23100 Pacific Hwy S Ste 201 Des Moines WA 98198
206-824-9500 / Fax 206-824-9654

Today's Date:_____

Welcome to Midway Chiropractic!

Your path to wellness begins now! Please complete this packet as best as you can. If you have any questions please let the staff know.

Last Name:	First:	Middle Initial:	Name you go by:
Birthdate:	Sex:	SSN:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed
Street Address:	City:	State:	ZIP:
Contact Phone:	Other Phone:	Email:	
How did you find out about us?	☐**Doctor:**_____ ☐**Family/Friend:**_____ ☐**Insurance Directory** ☐**Internet** ☐**Other:**_____		
I work / go to school: ☐**Full time** ☐**Part time**	Name of employer / school:	Phone/Fax:	
Emergency Contact Name:	Relation to you:	Contact Phone:	

Billing Information

Please select one or more options below:

☐ **I'm a returning patient (Welcome back!) and I'm updating my information**

☐ **I have health insurance. / ☐ I don't have health insurance.**

Please provide the front staff with your insurance card and driver's license.

It is our clinic policy to retain all private health insurance information regardless of claim type.

☐ **I was in an auto accident.** Do you have car insurance? □ Yes □ No Date of Accident:___/___/_____

Name of your car insurance company:_____

Claim#:_____**Name and number of representative:**_____

Was someone else at fault? □ Yes □ No

Name of other person:_____

Name of other person's car insurance:_____**Claim#:**_____

Name and number of representative for other company:_____

☐ **I was injured at work** Do you already have a claim? □ Yes □ No Date of Injury:___/___/_____

Claim#:_____**Claims Manager Name and number:**_____

Attending Physican Name:_____

Do you have an attorney? □ Yes □ No

Law office Name:_____**Phone#:**_____**Fax#:**_____

My Attorney's Name:_____

Payment must be made at time of service. We accept cash, debit, credit, and personal checks.

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 for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

I understand the massage given here is for the purpose of relief from muscular tensions or spasm, and for increasing circulation. I understand the massage practitioner does not diagnose illness, disease, or other physical or mental disorder. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor perform spinal manipulations. I understand massage is not a substitute for medical examinations and diagnosis, and that it is recommended to see a physician for any physical ailment I may have. Because a massage practitioner must be aware of existing conditions, I have stated all of my known medical conditions and take it upon myself to keep the practitioner updated on my physical, mental, and emotional health.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I have read and fully understand the above statements and therefore accept chiropractic care on this basis. I agree that financial responsibility for my treatment is ultimately my own.

I agree that a fee may be charged if I cancel my appointment less than 24 hours before it begins.

Patient / Guardian Signature:_____

Printed Name:_____

Date:_____

Consent to evaluate and adjust a minor child:

I, the above signed, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Name:_____

Health History

Please answer the following questions to help us better evaluate your condition for the best healthcare possible.

Have you ever been treated by a chiropractor before? YES NO

If yes how long ago and why? _____

Do you know what may have caused today's pain? (Brief Summary, please include estimated dates if possible)

_____

_____

Have you seen any other medical provider for this condition? YES NO

If yes, please list

Did the above listed providers help improve your condition? (Brief Explanation of your experience)

_____

_____

Please list all the medications or supplements, that you are currently taking, as well as any you have taken in the recent past.

Have you ever had any of the following medical conditions?

Eruption (rash) hives	Y	N	Asthma/hay fever	Y	N	Back or neck problems	Y	N
Glaucoma	Y	N	Persistent cough or sore throat	Y	N	Arthritis/rheumatism	Y	N
Loss of Hearing	Y	N	Difficulty breathing while laying down	Y	N	Hepatitis	Y	N
Ringing in ears	Y	N	Diabetes	Y	N	Ulcers	Y	N
Frequent nosebleeds	Y	N	Thyroid condition/goiter	Y	N	Kidney disease	Y	N
Sinus problems	Y	N	Chest pain/discomfort	Y	N	Venereal disease	Y	N
Stroke	Y	N	Heart attack/trouble	Y	N	Radiation therapy	Y	N
Headaches	Y	N	Shortness of breath	Y	N	Tumors or growths	Y	N
Convulsions/epilepsy	Y	N	High blood pressure	Y	N	Cancer	Y	N
Fainting	Y	N	Congenital heart disease	Y	N	A.I.D.S.	Y	N
Psychiatric treatment	Y	N	Artificial heart valve	Y	N	H.I.V. positive	Y	N
Tuberculosis	Y	N	Pacemaker	Y	N	Other _____		
Emphysema	Y	N	Heart surgery	Y	N			

Please list any other medical conditions you suffer, or have suffered from in the past.

_____

If you have had any surgeries or major medical treatments, please list them here with approximate dates.

Have you ever had any serious injuries? Please list them with approximate dates.

_____

_____

Are you currently wearing any kind of foot support? (Heel lifts, Arch Supports, etc.) YES / NO

Women - Are you pregnant? YES NO If yes, how long?_____ Nursing? YES NO Are you taking oral contraceptives? YES NO

Do you exercise regularly or participate in any sports? YES NO

Have you ever had a professional massage? YES NO

Signature:_____ Date:_____

Name:_____

Pain/Discomfort Rating Scale

Please choose the number which best describes your pain in each of the questions below

(0= No Pain 10= Unbearable Pain)

What is your pain/discomfort RIGHT NOW?

HEADACHE	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10
UPPER BACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10

What is your pain/discomfort TYPICAL OR AVERAGE?

HEADACHE	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10
UPPER BACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10

What is your pain/discomfort AT ITS WORST?

