Back to Health Chiropractic & Massage Clinic

Your Information:

Name: _____ Social Security #: _____-_____-_____

Address: _____

City: _____State: _____ Zip Code: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Would you like appointment reminders via text? ❑ Yes ❑ No **If yes, carrier: _____**

Disclaimer: Standard text messaging rates may apply. We use the information for appointment reminders only.
Please let the Front Desk know if you no longer wish to receive text appointment reminders.

Email: _____ Right or Left Handed: ❑ Right ❑ Left

Birthdate: _____/_____/_____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Employer: _____

Family Information: (Please check one) ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

How were you referred to our clinic? _____

Insurance Information:

Have you opened a claim through your auto insurance company? ❑ Yes ❑ No

Auto Insurance Company: _____ Phone #:(_____) _____-_____

Claim #: _____ Policy #: _____

Attorney Information:

Have you retained an attorney? ❑ Yes ❑ No

If yes, attorney's name: _____ Phone #:(_____) _____-_____

Were there any witnesses? ❑ Yes ❑ No

If yes, please list their names and phone numbers.

Name: _____ Phone #: (_____) _____-_____

Name: _____ Phone #: (_____) _____-_____

Was the police notified? ❑ Yes ❑ No

If yes, who was the investigation done by: _____

Who was at fault in the accident? ❑ Self ❑ Driver of car you were in ❑ Other driver

Other Driver's Information:

Name: _____ Phone #: (_____) _____-_____

His/Her Insurance Company: _____

Claim #: _____ Policy #: _____

Accident Information:

1. Date of accident: _____/_____/_____ Time of day: _____ ❑ A.M. ❑ P.M.
2. Were you: (check one) ❑ Driver ❑ Passenger If passenger, ❑ Front seat ❑ Rear seat
3. Number of people in your vehicle? _____ Number of people in **other** vehicle? _____
4. Road conditions at accident? ❑ Wet ❑ Dry ❑ Icy ❑ Other _____

Road surface at accident? ❑ Asphalt ❑ Gravel ❑ Dirt ❑ Other _____

5. What direction were **you** headed? ❑ North ❑ South ❑ East ❑ West

What state did the accident happen in? ❑ Washington ❑ Oregon ❑ Other _____

Accident Information Continued…

Name of street or hi-way accident happened? _____

6. What direction was the **other vehicle** headed? ❑ North ❑ South ❑ East ❑ West

7. Were **you** struck from? ❑ Behind ❑ Front ❑ Left side ❑ Right side

8. Were **you** wearing a seat belt? ❑ Yes ❑ No If yes, ❑ Lap belt ❑ Shoulder belt ❑ Both

Any bruising or soreness from the belt? ❑ Yes ❑ No If yes, explain _____

9. Did **your** airbags activate? ❑ Yes ❑ No ❑Car does not have airbags

Any bruising or soreness from the airbag? ❑ Yes ❑ No If yes, explain _____

10. **Your** position at time of impact? ❑ Facing forward ❑ Head turned, to the ❑ Right or ❑ Left ?

11. Does **your** car have a headrest? ❑ Yes ❑ No

If yes, about how far was the top of the headrest from the top of your head? _____inches ❑ above ❑ below

12. Were **you** knocked unconscious? ❑ Yes ❑ No **If yes**, for how long? _____

13. Were **you** aware of the approaching impact? ❑ Yes ❑ No

If yes, did **you** brace yourself for impact? ❑ Yes ❑ No If yes, how? _____

14. Was **your** vehicle stopped at time of impact? ❑ Yes ❑ No

If yes, was **driver's** foot on the brake pedal? ❑ Yes ❑ No ❑ Not sure

on the clutch pedal? ❑ Yes ❑ No ❑ Not sure

If yes, did **your** vehicle move forward on impact? ❑ Yes ❑ No ❑ Not sure

If vehicle was moving at time of the impact, were **you** (Please check one)

