Life Chiropractic
CENTER & Massage Therapy

Confidential Patient Information

Date: _____

Name: _____ Last Name: _____ Initial: _____

Dr. Ricky Sikka
P: (253) 874-4141
F: (253) 874-3601

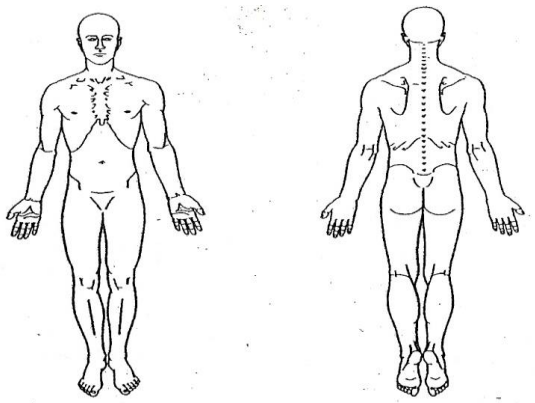
Major Complaint Information

What is your major complaint(s)? _____

_____

When did this (these) symptom(s) begin? _____

Using the symbols provided in the Pain Index, mark the areas on the illustrations below where you are experiencing pain, followed by a number from 1-10 indicating the extent of the pain.
(1 being minor and 10 being severe)



Pain Index

B Burning **S** Sharp/Stabbing **N** Numbness

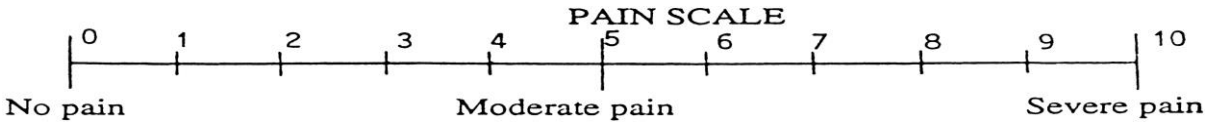
For example: if you are experiencing moderately severe burning pain in your neck, you should note "B8" on the neck of the illustration

If this is an injury, describe what happened:

_____

_____

_____



Have you experienced these symptoms before? ❍ Yes ❍ No When? _____

These symptoms developed from? ❍ Auto Accident ❍ Work-Related ❍ Other: _____

Have you reported this injury to your: Insurance Company ❍ Yes ❍ No Employer ❍ Yes ❍ No

What aggravates this condition? _____

What decreases the symptoms/pain? _____

Have you seen a doctor for this condition? ❍ Yes ❍ No Doctor's Name: _____

Date Consulted: _____ Diagnosis: _____

Have you missed work because of these injuries? ❍ Yes ❍ No From: _____ to _____

Does this condition interfere with your sleep? ❍ Yes ❍ No

If so, how many times do you wake up in pain per night? _____

In what position do you sleep? ❍ Back ❍ Stomach ❍ Side

Do you sleep with a pillow? ❍ Yes ❍ No How many? _____

Does heat affect the pain? ❍ Yes ❍ No If so, how? _____

Does cold affect the pain? ❍ Yes ❍ No If so, how? _____

Do you wear a heel lift? ❍ Yes ❍ No If so, which side? ❍ Right ❍ Left

Does it cause pain to cough, grunt, or sneeze? ❍ Yes ❍ No If so, where? _____

Check those activities below during which you experience difficulty and/or pain:

___ Lying on back	___ Getting in/out of car	___ Sleeping	___ Stooping	___ Standing for periods over 1 hour
___ Lying on side with knees bent	___ Gripping	___ Pushing	___ Sitting	___ Bending forward
	___ Climbing	___ Pulling	___ Coughing	___ Sneezing
___ Turning over in bed	___ Dressing self	___ Reaching	___ Walking	___ Bending Backward
___ Lying flat on stomach	___ Sexual activity	___ Kneeling	___ Other: _____	

Fill out the next three sections as they apply to you:

HEADACHES

Do you have a family history of headaches? ❍ Yes ❍ No Do you get headaches? ❍ Yes ❍ No Frequency? _____

Do you experience the following with your headaches: Pain or cracking in your jaw? ❍ Yes ❍ No

Abnormal blood pressure? ❍Yes ❍ No ❍ High ❍ Low Nausea, vomiting or visual disturbances? ❍ Yes ❍ No

When was your last eye exam by a doctor? ❍ 1-6 months ❍ 6-12 months ❍ 1-2 years ❍ over 2 years Results? _____

LOWER BACK PAIN

Do you ever experience a ripping or tearing sensation in your back? ❍ Yes ❍ No If so, where? _____

Does the pain radiate to the abdomen? ❍ Yes ❍ No

Do you ever have impaired bowel or urinary function? ❍ Yes ❍ No Explain: _____

NECK PAIN

If you have a neck injury, does it effect: (Check all that apply) ❍ Hearing ❍ Vision ❍ Balance ❍ Ringing in ears

Do you hear grating sounds? ❍ Yes ❍ No Do you feel pressure or pain behind your eyes? ❍ Yes ❍ No

