Welcome to Health First Chiropractic

Where we support, through chiropractic, each individual's full expression of life and wellness from within.

At Health First Chiropractic we are committed to quality chiropractic care and **advancement through research**. This clinic participates in practice based research and case studies. As a practice member here you are helping to advance the science of chiropractic. All personal information is protected. Health First is not only a researched based clinic, it is also a training facility. Chiropractors come from throughout the U.S. to train in our special approach.

On your first appointment we will perform a complete spinal exam and health history, specific spinal x-rays may be taken if needed. Except in some emergency cases **you will not be adjusted on the first visit**, as we need to assess results from your tests and x-rays in order to provide you with the highest quality chiropractic care.

On your second appointment you will complete the x-ray series, have a clinical consultation with the doctor to review your findings, and he/she will make recommendations for care. Then you will receive your first adjustment. After the adjustment there is a resting period. This appointment will take approximately one and a half hours, so please allow enough time.

Name: _____ **Date:** _____

Health First Chiropractic
Confidential Information

Contact Information Date _____

Name _____ Nickname _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____ SS# _____

Email _____ Occupation _____

Employer _____ Address _____ Phone_____

Spouse Name _____ Spouse Occupation _____

Do you have children? **Please list names and ages** _____

Emergency Contact _____ Phone _____

Office Information

Who referred you to our office? _____
Were you referred to a certain doctor in our office? _____

Is your visit due to an injury? □ No □ Yes *If yes, circle one*: Auto Work Other

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

Do we have permission to contact your other doctors if needed? □ No □ Yes

List other doctors you use for your health care:
Name: _____ Phone Number: _____
Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

Note any auto accidents with dates: _____

Insurance Information
Do you have insurance? □ Yes □ No Company _____

I.D. # _____ Policy Group # _____

Secondary Policy: Company _____

I.D. # _____ Policy Group # _____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if Health First Chiropractic extends credit to me and I understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors at Health First Chiropractic and whomever they may designate as their assistants; to administer treatments as they deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature: _____

INFORMED CONSENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one of more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

There are also potential associated side effects of the chiropractic adjustment, by signing below you acknowledge possible risks and give full informed consent of our chiropractic procedures. Possible associated side effects include: soreness: a nearly always temporary symptom while your body undergoes therapeutic change. Soft tissue injury: rarely a chiropractic adjustment may injure muscle or ligament structures resulting in a temporary increase in pain. Disc Herniation: occasionally chiropractic adjustments may aggravate a herniated disc, yet this problem occurs so rarely that there are no available statistics to quantify their probability. Stroke: Vertebral Basilar Artery (VBA) stroke is a very rare event in the population (1 in 3 million neck adjustments – Journal of the CCA, Vol. 37 No. 2, June, 1993). The increased risks of VBA stroke are likely due to patients with headache and neck pain from a VBA dissection seeking care before their stroke. Recent research has found no evidence of excess risk of VBA stroke associated with chiropractic care compared to primary care. (Spine, Vol. 33 No. 45, 2008)

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I thereby accept chiropractic care on this basis.

Patient's Signature **Date**

Health History

Please mark each item below for each sign and symptom you presently have with an (X) or previously had with (+). Please also include the date.

GENERAL SYMPTOMS
_____ Dizziness
_____ Fainting
_____ Fever
_____ Nervousness
_____ Numbness
_____ Wheezing
_____ Insomnia
Other: _____

NEUROLOGICAL
_____ Headaches
_____ Migraines
_____ Seizures
_____ Convulsions
Other: _____

MUSCLES & JOINTS
_____ Low Back Problems
_____Hip Pain
_____ Pain Between Shoulders
_____ Neck Problems
_____ Arm Problems
_____ Leg Problems
_____ Swollen Joints
_____ Painful Joints
_____ Stiff Joints
_____ Sore Muscles
_____ Weak Muscles
_____ Walking Problems
_____ Sprains/Strains
_____ Broken Bones
_____ Rheumatoid Arthritis
Other: _____

CARDIO-VASCULAR
_____ High Blood Pressure
_____ Heart Attack
_____ Pain Over Heart
_____ Poor Circulation
_____ Heart Trouble
_____ Rapid Heart
_____ Slow Heart
_____ Strokes
_____ Swelling Ankles
_____ Varicose Veins
Other: _____