❑ Gaining speed ❑ Slowing down ❑ Traveling at a steady speed

15. What was **your vehicle's** approximate speed? _____ miles per hour

16. Did **your vehicle** hit a second car? ❑ Yes ❑ No

another object? ❑ Yes ❑ No

17. Was the **other vehicle** moving at time of collision? ❑ Yes ❑ No

If yes, was the **other vehicle** (Please check one)

❑ Gaining speed ❑ Slowing down ❑ Traveling at a steady speed

18. What was the **other vehicle's** approximate speed? _____ miles per hour

19. What type/make of vehicle were **you** in?

_____

20. What type/make of **other vehicle**?

_____

21. In your own words, please describe the accident. Please include what you heard, saw, and felt.

_____

_____

_____

_____

_____

_____

_____

_____

22. Please diagram the accident including street names, car directions, street signs, etc.

NORTH

WEST **EAST**

SOUTH

23. Please describe how you felt:
Did you feel pain DURING the accident? ❑ Yes ❑ No
If yes, please explain _____
Did you feel pain IMMEDIATELY AFTER the accident? ❑ Yes ❑ No
If yes, please explain _____
Did you feel pain LATER THAT DAY after the accident? ❑ Yes ❑ No
If yes, please explain _____
Did you feel pain the DAY AFTER the accident? ❑ Yes ❑ No
If yes, please explain _____
24. Estimated cost of damage to your vehicle? $_____
Do you have photos showing the damage? ❑ Yes ❑ No

25. Which of the following body parts were hit/injured during the accident? (Please check all that apply)

❑ Head	❑ Right arm	❑ Right leg
❑ Chest	❑ Left arm	❑ Left leg
❑ Right shoulder	❑ Right hip	❑ Right knee
❑ Left shoulder	❑ Left hip	❑ Left knee
		❑ Other _____

26. Which of the following car parts were damaged **by your body** during the accident?
(Please check all that apply)

❑ Windshield	❑ Front seat
❑ Steering wheel	❑ Back seat
❑ Right side window	❑ Other _____
❑ Left side window	❑ Other _____

27. Did you have any physical complaints BEFORE THE ACCIDENT? ❑ Yes ❑ No
If yes, please describe in detail: _____
_____
_____
28. Do you have congenital (from birth) factors which relate to this problem? ❑ Yes ❑ No
If yes, please explain _____
_____

29. Do you have any previous illnesses relating to this case? ❑ Yes ❑ No
If yes, please explain _____
30. Did you receive **EMERGENCY** care pertaining to the accident? ❑ Yes ❑ No
If yes, please list where, the doctor's name and what type of treatment you received;
Where: _____Doctor's name: _____
Type of treatment: _____
Were you taken by an ambulance to the hospital? ❑ Yes ❑ No
31. Have you been treated by another doctor since the accident? ❑ Yes ❑ No
If yes, please list the doctor's name and treatment: _____
32. Since this injury occurred, are symptoms: ❑ Improving ❑ Getting worse ❑ Same

33. Please check all the symptoms that you have noticed **since** the accident:

❑ Headache	❑ Chest pain	❑ Sleeping problems
❑ Neck pain	❑ Foot pain	❑ Head seems heavy
❑ Neck stiffness	❑ Leg pain	❑ Depression
❑ Upper back pain	❑ Numbness in arms	❑ Nervousness
❑ Middle back pain	❑ Numbness in fingers	❑ Loss of smell
❑ Low back pain	❑ Numbness in legs	❑ Ears ring
❑ Hip pain	❑ Numbness in toes	❑ Shortness of breath
❑ Knee pain	❑ Pins/needles in arms	❑ Eyes sensitive to light
❑ Loss of memory	❑ Pins/needles in legs	❑ Loss of taste
❑ Shoulder pain	❑ Feet cold	❑ Face flushing
❑ Elbow pain	❑ Fatigue	❑ Cold sweats
❑ Wrist pain	❑ Dizziness	❑ Fever
❑ Arm pain	❑ Fainting	❑ Diarrhea
❑ Hands cold	❑ Irritability	❑ Right leg