Do you feel ripping or tearing? ❍ Yes ❍ No Where? _____

Do you have difficulty lifting or turning your head? ❍ Yes ❍ No If so, which direction? ❍ Right ❍ Left ❍ Up ❍ Down

Are you pregnant? ❍ Yes What is your due date? _____ ❍ No ❍ Not Sure First day of last menstrual cycle? _____

List all medications you are taking now, including over the counter medications. _____

_____

Are you allergic to any medication: ❍ Yes ❍ No ❍ Not Sure Please list: _____

_____

Have you ever had any surgeries or hospitalizations? ❍ Yes ❍ No Please List:

Type of Hospitalization/Surgery:	Date:	Type of Hospitalization/Surgery:	Date:
_____	_____	_____	_____
_____	_____	_____	_____

Have you been x-rayed in the last 12 months? ❍ Yes ❍ No Where? _____

Have you seen a chiropractor before? ❍ Yes ❍ No Please list:

Name of Chiropractor:	Date:	Name of Chiropractor:	Date:
_____	_____	_____	_____

Do you have a family physician? ❍ Yes ❍ No Name of physician: _____ Phone number: _____

Address: _____

City/State/Zip: _____

Additional Complaints

Please check all additional complaints that you have at this time:

❍ Digestion Trouble	❍ Neck Stiffness	❍ Neck Pain	❍ Cold Feet	❍ Arthritis	❍ Jaw Pain	❍ HIV (Aids)
❍ Loss of Concentration	❍ Neck Motion Restricted	❍ Irritable	❍ Anxiety	❍ Depression	❍ Insomnia	❍ Diarrhea
❍ Loss of Consciousness	❍ Upper Back Pain/Stiffness	❍ Hypertension	❍ Diabetes	❍ Hepatitis	❍ Convulsions	❍ Other: (List)
❍ Eyes Sensitive to Light	❍ Mid Back Pain/Stiffness	❍ Memory Loss	❍ Flushed Face	❍ Dizziness	❍ Fainting	_____
❍ Heavy Feeling in Head	❍ Low Back Pain/Stiffness	❍ Palpitation	❍ Chest Pain	❍ Nausea	❍ Vomiting	_____
❍ Shortness of Breath	❍ Right/Left Shoulder Pain	❍ Anemia	❍ Nervousness	❍ Cold Hands	❍ Constipation	❍Allergies(List)
❍ Excessive Perspiration	❍ Right/Left Arm Pain	❍ Sinus Trouble	❍ Vision Problems	❍ Loss of Smell	❍ Cancer	_____
❍ Loss of Balance	❍ Right/Left Leg Pain	❍ Headaches	❍ Heart Disease	❍ Loss of Taste	❍ Fatigue	_____

❍ Pins & Needles Arm/Leg **PLEASE SPECIFY LOCATIONS:** ❍ Swelling _____ ❍ Numbness _____

❍ Pain behind Eyes ❍ Bruising _____ ❍ Cuts _____ ❍ Bleeding _____

Do you have, or have you ever had, any diseases or medical problems not listed above? ❍ Yes ❍ No If so, please list: _____

_____

Any additional information you would like the doctor to know before beginning care at Life Chiropractic Center? _____

_____

Emergency Contact

Name: _____ Relation: _____

Contact Number: _____Address:_____

Insurance Information **Give Insurance Card to Receptionist**

Insurance Company: _____ ID Number: _____

Secondary Coverage: _____ ID Number: _____

Personal Information

Address: _____ City: _____ State: _____Zip: _____

❍ Home #: _____ ❍ Cell #: _____ Cell Carrier (Appt. Reminders): _____

❍ Email: _____ (Check best way to contact you)

Sex: ❍ M ❍ F Soc. Security #: _____ Age: _____ Date of Birth: _____

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍Widowed ❍ Separated Spouse Name: _____ # of children: _____

Occupation/Job Title: _____ Employer: _____

Employers address: _____

How were you referred to Life Chiropractic Center? _____

Do you have an attorney? ❍ Yes ❍ No Name: _____

Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at Life Chiropractic (aka R&R Chiropractic LLC) to treat my condition as deemed appropriate. It is understood and agreed the amount paid to the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Life Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care.

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a disc injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for case considered at risk. Treatment is performed carefully to minimize such risk.

Stroke- Stroke is the most serious complication of chiropractic treatment. The most recent studies (*Journal of the CAA*, Vol. 37 No. 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Other Problems- There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my consent to have chiropractic treatment administered to myself or the person named below.

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Interpreter Name Date

NOTICE OF PRIVACY PRACTICES

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

In the course of your care as a patient at Life Chiropractic Center we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, e-mail address, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
- If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office. We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to redisclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a specific form please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information, and are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, or if you would like further information about our privacy policies and practices, please contact:

Dr. Ricky Sikka – Privacy Officer, 34507 Pacific Hwy S, Ste 4, Federal Way WA 98003 (253) 874-4141

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue, and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This office utilizes an "open adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same general adjusting area at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, other arrangements will be made for you.

This notice is effective as of January 2, 2015. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name (Please Print) Signature Date

_____ _____

Parent/Legal Guardian Signature Date