Today's Date:_____

Welcome to Fairwood Chiropractic!

14410 SE PETROVITSKY RD STE 109
RENTON WA 98058
425-226-1856 / Fax 425-226-0231

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:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed	
Social Security Number:	SSN is required by most insurances for billing purposes. If you leave this blank, your insurance may not pay.		
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 current employer / school:	Phone/Fax:	
Emergency Contact Name:	Relation to you:	Contact Phone:	

Billing Information

Please select one or more options below:

☐ **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.** **ALL** information REQUIRED for auto accident claims

Do you have car insurance? □ Yes □ No Date of Accident:___/___/_____

Name of your car insurance company:_____

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

Your car insurance information is required even if you aren't at fault!

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:___/___/_____

Employer Name:_____ **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

Every type of health care is associated with some risks of potential problems. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a mechanical device or machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated. In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-rays, physical therapy application, traction, massage therapy, exercise instruction, Class IV laser, spinal decompression, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Neck Artery Dissection and Stroke: Dissection is when the lining of a neck artery breaks down. This might happen spontaneously or from an injury or from a trivial movement (hair shampooing, checking traffic, looking up, etc.). Dissections tend to cause neck pain and/or headache. Dissections may form a clot that can dislodge and interfere with blood flow. If that happens, it is called a stroke. Stroke means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with stroke or not. Recent evidence suggests that it is not (2008, 2015, 2016, 2019), although the same evidence often suggests that the patient may be entering the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous dissection of a neck artery. There are no in-the-office tests to diagnose a spontaneous neck artery dissection (2020), but they might be detectable with advanced imaging (CT/MRI, etc.). If we think you may be suffering from a spontaneous neck artery dissection and/or associated stroke, you will be immediately referred to emergency services. Anecdotal cases suggest that chiropractic adjustments may be associated with dissection and/or stroke that arise from the vertebral artery; this is because the vertebral artery is located inside the neck vertebrae. The adjustment that is suggested to increase the strain on the vertebral artery is called the "extension-rotation-thrust atlas adjustment." We do not do this type adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. It is estimated that the incidence of this type of stroke ranges between 1 per every 400,000-3,000,000 neck adjustments. If you experience any of the "5 Ds And 3 Ns" before, during or after an adjustment, tell us immediately, and if we can't be reached, go to the emergency department immediately. Two other potential problems that are not quantifiable because they are extremely rare and may have no association with chiropractic adjusting are carotid artery injury, and spinal dural tear resulting in a leak of cerebral spinal fluid.

Disc Herniation: Both neck and back disc herniations may create pressure on the spinal nerve or on the spinal cord. They are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. Occasionally chiropractic treatment (adjustments, traction, etc.) may aggravate a disc/nerve problem and rarely surgery may become necessary for correction.

Cauda Equina Syndrome: Cauda Equina Syndrome occurs when a low back disc problem puts pressure on the nerves that control bowel, bladder, and sexual function. Representative symptoms include leaky bladder, or leaky bowels, or loss of sensation (numbness) around the pelvic sexual organs (the saddle area), or the inability to start/stop urination or to start/stop a bowel movement.

Cauda Equina Syndrome is a medical emergency because the nerves that control these functions can permanently die, and those functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves, and the window to do so may be as short as 12- 72 hours, depending. If you have any of these symptoms, tell us immediately, and if we can't be reached, go to the emergency department immediately.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may overstretch some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient.

Rib and other Fractures: Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. We adjust all patients very carefully, and especially those who have known osteoporosis. Other fraction locations are extremely rare but possible, especially in those aged over 65 years and/or on steroid drugs.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat or ice can burn or irritate the skin. The result is a temporary increase in pain, and there may even be some blistering of the skin. Never put an ice pack directly on the skin, always have an insulating towel between.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it. Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment. Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation. Alternatives to chiropractic care include: do nothing, drugs, surgery, acupuncture, massage, etc. Risks from these procedures should be discussed with that particular provider.

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.

I have read and fully understand the above statements,
and therefore accept 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.

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

_____

_____

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

If yes how long ago and why? _____

Have you seen any other medical provider for this condition? YES / NO If yes, please list them below.