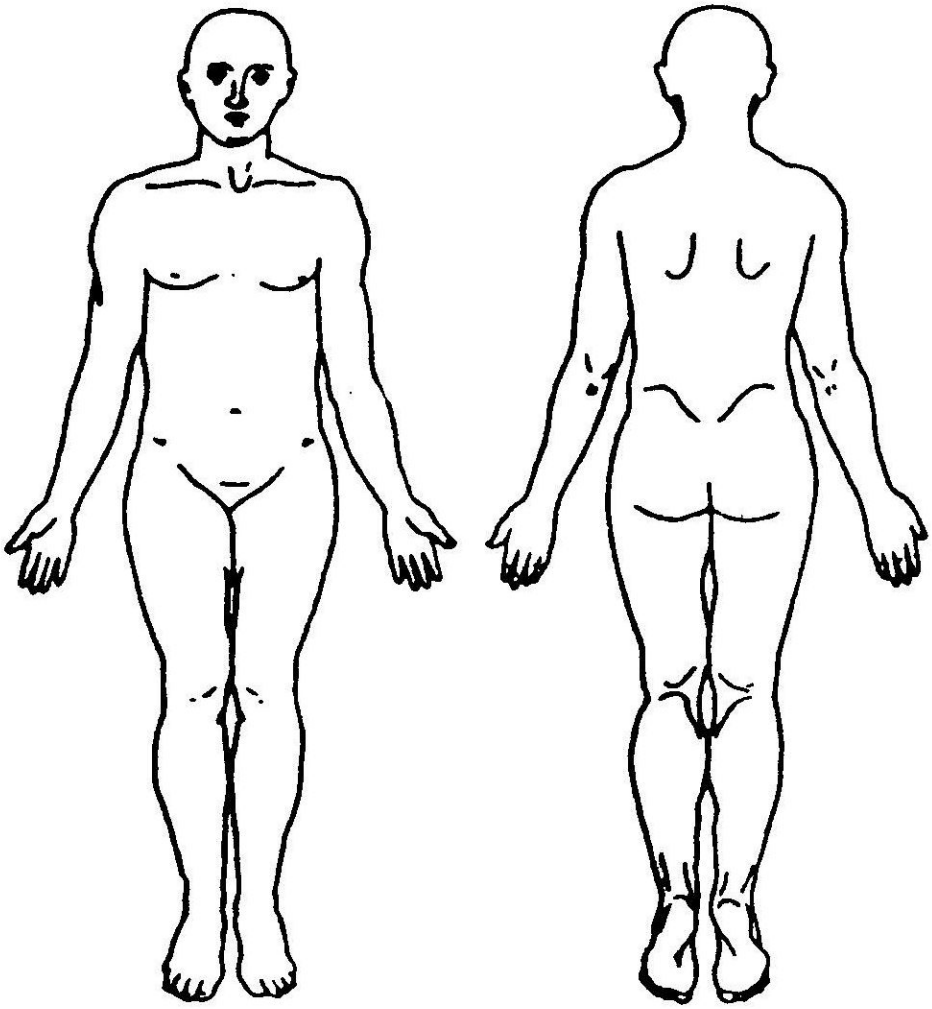
34. Have you lost time from work as a result of the accident? ❑Yes ❑No
If yes, when were you off from work? From _____to_____
Are you being compensated for lost time? ❑No ❑Yes, On medical release? ❑No ❑Yes

35. Since the accident, do you notice any activity restrictions in your capacity for:
Work? ❑No ❑Yes, please explain_____
_____
Family? ❑No ❑Yes, please explain_____
_____
Recreation? ❑No ❑Yes, please explain_____
_____
36. Other pertinent information? _____
_____
37. Have you even been involved in an accident before? ❑No ❑Yes
If yes, Date of accident(s)_____ Type of accident(s)_____
Injury(s)? _____