EAR/NOSE/THROAT
_____ Earache
_____ Ear Noises
_____ Enlarged Thyroid
_____ Frequent Colds
_____ Hay Fever
_____ Nasal Blockage
_____ Nose Bleeds
_____ Pain Behind Ears
_____ Poor Vision
_____ Sinusitis
_____ Sore Throat
_____ Tonsillitis
Other: _____

GASTRO-INTESTINAL
_____ Belching/Gas
_____ Colon Problems
_____ Constipation
_____ Diarrhea
_____ Excessive Hunger
_____ Excessive Thirst
_____ Gall Bladder
_____ Hemorrhoids
_____ Liver
_____ Nausea
_____ Abdominal Pain
_____ Ulcer
_____ Poor Appetite
_____ Poor Digestion
_____ Vomiting
_____ Vomiting Blood
_____ Black Stool
_____ Bloody Stool
_____ Weight Loss/Gain
Other: _____

PSYCHIATRIC
_____ Depression
_____ Anxiety
_____ Mood Swings
_____ Hallucinations
_____ Attention Issues
_____ Panic Attacks
_____ Stress
Other: _____

RESPIRATORY
_____ Asthma
_____ Emphysema
_____ Chronic Cough
_____ Difficulty Breathing
_____ Spitting Blood
_____ Spitting Phlegm
Other: _____

GENITO-URNIARY
_____ Blood in Urine
_____ Kidney Infection
_____ Painful Urination
_____ Prostate Problems
_____ Loss of Bladder Control
_____ Genital Concerns
Other: _____

SKIN OR ALLERGIES
_____ Boils
_____ Bruising Easily
_____ Dryness
_____ Eczema/Rash/Dermatitis
_____ Hives
_____ Itching
_____ Sensitive Skin
_____ Allergy

EYES
_____ Glasses/Contacts
_____ Eye Concerns
Other: _____

FOR WOMAN ONLY
_____ Irregular Cycle
_____ Painful Periods
_____ Pregnant at This Time

Are there any other health concerns you would like to address? _____
_____
_____
_____

On a scale of 1-10, how committed are you to resolving this complaint?
_____

I hereby certify that the statements and answers given are accurate to the best of my knowledge and understand that it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation and provide me with chiropractic care.

Patient Signature: _____ Date: _____

Health History Continued

Name: _____ Date: _____

Have you ever received chiropractic care? Y / N If yes, please list where and what year: _____

Primary reason for seeking chiropractic care now? _____

_____

Secondary reason: _____

Other reasons: _____

Past Health History: Please be as complete as possible

Previous illnesses you've had in your life: _____

_____

Previous injuries or trauma with dates: _____

_____

Previous broken bones with dates: _____

_____

List any allergies: _____

List any medication, vitamins, supplements, homeopathic remedies and herbs and what condition it is for: _____

_____

_____

_____

Social/Occupational History: These are important in prevention and often times finding the cause and cure.

Occupation: _____

Recreational activities/Exercise habits: _____

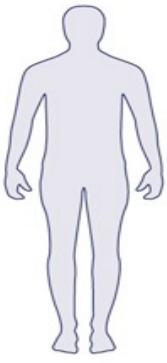
_____

Eating habits: _____

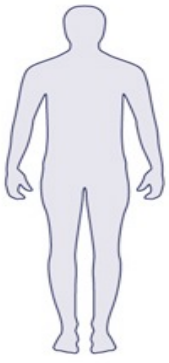
Are you a smoker of any kind? If yes, please list what and how often: _____

_____

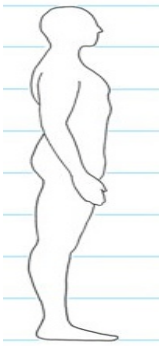
Please mark with an (X) areas of discomfort, pain, numbness or tingling:



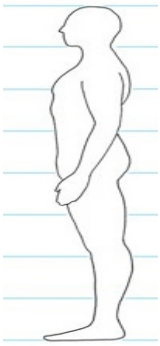
FRONT



BACK



Right Side



Left Side

Notices of Privacy Practices

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

Health First is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations (example)

> "On occasion, it may be necessary to seek consultation regarding your treatment from other health care providers associated with Health First Chiropractic"
>
> "It is our policy to provide a substitute health care provider, authorized by Health First Chiropractic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness or other emergency situation."

