ENERGIZE CHIROPRACTIC + WELLNESS

CHIROPRACTIC INTAKE

PATIENT INFORMATION

Patient Name _____

Address _____

City_____State _____Zip:_____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age ___ Birthday_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School _____

Occupation_____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today?

_____

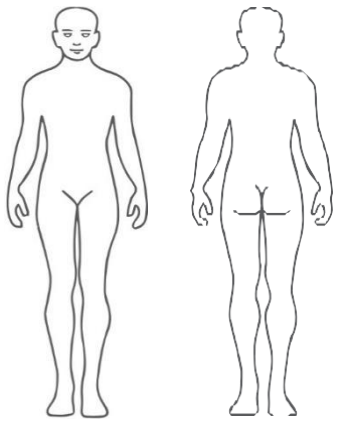
If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness ☐ Sharp

☐ Tingling ☐ Shooting

☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing

☐ Aching ☐ Stabbing

☐ Cramping ☐ Swelling

☐ Nagging ☐ Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

NOT COMMITED — VERY COMMITED

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONGTERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____

ALLERGIES

_____

_____

_____

MEDICATIONS

_____

_____

_____

SUPPLEMENTS

_____

_____

_____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly under-stand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

_____ _____

SIGNATURE: DATE:

_____ _____

GUARDIAN AUTHORIZING CARE SIGNATURE: DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ WORKERS COMP ❑ AUTO INSURANCE ❑ MEDICARE ❑ HEALTH INSURANCE

ENERGIZE CHIROPRACTIC + WELLNESS

AUTHORIZATION

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room 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. The environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters. In the event you or someone else would not agree with us, we are providing this disclosure.

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 healthcare and health information. If you choose not to be adjusted in an open adjusting environment, other arrangements will be made for you.

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care, a health oriented newsletter, 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 different form, please advise us in writing as to your preferences.

The use of this information is intended to make your experience with our office more efficient, productive, and to further enhance your access to quality healthcare.

Your decision will have no adverse effect on our care from Energize Chiropractic + Wellness or on your relationship with our staff.

This notice is effective as of April 14, 2015. This notice, and any alterations or amendments hereto will expire 15 years after the date upon which the record was created.

Your signature indicates your authorization of this activity.

_____

Name (printed) **Signature** **Date**

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Energize Chiropractic + Wellness
Privacy Policy

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
In the course of your care as a patient at Energize Chiropractic + Wellness (ECW), we may use or disclose personal and health related information about you in the following ways:
• Your personal 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 your services).
• Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or other health related information that may be of interest to you.

You have the 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. If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:
• If we are providing health care services to you based on the orders of another health care provider.
• 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 that you intend for us to provide care.
• If we are ordered by the courts or another appropriate agency

You have the right to receive an accounting of any such disclosures made by this office.
Any use or disclosure of your of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.
Information that we use or disclose based on this privacy notice may be subject to re-disclosure 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 care 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 different 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.
We reserve the right to alter or amend to 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 our files.
If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Jeremy Meadows D.C.

If you would like further information about our privacy policies and practices please contact: Dr. Jeremy Meadows D.C.
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 adjusting room 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 this is NOT the environment used for taking patient histories, providing examinations or presenting report 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 April 10 2015. This notice, and any alterations or amendments made hereto, will expire 15 years after the date upon which the record was created

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Description of the authority to act on behalf of the patient

MECHANISM OF INJURY QUESTIONNAIRE

Name:_____
Date of Collision:_____ Time: _____
Place: _____
Intersecting with: _____

Police Investigation by:
☐ Washington State Patrol ☐ _____ City Police
☐ _____ County Police ☐ No investigation

Please describe, to the best of your knowledge, what happened during this collision:
_____
_____
_____

What is the last thing you remember before the collision?_____
_____

What is the next thing you remember after the collision? _____
_____

What type of car were you in? (Year, make and model) _____

What type of car impacted with your vehicle? (Year, make and model)_____

Road conditions at time of accident: ☐ Wet ☐ Dry ☐ Icy
☐ Other—Describe: _____

Where were you seated in vehicle? _____

Were you aware of the approaching collision prior to impact or did the impact catch you by surprise? ☐ Aware ☐ Surprise

Were you wearing a seat belt? ☐ Yes ☐ No
If so, what type? ☐ Lap belt only ☐ Shoulder and lap belt

Did you have any bruising or tenderness on your body in the area of the seatbelt following the collision? ☐ Yes ☐ No, please describe:_____
_____

Was your vehicle equipped with headrests? ☐ Yes ☐ No

How far is the top of the headrest from the top of your head?
Approximately ____ inches above Approximately ____ inches below

Was the headrest altered or damaged in the collision? ☐ Yes ☐ No

Did your head go back over the top of the headrest? ☐ Yes ☐ No ☐ Unsure

Is your car equipped with an air bag? ☐ Yes ☐ No
If yes, did the air bag activate? ☐ Yes ☐ No

If yes, did you receive any injury from the airbag? ☐ Yes ☐ No, please describe_____
_____

Were you struck:
☐ Behind ☐ Front ☐ Driver side ☐ Passenger side ☐ Other _____

Was your car stopped at the time of impact? ☐ Yes ☐ No
If no, then estimate the speed of the vehicle you were in: _____ mph
If yes, was the driver's foot on the brake? ☐ Yes ☐ No
If your foot was on the brake, was it pressing down ☐ slightly ☐ moderately ☐ strongly

If your vehicle was moving at the time of impact, was it slowing down? ☐ Yes ☐ No
If no, was your vehicle accelerating speed? ☐ Yes ☐ No
Was it traveling at a steady rate of speed at the time of impact? ☐ Yes ☐ No _____ mph

Was your vehicle pushed forward from the impact? ☐ Yes ☐ No If yes, how much?
☐ More than one car length _____☐ One car length
_____☐ One-half car length ☐ Less than one-half car length
_____☐ Not at all

Did your car hit anything else after the first impact?_____

What is the cost damage to the vehicle you were in?_____

What of the following car parts broke during the accident? _____

a.	Windshield	_____	d.	Front seat back	_____
b.	Right/Left side window	_____	e.	Other	_____
c.	Steering wheel	_____	f.	Other	_____

Was the other vehicle moving at the time of the collision? ☐ Yes ☐ No
If yes, what was its approximate speed? Approximately _____ mph

If the other vehicle was moving at the time of collision, was it:
☐ Slowing down? ☐ Gaining speed? ☐ Steady speed?

What direction was your head pointed at the time of the collision? _____

What was the position of your hands at the time of the collision? _____

What was the position of your legs at the time of the collision? _____

Were you wearing a hat or eyeglasses at the time of the collision? ☐ Yes ☐ No

What bruises or cuts did you get from this collision?_____
_____
On what part of the automobile did the following body parts hit:
A. Head hit _____
B. Chest hit _____
C. Right/left shoulder hit_____
D. Right/left arm hit _____
E. Right/left hip hit _____
F. Right/left leg hit _____
G. Right/left knee hit _____
H. Other _____
_____
What hurts? _____
_____
_____
When did you first notice pain or symptoms?_____