COMPLETE THE FOLLOWING:

38. Please fill in current areas of complaint, by placing the appropriate abbreviated letter on the people diagrams below:

P=Pain
B=Burning
S=Stiffness
T=Tingling
N=Numbness



Front **Back**

Previous Health History: (Please check Yes or No)

- ❑ Yes ❑ No Anemia/Radiation Treatment
- ❑ Yes ❑ No Artificial Bones/ Joints
- ❑ Yes ❑ No Artificial Valves
- ❑ Yes ❑ No Blood Transfusion
- ❑ Yes ❑ No Cancer/ Chemotherapy
- ❑ Yes ❑ No Congenital Heart Defect
- ❑ Yes ❑ No Diabetes/ Tuberculosis (TB)
- ❑ Yes ❑ No Drug/ Alcohol Abuse
- ❑ Yes ❑ No Emphysema/ Glaucoma
- ❑ Yes ❑ No Epilepsy/ Seizures/ Fainting
- ❑ Yes ❑ No Fever Blisters/ Herpes
- ❑ Yes ❑ No Heart Attack/ Stroke
- ❑ Yes ❑ No Heart Murmur
- ❑ Yes ❑ No Heart Surgery
- ❑ Yes ❑ No Hemophilia
- ❑ Yes ❑ No Hepatitis
- ❑ Yes ❑ No High/ Low Blood Pressure
- ❑ Yes ❑ No HIV/ Aids
- ❑ Yes ❑ No Hospitalized For Any Reason
- ❑ Yes ❑ No Kidney Problems
- ❑ Yes ❑ No Mitral Valve Prolapse
- ❑ Yes ❑ No Psychiatric Problems
- ❑ Yes ❑ No Rheumatic/Scarlet Fever
- ❑ Yes ❑ No Severe/ Frequent Headaches
- ❑ Yes ❑ No Shingles
- ❑ Yes ❑ No Sinus Problems
- ❑ Yes ❑ No Ulcers/ Colitis
- ❑ Yes ❑ No Venereal Disease
- ❑ Yes ❑ No Stroke

Please list any serious medical problem(s) or surgeries that you have had:

_____

_____

_____

_____

_____

IS THERE A POSSIBILITY YOU MAY BE PREGNANT? (Please check one) ❑ **Yes** ❑ **No**

The above information is true and correct to the best of my knowledge, I accept and acknowledge ultimate responsibility for all charges I incur in this office. I, hereby authorize Back to Health Chiropractic Clinic, to release to my insurance carrier any information required for my claim.

Patient's Signature: _____ **Date**: _____/_____/_____

Effects of Massage:

1. More flexibility
2. Improves circulation
3. Breaks down or prevents formation of adhesions
4. Reduces danger of fibrosis
5. Relieves muscle tension
6. Increases blood and nutritional supply in muscles
7. Removal of waste product (helps overcome fatigue)
8. Improves muscle and elasticity
9. Helps prevent or delay muscle atrophy
10. Strengthens the entire muscular system
11. Helps return venous blood to the heart
12. Blood circulation increases white blood cells, blood pressure decrease
13. Increases number of red blood cells, especially in cases of anemia
14. Increases lymph flow, aiding the body in the elimination of wastes and toxins in the fluid, this aids the cells in their ability to receive nutrients and oxygen.

MASSAGE POLICY

We are happy that you are choosing massage therapy to help regain your health. Due to the limited availability in the massage therapy schedule book, we have certain guidelines regarding unexcused absences.

If you are unable to make your appointment, please call at least **24 hours** in advance. If you call **24 hours** in advance, we can easily fill that appointment with another patient.

