CONFIDENTIAL INFORMATION

Name _____ Date _____

Address _____ City _____

State _____ Zip _____ Cell Phone _____ Home Phone _____

Email _____ Date of Birth _____

Sex _____ Marital Status _____ SSN: _____

Occupation _____ Employer _____

Emergency Contact: _____ Relation to you? _____

Emergency Contact Phone: _____

How did you hear about us? _____

(If this visit is due to a work or auto injury, please ask for a special injury form)

Insurance Information: Barlas Chiropractic is an in-network, preferred provider with most insurance plans in the state of Washington. **(Please present your insurance card when returning this form)**
Assignment of Benefits: I hereby assign and grant the benefits that I am eligible to receive for professional services rendered in this office to Barlas Chiropractic. I authorize the release of any medical information necessary to process any insurance claims for payment. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that insurance coverage is not a guarantee of payment and that I may be responsible for amounts pertaining to deductible, copay, or coinsurance as dictated by my insurance plan. I understand that Barlas Chiropractic will verify coverage and benefits, but that it is my responsibility as a patient to understand the details of my insurance plan and that a quote of benefits and/or authorization does not guarantee eligibility or payment. I understand that eligibility and payment of benefits are subject to all terms, conditions, limitations, and exclusions of my contract with my insurance company at the time of service. I understand that if insurance does not pay, I will be responsible to pay my bill in a timely manner or as arranged with Barlas Chiropractic.

_____ _____/_____/_____
Patient's Signature (Parent of Guardian if minor) **Date**

Do you have insurance? □ Yes □ No Company _____

I.D. # _____ Policy Group # _____

HEALTH HISTORY

Name: _____ **Women only** - Are you pregnant? □ No □ Yes

Description of primary complaint(s):

_____

_____

When did you first start experiencing this issue?:

_____

_____

You experience this issue: □ Constantly □ Daily □ Weekly □ Monthly □ Irregularly (explain)

_____

Please describe as: □ Ache □ Stiff □ Tight □ Spasm □ Sharp □ Numbness □ other(please describe)

_____

The discomfort/pain involved:
□ is localized □ originates from another location □ travels to another location_____

What caused this problem (i.e., accident, work, sports, certain activity or movement, unsure)?

_____

Have you had problems/injuries involving (these) areas of your body in the past? □ Yes □ No
If Yes, please describe:

_____

When present, how long do your symptoms last? _____

Have you lost sleep due to this/these problem(s)? □ Yes □ No
If so, how many hours per night do you lose?

_____

Are there things that make the condition:

Better: _____

Worse: _____

On a 0-10 scale, please rate your <u>average</u> pain in the past week: _____
On a 0-10 scale, rate your pain at its <u>worst</u> in the past week: _____

Have you seen another health care professional for this/these problem(s)?

_____

Did you receive treatment? Y / N If yes, did the treatment help? Y / N

YOUR GOALS FOR TREATMENT

- ▫ Relieve Pain/Discomfort
- ▫ Increase Performance
- ▫ Improve Posture
- ▫ Prevention
- ▫ Other _____
- ▫ Improve Mobility
- ▫ Increase Energy
- ▫ Motor vehicle accident
- ▫ Work-related injury

MEDICAL HISTORY

Please complete this to the best of your ability, including dates, or mark N/A

Previous surgeries and hospitalizations	
Previous fractures and other injuries	
Conditions you currently have or have previously been diagnosed with	
Prior imaging (MRI, X-Ray, etc.) with dates	
Current medications	
Family history of disease	
Allergies	
Other doctors you use for your health care	

Have you experienced any **changes to your bowel or bladder function**? □ Yes □ No
If so, please describe: _____

LIFESTYLE

1. a) Do you smoke? Y / N # cigarettes per day/occasion? _____

   b) Did you previously smoke? Y / N If yes, when was the last time you smoked? _____

2. a) Do you drink alcohol? Y / N # drinks per week _____

   b) Do you currently or did you previously have a history of substance/drug abuse? _____

3. a) # of days per week that you exercise _____ b) For how long do you exercise each session? _____

   c) Exercise activities? _____

4. Do you drink coffee or caffeinated beverages? Y / N # cups/drinks per day? _____

5. Approximately how much water do you drink each day? _____

6. a) Do you generally sleep soundly? Y / N # of hours of sleep per night? _____

7. a) Nutrition- Would you rate your nutrition: ▫ Excellent ▫ Very Good ▫ Good ▫ Fair ▫ Poor

   b) # servings of fruits and vegetables daily: _____

   c) Do you adhere to a particular diet? Y / N Please describe: _____

   d) Supplements? Y / N Please list: _____

8. How would you rate your stress level? ▫ Very stressed ▫ Stressed ▫ Slightly stressed ▫ No stress

ACCIDENTS & TRAUMA

1. Have you ever been in an auto accident? Y / N If yes, how many?: _____

   a) When was the most recent?: _____

2. Have you ever had a work injury? Y / N If yes, please elaborate:

_____

Please check all that apply if you are currently experiencing or have had chronic recurrences of the following conditions:

General
□ Allergies
□ Depression
□ Dizziness
□ Fainting
□ Fatigue
□ Fever
□ Headaches
□ Loss of sleep
□ Mental illness
□ Nervousness
□ Tremors
□ Weight loss / gain

Muscle / Joint
□ Arthritis / rheumatism
□ Bursitis
□ Foot trouble
□ Muscle weakness
□ Low back pain
□ Neck pain
□ Mid back pain
□ Joint pain