HEADACHE	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10
UPPER BACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10

PAIN DISABILITY INDEX QUESTIONNAIRE

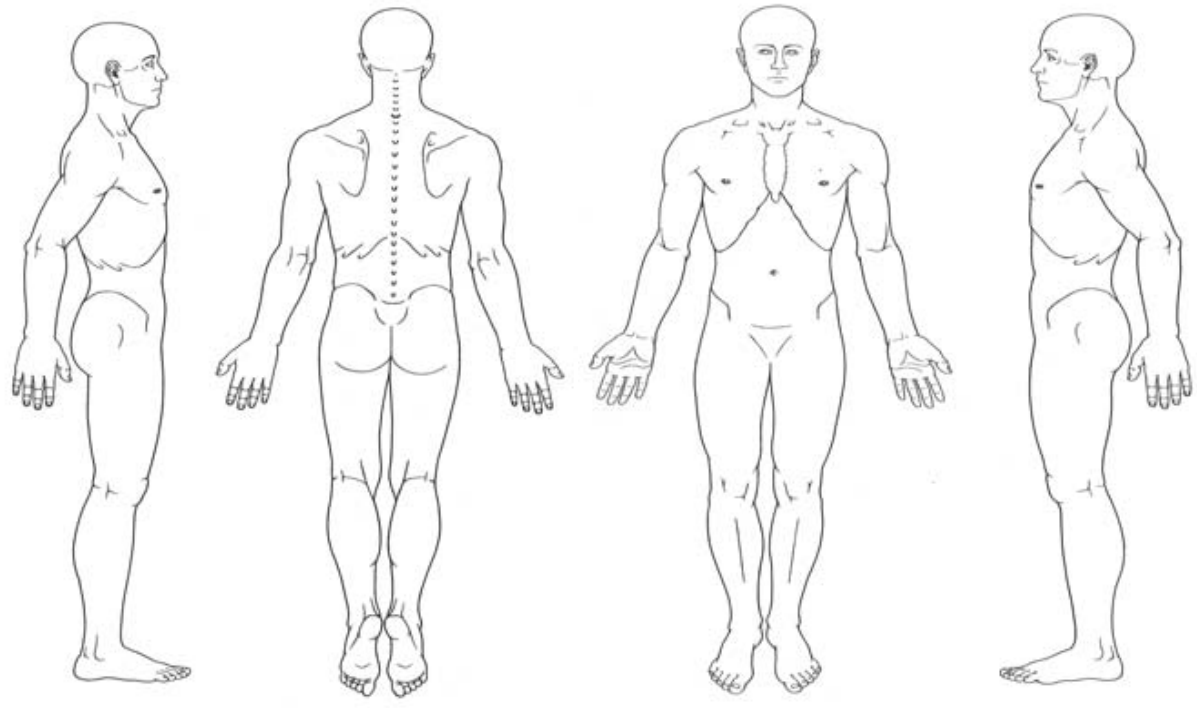
PLEASE USE THE LETTERS BELOW TO MARK THE AREAS IN WHICH YOU FEEL THE CORRESPONDING SENSATIONS.

A = ACHE **B** = BURNING

S = STABBING **P** = PINS/NEEDLES

O = OTHER **N** = NUMBNESS

COLOR IN AREAS TO INDICATE BRUISING



PATIENT SIGNATURE:_____ DATE:_____

DOCTOR SIGNATURE:_____

PATIENT-SPECIFIC FUNCTIONAL SCALE

NAME:_____

We want to know what 3 activities in your life you are unable to perform, or are having the most difficulty performing, as a result of your chief problem.

In the 3 boxes below marked “Activity”, write down 3 different activities that are being affected by your problem. You can choose any activity you like, such as running, using the computer, washing the dishes, lifting your children, or even simply sitting.

10 MEANS YOU ARE PERFECTLY FINE AND 0 MEANS YOU CAN’T DO IT!!!

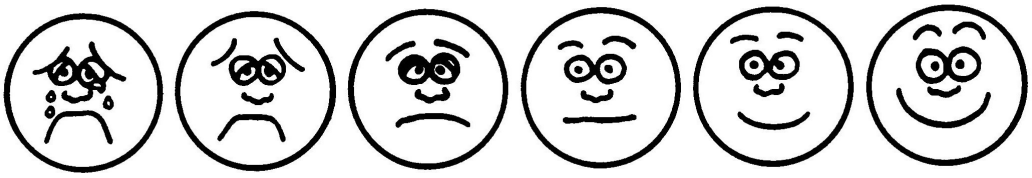
ACTIVITY 1	SCORE
ACTIVITY 2	SCORE
ACTIVITY 3	SCORE

After you’ve listed your activities, now it’s time to *score* them. Look at the number scale below. On this scale, **0** means that you can’t do your activity at all, for example you can’t sit because of your problem. **10** would mean that you can sit normally, like before your problem started. Using the scale, write a number to the right of each activity above. After you finish, sign your name at the bottom of this form and you’re done!

Unable to Perform Activity

Able to Perform Activity At Same Level As Before Injury/Problem

0 1 2 3 4 5 6 7 8 9 10



IMPORTANT: PLEASE READ THIS FORM CAREFULLY. IT MUST BE COMPLETED BEFORE YOU CAN BEGIN/CONTINUE TREATMENT.

PATIENT SIGNATURE:_____ DATE:_____

DOCTOR SIGNATURE:_____

MIDWAY CHIROPRACTIC

Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights. **We are required by federal law to include this notice.**

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our chiropractic care operations. Your personal health information will never be otherwise given to anyone- even family members- without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality chiropractic care, Implement payment activities, conduct normal chiropractic practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use our information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

PATIENT RIGHTS

You have a right to request copies of your health care information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies the amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services. We thank you for being a patient here. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

SIGNATURE:_____ DATE:_____