An unexcused absence is missing an appointment without calling **24 hours** in advance. Of course, emergency absences are accepted. However, if it is not an emergency then you will be charged a **$25.00 non-refundable fee.**
If you miss **3** appointments that are classified as unexcused, then you will need to pre-pay for you massage appointments at the time of scheduling.

I have read the above statements and agree to them:

Patient's Name (Printed): _____

Patient's Signature: _____ **Date**: _____/_____/_____

BACK TO HEALTH CHIROPRACTIC & MASSAGE

6307 N.E. 117th Ave., Suite C.
Vancouver, WA 98662
Telephone: (360) 253-4285
Fax: (360) 253-9469

Thomas S. Saeman, D.C. - Jonathan S. Sears, D.C.

AUTHORIZATION FOR RELEASE OF X-RAYS AND RECORDS

TO: BACK TO HEALTH CHIROPRACTIC CLINIC
6307 N.E. 117th Avenue, Suite C
Vancouver, WA 98662
360-253-4285 PHONE
360-253-9469 FAX

I authorize any doctor, hospital, employer, insurer, or other person, to whom a signed, original or photocopy of this authorization is delivered, to furnish any information, reports, or copies of records or radiological information which may be requested from Back to Health Chiropractic Clinic. This authorization shall remain valid for one year from the date signed.

_____
SOCAL SECURITY #:

_____
DATE OF BIRTH:

_____
PRINTED NAME:

_____
SIGNATURE:

_____
DATE SIGNED:

BACK TO HEALTH CHIROPRACTIC & MASSAGE

6307 N.E. 117th Ave., Suite C.
Vancouver, WA 98662
Telephone: (360) 253-4285
Fax: (360) 253-9469

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both the patient and the doctor to be working toward the same objective. It is important that each patient understands both the objective and the method that will be used to attain this objective. 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 affect 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 vertebra 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.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings 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 the basis.

_____ _____ _____/_____/_____

Print Name **Signature** **Date**

X-ray/Pregnancy Release (Women Only):

This is to certify that to the best of my knowledge that I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. If at any point during my treatment with this office I become pregnant, I fully understand that it is imperative that I notify the doctor immediately.
This office and the treating doctor take no responsibility for not being informed of a pregnancy.

Date of Last Menstrual Cycle: _____/_____/_____

Patient's Signature: _____ Date: _____/_____/_____

Consent to Evaluate and Adjust a Minor Child:

I, _____ 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.

Parent/Guardian's Signature: _____ Date: _____/_____/_____

BACK TO HEALTH CHIROPRACTIC & MASSAGE

6307 N.E. 117th Ave., Suite C.
Vancouver, WA 98662
Telephone: (360) 253-4285
Fax: (360) 253-9469

Thomas S. Saeman, D.C. - Jonathan S. Sears, D.C.

Consent for Release of Protected Health Information

I, _____, consent to the release of protected health information that is required to carry out treatment and payment of healthcare operations on my behalf.

I have read the Notice of Privacy Practices and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that Back to Health Chiropractic Clinic is not required to agree with my request restrictions. I also understand that once Back to Health Chiropractic Clinic agrees to my restrictions, it must comply with those restrictions.
- I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement that is signed by me.
- I understand that Back to Health Chiropractic Clinic must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- Back to Health Chiropractic Clinic has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the Notice accordingly: and we will inform you by providing you with a new notice.

Individual:	Witness (Chiropractic Assistant):
_____	_____
Printed Name	Printed Name
_____	_____
Signature	Signature
_____/_____/_____	_____/_____/_____
Date	Date

BACK TO HEALTH CHIROPRACTIC & MASSAGE

6307 N.E. 117th Ave., Suite C.
Vancouver, WA 98662
Telephone: (360) 253-4285
Fax: (360) 253-9469

Thomas S. Saeman, D.C. - Jonathan S. Sears, D.C.

