9) 10

What is your pain **RIGHT NOW**?

0 1 2 3 4 5 6 7 8 9 10

What is your **TYPICAL** or **AVERAGE** pain?

0 1 2 3 4 5 6 7 8 9 10

What is your pain level **AT ITS BEST** (How close to "0" does your pain get)?

0 1 2 3 4 5 6 7 8 9 10

What is your pain level **AT ITS WORST** (How close to "10" does your pain get)?

0 1 2 3 4 5 6 7 8 9 10

Review of Symptoms

Are you currently or have you ever experienced any of the following? (Check box if yes)

Musculoskeletal System

- ☐ Weak Muscles
- ☐ Hernia
- ☐ Broken Bones
- ☐ Herniated Disk
- ☐ Teeth Grinding
- ☐ Tension Headache
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Inflammatory Disorder

Nervous System

- ☐ Permanent Numbness
- ☐ Persistent Dizziness
- ☐ Muscles Twitch/Spasm
- ☐ Seizures
- ☐ Loss of Feeling
- ☐ Fainting
- ☐ Concussion
- ☐ Tingling in Hands/Feet
- ☐ Paralysis
- ☐ Depression/Anxiety

Cardio/Respiratory

- ☐ Chest Pain
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Cholesterol Elevated
- ☐ Lung Problems
- ☐ Arteriosclerosis/Atherosclerosis
- ☐ Blood Disorder
- ☐ Stroke
- ☐ Transient Ischemic Attacks
- ☐ Clots/Thrombosis

Other

- ☐ Cancer
- ☐ Diabetes
- ☐ Currently Pregnant

Patient Agreement

Reminder: Your health insurance is an agreement between you and your insurance company. You must clearly understand and agree that for all services rendered to you in our office, you will be charged directly and you are personally responsible. As a courtesy to our patients, our office will submit your insurance claims in a timely manner at no charge to you. If your insurance company requires a referral, it is your responsibility to obtain one prior to receiving care. If you do not have prior authorization, you are responsible for any charges not covered by your insurance. Any co-payments due must be made the day services are rendered. If we are not billing your insurance, full payment for services rendered are due at the time of each visit. If for any reason this request cannot be met, arrangements must be made in advance, before seeing the doctor.

By signing below, I permit Spokane Chiropractic & Sports Injury Clinic to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered are charged directly to my account and that I am personally responsible for payment. I hereby authorize the doctors of Spokane Chiropractic & Sports Injury Clinic and whomever they may designate as their assistants, to administer treatment as they so deem necessary.

I also authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations. I am authorizing Spokane Chiropractic & Sports Injury Clinic to contact me and leave messages for me on the phone number I listed on page 1 of this form.

By signing on the signature line below, I acknowledge that I was given a copy of Spokane Chiropractic & Sports Injury Clinic's Notice of Privacy Practices for my review.

Signature:_____ Date:_____

I understand that I will be charged an interest rate of 2% per month or 24% per year on any unpaid balances over 60 days past due. I am also advised there is a $35.00 returned check fee on all checks that are returned to Spokane Chiropractic & Sports Injury Clinic.

**We realize that emergencies come up, but if you need to cancel your appointment for any reason, we request that every attempt is made to give us a minimum of 24 hours notice. If you fail to contact our office to cancel your appointment on more than one occasion, you will be charged for that date of service.

I understand that the above information and statements made on this form are accurate to the best of my knowledge, and I understand it is my responsibility to inform the office of any future changes in personal, insurance and medical status.

Signature:_____ Date:_____

Parent or Guardian's Signature:_____