



**CONFIDENTIAL PATIENT INFORMATION**

**PLEASE PRINT**

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_ Age: \_\_\_\_\_

Soc. Sec. No.: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM/DD/YYYY

Spouse: \_\_\_\_\_ Referred By: \_\_\_\_\_  
Last First M.I.

Patient's nearest relative: \_\_\_\_\_ Phone: \_\_\_\_\_

Male  Female

Married  Widowed

Single  Divorced

**Employment Information**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State Zip

**Insurance Information**

Insurance Company: \_\_\_\_\_  Auto Accident  Workers Compensation

Please make sure we have a copy of your insurance card and all necessary insurance information.

**Complaint Information**

Purpose of this appointment (Major Complaint): \_\_\_\_\_ (Please indicate on pain drawing)

When did you first notice the pain/symptoms? \_\_\_\_\_

How often do you experience your symptoms?  Constantly (76-100% of the time)  Frequently (51-75% of the time)  
 Occasionally (26-50% of the time)  Intermittently (1-25% of the time)

How are your symptoms changing with time?  
 Getting Worse  Staying the Same  Getting Better

How much has the problem interfered with your work?  
 Not at all  A little bit  Moderately  Quite a bit  Extremely

How much has the problem interfered with your social activities?  
 Not at all  A little bit  Moderately  Quite a bit  Extremely

How do you think your problem began? \_\_\_\_\_

Do you consider your problem to be severe?  Yes  Yes, at times  No

What activities aggravate your condition? \_\_\_\_\_

What concerns you the most about your problem; what does it prevent you from doing?  
 \_\_\_\_\_

Have you lost any days from work?  Yes  No

Other doctors seen for this condition:  MD/DO  PT  MT  DC  other: \_\_\_\_\_

**Past History**

Have you been treated for any health conditions by a physician in the last year?  Yes  No

Describe: \_\_\_\_\_

What medications, vitamins, or drugs are you taking? \_\_\_\_\_

What operations have you had? \_\_\_\_\_

Describe any serious illnesses: \_\_\_\_\_

Have you ever been under Chiropractic Care?  Yes  No Doctor's Name: \_\_\_\_\_

**Review of Systems**

**Have you Ever Suffered From:**

Now / Past	Condition	Please Describe	Now/Past	Condition	Please Describe
<input type="checkbox"/>	<input type="checkbox"/> Asthma	_____	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination	_____
<input type="checkbox"/>	<input type="checkbox"/> Allergies/Hay Fever	_____	<input type="checkbox"/>	<input type="checkbox"/> Prostate Trouble	_____
<input type="checkbox"/>	<input type="checkbox"/> Colds/Sinus Infection	_____	<input type="checkbox"/>	<input type="checkbox"/> Hemorrhoids	_____
<input type="checkbox"/>	<input type="checkbox"/> Difficulty Breathing	_____	<input type="checkbox"/>	<input type="checkbox"/> Venereal Disease	_____
<input type="checkbox"/>	<input type="checkbox"/> Headaches	_____	<input type="checkbox"/>	<input type="checkbox"/> Bruising Easily	_____
<input type="checkbox"/>	<input type="checkbox"/> Dizziness	_____	<input type="checkbox"/>	<input type="checkbox"/> Itching	_____
<input type="checkbox"/>	<input type="checkbox"/> Eye Pain/Failing Vision	_____	<input type="checkbox"/>	<input type="checkbox"/> Bursitis/Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/> Deafness/Ear Noises	_____	<input type="checkbox"/>	<input type="checkbox"/> Varicose Veins	_____
<input type="checkbox"/>	<input type="checkbox"/> Nosebleeds	_____	<input type="checkbox"/>	<input type="checkbox"/> Anemia/Fatigue	_____
<input type="checkbox"/>	<input type="checkbox"/> High/Low Blood Pressure	_____	<input type="checkbox"/>	<input type="checkbox"/> Swelling of Ankles/Joints	_____
<input type="checkbox"/>	<input type="checkbox"/> Rapid/Slow Hear Rate	_____	<input type="checkbox"/>	<input type="checkbox"/> Poor Circulation	_____
<input type="checkbox"/>	<input type="checkbox"/> Nervousness/Depression	_____	<input type="checkbox"/>	<input type="checkbox"/> Cramps or Backache	_____
<input type="checkbox"/>	<input type="checkbox"/> Kidney Infection or Stones	_____	<input type="checkbox"/>	<input type="checkbox"/> Irregular Cycle/Excessive Menstrual Flow	_____
<input type="checkbox"/>	<input type="checkbox"/> Indigestion/Nausea	_____	<input type="checkbox"/>	<input type="checkbox"/> Lumps in Breast	_____
<input type="checkbox"/>	<input type="checkbox"/> Ulcers	_____	<input type="checkbox"/>	<input type="checkbox"/> Hot Flashes	_____
<input type="checkbox"/>	<input type="checkbox"/> Colon Trouble/Diarrhea	_____	<input type="checkbox"/>	<input type="checkbox"/> Foot Trouble	_____