Irrevocable Assignment of Insurance Payments and Tort Damages and Irrevocable Letter of Instruction

Date of Injury: _____/_____/_____
Patient's Name: _____
Party Causing Injury: _____
Other Party's Insurance: _____

To: Back To Health Chiropractic Clinic

1. In exchange for Back to Health Chiropractic Clinic proving care until insurance cover or tort damages are available to pay for treatment charges, I agree to irrevocably assign Back to Health Chiropractic Clinic any payments now or hereafter due me from any insurance company, attorney or third party responsible for my injuries. I also irrevocably instruct and request those parties pay any sums due me directly to Back to Health Chiropractic Clinic, up to the amount of my unpaid bill.

2. I also irrevocably instruct my attorney to pay Back to Health Chiropractic Clinic directly for any amount I owe in connection with my injuries from the proceeds of any settlement or verdict obtained on my behalf, whether or not the damages recovered are categorized as general or special damages.

3. I agree that a photocopy of this document, including my photocopied signature, will be as valid and binding on all parties involved as the original.

Dated this _____ day of _____ 20_____, at _____, Washington

Patient's Signature: _____ **Date**: _____/_____/_____

Parent or Legal Guardian for Patient (Print Name): _____

Parent/Guardian's Signature: _____

BACK TO HEALTH CHIROPRACTIC & MASSAGE

6307 N.E. 117th Ave., Suite C.
Vancouver, WA 98662
Telephone: (360) 253-4285
Fax: (360) 253-9469

Thomas S. Saeman, D.C. - Jonathan S. Sears, D.C.

Financial Arrangements and Medical Lien Disclosure

I do, hereby, acknowledge that I am receiving (or about to receive) health care services at Back to Health Chiropractic Clinic. My Financial Agreement is as follows:

1. Insurance Payments: As a courtesy, Back to Health Chiropractic Clinic will submit all services to your insurance carrier. In the event of insurance payment(s) to not forth come, you will be liable for all charges you incurred during the course of treatment.

I understand that for treatment provided by **Back to Health Chiropractic** related to an automobile collision, primary first party insurance is with the Personal Injury Protection (PIP) Insurance for the car I was driving, riding in as a passenger, or struck by as a pedestrian/bicyclist. I understand and authorize Back to Health Chiropractic to bill PIP and authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations.

Should PIP insurance not be available, exhaust or terminate for any reason, I authorize Back to Health Chiropractic to bill any applicable health insurance I may have available, subject to any contract Back to Health Chiropractic may have with such carrier. I understand and authorize Back to Health Chiropractic to bill health insurance, if applicable, and authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations.

In the event I do not have PIP of health insurance available for the automobile collision, I authorize Back to Health Chiropractic to hold my bills pending final claim resolution and file a medical lien against any applicable third-party insurance settlement pursuant to TCW 60.44.010, et seq. I understand and acknowledge that in the event a medical lien is filed, and that if the lien is paid or settles, I will be provided with an original, written Satisfaction of Lien and I am responsible for filing the Satisfaction of Lien with the County Auditor and for paying the filing fee costs associated with filing any such Satisfaction of Lien. I further understand that payment of any medical lien, in some circumstances, may not fully pay my outstanding final charges due to Back to Health Chiropractic for treatment provided, and I may be required to make additional payments after satisfaction of the lien.

2. Cash Payment: I am responsible for services rendered to me at the time of service.

3. Other Financial Arrangements: _____.

4. I, _____, understand that no doctor can or should guarantee any "cure" for any course of treatment and that no spinal correction therefore can be guaranteed. If any pre-payment is made, and I discontinue care for any reason, any unused portion of the pre-payment is refundable, and any plan becomes null and void. Where care is resumed, new financial arrangements will need to be made.

I fully understand the terms of this agreement and can receive a copy of this agreement.

Dated this _____ day of _____ 20_____, at _____, Washington

Patient's Signature: _____

Chiropractic Assistant's Signature: _____