

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:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malaria | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> 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

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

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

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

NONE LIGHT MODERATE HEAVY

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Coffee |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drug |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Exercise |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Soft Drinks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco |

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: _____
(Patient, Guardian* or Authorized Representative*)

DATE: _____

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.

SIGNATURE: _____ DATE: _____

WITNESS BY: _____ DATE: _____

**VOSS CHIROPRACTIC FEE POLICY
INSURED PATIENTS**

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

As a courtesy to our patients, Voss Chiropractic may verify chiropractic insurance benefits with the patients' insurance plan when possible. **It is ULTIMATELY the patients' responsibility to know their benefits and insurance limitations by calling the phone number on the back of the insurance card.** Non-covered benefits will ultimately become the patient's responsibility.

Insurance Information:

Name of Insured: _____

Insurance Company: _____

Adjuster Name: _____

Phone # _____

Claim # _____

My signature below acknowledges I understand the above outlined financial policy.

Patient Signature: _____ Date: _____

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:** _____

Insurance Opt Out

SIGN BELOW IF YOU DO NOT WISH VOSS CHIROPRACTIC TO BILL YOUR INSURANCE COMPANY

I, _____, choose to opt out of my health insurance benefits and have requested that Voss Chiropractic not bill my personal health insurance. I am choosing to pay cash at the time of service for my visit until further notice.

PATIENT SIGNATURE: _____ DATE: _____