**Activities of Daily Living**

Habits:	Heavy	Moderate	Light	None	
Alcohol	_____	_____	_____	_____	
Coffee	_____	_____	_____	_____	
Tobacco	_____	_____	_____	_____	
Drugs	_____	_____	_____	_____	
Exercise	_____	_____	_____	_____	
Sleep	_____	_____	_____	_____	
Appetite	_____	_____	_____	_____	
What activities do you do at work?					
<input type="checkbox"/> Sit:		<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day	
<input type="checkbox"/> Stand:		<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day	
<input type="checkbox"/> Computer work:		<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day	
<input type="checkbox"/> On the phone:		<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day	
Have you ever been hospitalized?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, why:	_____				
What would you rate your overall health?		<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor
What type of exercise do you do?		<input type="checkbox"/> Strenuous	<input type="checkbox"/> Moderate	<input type="checkbox"/> Light	<input type="checkbox"/> None
Indicate if you have any immediate family members with any of the following:					
<input type="checkbox"/> Rheumatoid Arthritis		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Lupus	
<input type="checkbox"/> Heart Problems		<input type="checkbox"/> Cancer		<input type="checkbox"/> ALS	

**PAYMENT IS EXPECTED AT TIME OF VISIT!**

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any insurance claim forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account.

However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Should no payment be received on my account for sixty days there will be a 1.5% or \$2.00 minimum service charge added to the account each month.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Gaurdian or Spouse's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

Information Taken By: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_



The  
**CHAN INSTITUTE**  
of Health and Wellness

Chan Chiropractic Clinic, P.S.

4339 West Kennewick Ave  
Kennewick, WA 99336-2802

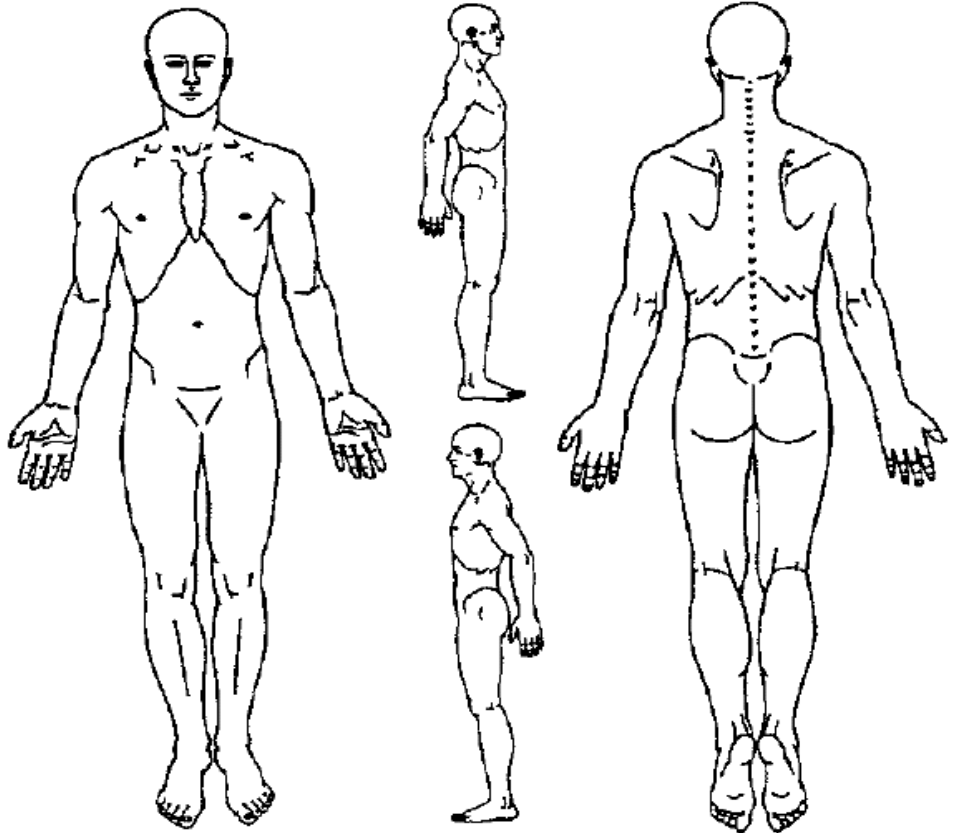
## Pain Drawing Quadruple Index

Patient Name(Print) \_\_\_\_\_ Date \_\_\_\_\_

Patient ID# \_\_\_\_\_

Please circle the location of pain or discomfort on the images below. Use the letters shown to represent the type of pain:

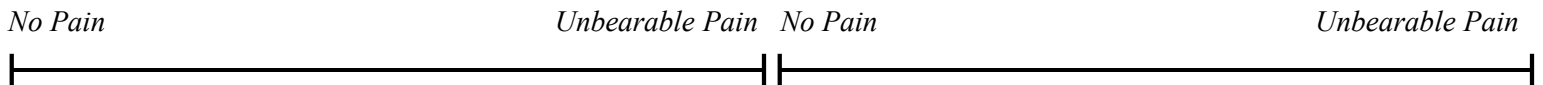
- D=Dull/Achy
- S=Stabbing/Cutting
- B=Burning
- T=Tingling  
(Pins&Needles)
- N=Numb
- S=Shooting
- C=Cramping



On the scales below, please draw a vertical line representing your pain or discomfort.

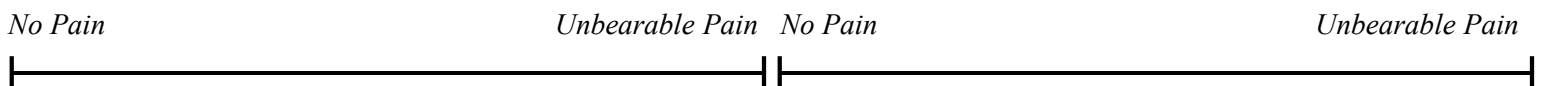
Rate the pain you have right **NOW**:

Rate your pain at its **BEST** in the past week:



Rate your **AVERAGE** pain in the past week:

Rate your **WORST** pain in the past week:



**The Chan Institute of Health and Wellness  
4339 West Kennewick Avenue  
Kennewick, Washington 99336-2802  
509-735-0311**

**Consent for Purposes of Treatment, Payment & Healthcare Operations (6/04)**

In this document, “I” and “my” refer to the patient,  
and “Institute” refers to The Chan Institute of Health and Wellness.

I consent to the use or disclosure of my protected health information by Institute for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Institute. I understand that analysis, diagnosis or treatment of me by Institute may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Institute is not required to agree to the restrictions that I may request. However, if Institute agrees to a restriction that I request, the restriction is binding on Institute.

I have the right to revoke this consent, in writing, at any time, except to the extent that Institute has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Institute and understand that I have a right to a copy of the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Institute. The Notice of Privacy Practices for Institute is also posted in the waiting room at 4339 W. Kennewick Ave., Kennewick, WA 99336. This Notice of Privacy Practices also describes my rights and duties of the Institute with respect to my protected health information.

Institute reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Institute and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date of Signing

\_\_\_\_\_  
Description of Personal Representative's Authority

# CHAN CHIROPRACTIC CLINIC, P.S.

## Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you read and sign prior to any treatment.

**FULL PAYMENT (DEDUCTIBLES AND CO-PAYS) IS DUE AT TIME OF SERVICE.**

**WE ACCEPT CASH, CHECKS AND MOST CREDIT CARDS.**

**WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL.**

### Regarding Insurance:

We may accept assignment of insurance benefits. However, we do require 50% of the bill to be paid at time of service unless arrangements are made with the doctor. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and/or an original claim form. **Your insurance policy is a contract between your insurance company and you.** We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to you for payment. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurances.

### Authorization Requirements:

When insurance companies require pre-authorization, we will apply on your behalf. However, your insurance company may refuse to authorize the treatment plan recommended by the doctor. You will be financially responsible for the non-authorized visits.

### Arbitration Agreement:

Should any dispute as to malpractice arise, the case will be determined by submission to arbitration as provided by state and federal law. By signing this you are giving up your constitutional right to have such dispute decided in a court of law before a jury and are accepting the use of arbitration.

### Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and/or customary rates.

### Adult and Minor Patients:

Adult patients are responsible for full payment at time of service. The adult accompanying a minor and the parents (or legal guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless arrangements have been made for payment by cash or check at time of service.

### Missed Appointments:

Unless canceled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

### Third Party Payment:

In certain cases, a third party may be responsible for payment of your account. We may hold any outstanding bills and file a medical lien to secure the payment of this debt. The lien will be filed with the County Auditor's office and will remain on file until the account is settled or the claim is closed, at which time payment is due. A charge for processing the lien and administrative fees will be applied to your account balance.

I have read the Financial Policy. I understand and agree to this Financial Policy: I hereby assign payment of Insurance benefits to Chan Chiropractic Clinic, P.S.

X \_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Signature of Co-Responsible Party

\_\_\_\_\_  
Date

# 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 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.

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.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

\_\_\_\_\_

Print Name

\_\_\_\_\_

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.

## **Pregnancy Release:**

This is to certify that to the best of my knowledge 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.

Date of last menstrual cycle: \_\_\_\_\_

\_\_\_\_\_

Signature

\_\_\_\_\_

Date