Due to the nature of Health First Chiropractic's open adjustment areas, others may overhear conversations between the doctor and patient although every effort will be made to avoid loss of confidentially. At any time you may request a private consultation with the doctor.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> "As a courtesy to our patients, we will submit an itemized statement to your insurance center for the purpose of payment to Health First Chiropractic for health care services rendered. If you pay for your health care services personally we will, as a courtesy to you, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information including diagnosis, date of injury or condition, and codes which may describe the health care services received."

Research
This office is engaged in clinical research. Please carefully read the authorization to use and disclose individual health information for research purpose and initial where indicated.

1. Purpose. As a research participant, I authorize Health First Chiropractic and the researcher's staff to use and disclose my individual health information for the purpose of conducting the research.

2. Individual Health Information to be Used or Disclosed. I understand that my social security number will not be disclosed. Individual health information that may be used or disclosed to conduct this research includes: any data/information necessary to demonstrate therapeutic benefit, included but not limited to; Spinal Ranges of Motion, X-ray, Leg Length Imbalances, Rand-36 1.0 scores.

3. Parties Who May Disclose My Individual Health Information.
The researcher and the researcher's staff may obtain my individual health information from other healthcare providers, such as laboratories, which are a part of this research, as well as healthcare providers that are not part of this research (other doctors, hospitals and/or clinics) for the purposes of carrying out this research study. I authorize these parties to disclose my individual health information to the researcher and the researcher's staff for the purposes of carrying out this research.

4. Parties Who May Receive or Use My Individual Health Information. The individual health information disclosed by parties in item 3 and information disclosed by me during the course of the research may be received and used by Health First Chiropractic and the researcher's staff

5. Right to Refuse Participation. I do not have to participate in research study. If I decide not to participate, I may not receive research related treatment that is provided through the study. However, my decision not to participate will not affect any other treatment, payment, or enrollment in health plans or eligibility for benefits.

6. Right to Revoke. I can change my mind and withdraw this authorization at any time by sending a written notice to Health First Chiropractic to inform the researcher of my decision. If I withdraw this authorization, the researcher may only use and disclose the protected health information already collected for this research study. No further health information about me will be collected by or disclosed to the researcher for this study.
Address to send written right to revoke:

Health First Chiropractic
700 Murdock St. Suite B
Sedro Woolley WA 98284

7. Potential for Re-disclosure. Once my health information is disclosed under this authorization, there is a potential that it will be re-disclosed outside this study and no longer covered by this authorization. However, the research team and the Institutional Review Board (the committee that reviews studies to be sure that the rights and safety of study participants are protected) are very careful to protect your privacy and limit the disclosure of identifying information about you.

7A. Also, there are other laws that may require my individual health information to be disclosed for public purposes. Examples include potential disclosures if required for mandated reporting of abuse or neglect, judicial proceedings, health oversight activities and public health measures.

8. [Optional Item] **Suspension of Access**. I may not be allowed to review the information collected for this study, including information recorded in my medical record, until after the study is completed. When the study is over, I will have the right to access the information again.

This authorization does not have an expiration date.

I am the research participant or personal representative authorized to act on behalf of the participant.

_____ _____
signature of research participant or research participant's personal representative — date

_____ _____
printed name of research participant or research participant's act on personal representative — description of personal representative's authority to on behalf of the research participant

Worker's Compensation
We may disclose your health information as necessary to comply with State Workers Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or your death.

Public Health
As required by law, we may disclose your health information to public health authorities for the purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infectious exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order of subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lesson a serious and imminent threat to the health or safety of a particular person or to the general public

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

> "As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."
>
> "It is our practice to participate in charitable events to raise awareness, food donations, etc. During these times, we may need to send you a letter, post card or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Health First Chiropractic Clinic sponsored fund-raising events."

Change of Ownership
In the event that Health First Chiropractic Clinic is sold or merged with another organization, your health information will become the property of the new owner.