Skin
□ Boils
□ Bruise easily
□ Dryness
□ Hives or allergies
□ Itching
□ Rash
□ Varicose veins

Eye, Ear, Nose & Throat
□ Colds
□ Deafness
□ Ear ache
□ Eye pain
□ Gum trouble
□ Hoarseness
□ Nasal obstruction
□ Nose bleeds
□ Ringing of the ears (tinnitus)
□ Sinus infection
□ Sore throat
□ Tonsillitis
□ Vision problems

Gastrointestinal
□ Abdominal pain
□ Bloody or tarry stool
□ Colitis / Crohn's
□ Colon trouble
□ Constipation
□ Diarrhea
□ Difficult digestion
□ Diverticulosis
□ Bloated abdomen
□ Excessive hunger
□ Gallbladder trouble
□ Hernia
□ Hemorrhoids
□ Intestinal worms
□ Jaundice
□ Liver trouble
□ Nausea
□ Painful deification
□ Pain over stomach
□ Poor appetite
□ Vomiting
□ Vomiting of blood

Genitourinary
□ Bed-wetting
□ Bladder infection
□ Blood in urine
□ Kidney infection
□ Kidney stones
□ Prostate trouble
□ Pus in urine
□ Stress incontinence
Urination
□ Overnight more than twice
□ More than 8x in 24hrs
□ Decreased flow/force
□ Painful urination
□ Urgency to urinate

Cardiovascular
□ High blood pressure
□ Low blood pressure
□ Hardening of the arteries
□ Irregular pulse
□ Pain over heart
□ Palpitation
□ Poor circulation
□ Rapid heart beat
□ Slow heart beat
□ Swelling of ankles

Respiratory
□ Chest pain
□ Chronic cough
□ Difficulty breathing
□ Hay fever
□ Shortness of breath
□ Spitting up phlegm/blood
□ Wheezing

Women only
□ Congested breasts
□ Hot flashes
□ Lumps in breast
□ Menopause
Menstrual flow:
□ Reg. □ Irreg. □ Pain/ cramps
Are you pregnant?
□ yes, □ no
If yes, how many months?
____
How many children do you have? ____

Check any of the conditions you have or have had:
□ Alcoholism
□ Anemia
□ Appendicitis
□ Arteriosclerosis
□ Asthma
□ Bronchitis
□ Cancer
□ Chicken pox
□ Cold sores
□ Diabetes
□ Eczema
□ Edema
□ Emphysema
□ Epilepsy
□ Goiter
□ Gout
□ Heart burn
□ Heart disease
□ Hepatitis
□ Herpes
□ High cholesterol
□ HIV/AIDS
□ Influenza
□ Malaria
□ Measles
□ Miscarriage
□ Multiple sclerosis
□ Mumps
□Numbness/tingling
□ Pace maker
□ Osteoporosis
□ Pneumonia
□ Polio
□ Rheumatic fever
□ Stroke
□ Thyroid disease
□ Tuberculosis

MISSED APPOINTMENTS AND CANCELLATION POLICY

A missed appointment is considered being more than 10 minutes late for the scheduled time, and will result in an automatic charge of $45. All appointments will require 24 hours of notice for cancellations and rescheduled appointments. Failure to do so will also result in an automatic charge of $45. We reserve the right to exercise circumstantial discretion when it comes to late or missed appointments.

By signing below I acknowledge and agree to the policies regarding cancelled and missed appointments. I understand that I am ultimately responsible for the penalties if I am unable to comply.

Patient Signature: _____ Date: _____/_____ /_____

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may collect, use and disclose your personal information, and your rights regarding that information. Under the Health Insurance Portability and Accountability Act of 1996, health care providers must take measures to protect the privacy of your personal information. We are required by law to:

- Protect the privacy of personal information.
- Provide this Notice explaining our duties and privacy practices.
- Abide by the terms of this notice.

Ways We Protect Your Personal Information: We allow only Barlas Chiropractic PLLC personnel access to the records and use personal information only to the extent necessary to conduct the practice of healthcare services. We secure the building, patient charts and computer records each day after work. We train our staff on our written confidentiality policy and procedures and employees are subject to discipline if they violate them. We will protect your privacy even if you no longer are a patient here. We shred old documents prior to discarding them.

How We Collect Your Personal Information: We collect the information from you in our initial Patient Information and Health History forms. We may also collect information regarding previous chiropractic treatment and medical conditions from health care providers you have seen in the past.

How We Use Your Personal Information: We use your information to determine appropriate care during your treatment here. We use personal information we collect here (i.e., X-ray records, charting information) to determine what chiropractic treatment we will provide. We may share this information with other chiropractic specialists to help determine your treatment. We use Social Security numbers, birth date and employer information to identify you with health care insurance groups. We use phone numbers, addresses, and email to communicate with you regarding appointments and billing for services. Unless you request us not to, we may discuss your information with your immediate family, i.e., with a spouse, also we discuss dependent's treatment with parents of minors. We may be ordered by the Court in some unusual situations to release information and do so if it is required.

Your Rights: You may inspect records we retain regarding personal information and amend them if you feel they are in error. You may request we restrict the sharing of your information except on a case-by case basis. You may request we only contact you at specific locations, i.e. only at work. You may also request records; we may charge a reasonable fee for this service. You may ask questions regarding your Personal information here.

Patient acknowledgement of Privacy Practices: I have seen the Privacy Practices notice as required by HIPAA, have read it and been given the opportunity to ask questions.

Patient Signature: _____ Date: ____/____ /____

Parent or Guardian's Signature: _____ Date: ____ /____ /____