<u>Your Health Information Rights</u>

- ❑ You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Health First Chiropractic Clinic is not required to agree to the restriction you requested.
- ❑ You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- ❑ You have the right to inspect and receive a copy of your health information.
- ❑ You have the right to request that Health First Chiropractic Clinic amend your protected health information. Please be advised, however, that Health First Chiropractic Clinic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- ❑ You have the right to receive an accounting of disclosures of your protected health information made by Health First Chiropractic Clinic

- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Health First Chiropractic Clinic reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all the information that it maintains. Until such an amendment is made, Health First Chiropractic Clinic is required by law to comply with this Notice.

Health First Chiropractic Clinic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights

Complaints

Complaints about your Privacy rights, or how Health First Chiropractic Clinic has handled your health information should be directed to Sheila Neill by calling this office at 360-855-1021. If she is not available you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, SW
Room 509F HHH Building
Washington, D.C. 20201

I have read the Privacy Notice and understand my rights contained in the notice

By way of my signature, I provide Health First Chiropractic Clinic with my authorization and consent to use and disclose my protected health care information for the purposes of the treatment, payment and health care operations as described in the Privacy Notice

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_____ _____

Patient's Name (print) Date

_____ _____

Patient's Signature Date

NAME_____ **DATE**_____ **COMPULINK #**_____

☐ ROF ☐ 6 WK ☐ 12 WK ☐ 6 MTH ☐ YR ☐ PIP

1. In general, would you say your health is:
   - Excellent 1
   - Very Good 2
   - Good 3
   - Fair 4
   - Poor 5

2. **Compared to 1 year ago**, how would you rate your health in general **now**?
   - Much better now than 1 year ago 1
   - Somewhat better now than 1 year ago 2
   - About the same 3
   - Somewhat worse now than 1 year ago 4
   - Much worse now than 1 year ago 5

The following items are about activities you might do during a typical day. **Does your health now limit you in these activities? If so, how much?**

CIRCLE ONE NUMBER ON EACH LINE

	Yes Limited a lot	Yes limited a little	No not limited at all
3. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
4. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	1	2	3
5. Lifting or carrying groceries	1	2	3
6. Climbing **several** flights of stairs	1	2	3
7. Climbing **one** flight of stairs	1	2	3
8. Bending, kneeling or stooping	1	2	3
9. Walking **more than a mile**	1	2	3
10. Walking **several blocks**	1	2	3
11. Walking **one block**	1	2	3

12. Bathing or dressing yourself 1 2 3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**

	CIRCLE ONE NUMBER ON EACH LINE	
	Yes	**No**
13. Cut down the **amount of time** you spend on work or other activities	1	2
14. **Accomplished less** than you would like	1	2
15. Were limited in the **kind** of work or other activities	1	2
16. Had **difficulty** performing the work or other activities (for example it took extra effort)	1	2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)

	CIRCLE ONE NUMBER ON EACH LINE	
	Yes	**No**
17. Cut down the **amount of time** you spend on work or other activities	1	2
18. **Accomplished less** than you would like	1	2
19. Didn't do work or other activities as **carefully** as usual	1	2

20. During the **past 4 weeks**, to what extent has your physical health or emotional problem interfered with your normal social activities with family, friends, neighbors or groups?
    - Not at all 1
    - Slightly 2
    - Moderately 3
    - Quite a bit 4
    - Extremely 5

21. How much **bodily** pain have you had in the **past 4 weeks?**
    - None 1
    - Very mild 2
    - Mild 3
    - Moderate 4
    - Severe 5
    - Very severe 6

22. During the **past 4 weeks**, how much did **pain** interfere with your normal work (Including work outside the house **and** housework)

Not at all 1
Slightly 2
Moderately 3
Quite a bit 4
Extremely 5

These questions are about how you feel and how things have been with you **during the last 4 weeks.** For each question, please give the 1 answer that comes closest to the way you have been feeling. **How much of the time during the last 4 weeks...**

CIRCLE ONE NUMBER ON EACH LINE

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.) ?

All of the time 1
Most of the time 2
Some of the time 3
A little of the time 4
None of the time 5

How TRUE or FALSE is *each* of the following statements for you?

CIRCLE ONE NUMBER ON EACH LINE

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a lot easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse.	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

Patient Signature: _____ DATE: _____