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

_____

_____

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 all medications and supplements that you take regularly

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

Have you ever had a professional massage? YES / NO

Are you interested in Acupuncture? YES / NO

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

Are you interested in weight loss? YES / NO

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

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

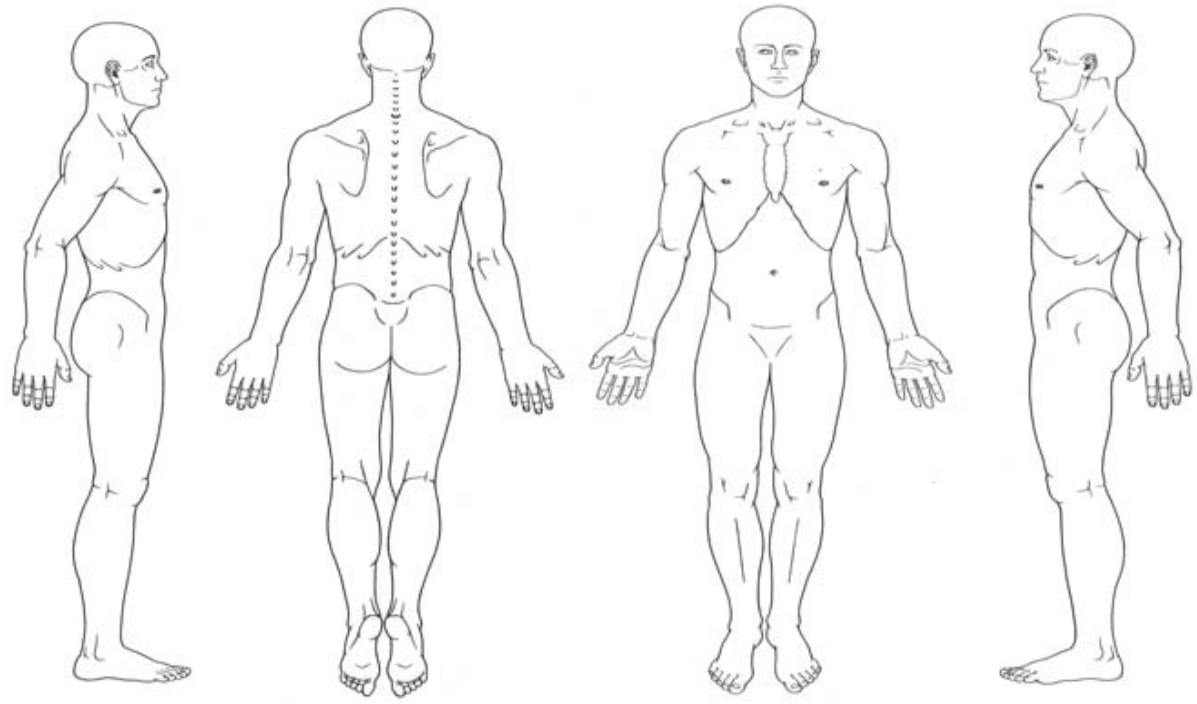
PLEASE USE THE LETTERS BELOW TO MARK THE AREAS IN WHICH YOU FEEL THE CORRESPONDING SENSATIONS.

A = ACHE **B** = BURNING

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

O = OTHER **N** = NUMBNESS

COLOR IN AREAS TO INDICATE BRUISING



PATIENT SIGNATURE:_____ DATE:_____

Neck Index

Patient Name:_____

*This questionnaire will give your provider information about how your **neck** condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain comes and goes and is moderate.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hour sleepless).
☐ My sleep is mildly disturbed (1-2 hours sleepless).
☐ My sleep is moderately disturbed (2-3 hours sleepless).
☐ My sleep is greatly disturbed (3-5 hours sleepless).
☐ My sleep is completely disturbed (5-7 hours sleepless).

Reading

☐ I can read as much as I want with no neck pain.
☐ I can read as much as I want with slight neck pain.
☐ I can read as much as I want with moderate neck pain.
☐ I cannot read as much as I want because of moderate neck pain.
☐ I can hardly read at all because of severe neck pain.
☐ I cannot read at all because of neck pain.

Concentration

☐ I can concentrate fully when I want with no difficulty.
☐ I can concentrate fully when I want with slight difficulty.
☐ I have a fair degree of difficulty concentrating when I want.
☐ I have a lot of difficulty concentrating when I want.
☐ I have a great deal of difficulty concentrating when I want.
☐ I cannot concentrate at all.

Work

☐ I can do as much work as I want.
☐ I can only do my usual work but no more.
☐ I can only do most of my usual work but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I cannot do any work at all.

Personal Care

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but I manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it causes extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
☐ I can only lift very light weights.
☐ I cannot lift or carry anything at all.

Driving

☐ I can drive my car without any neck pain.
☐ I can drive my car as long as I want with slight neck pain.
☐ I can drive my car as long as I want with moderate neck pain.
☐ I cannot drive my car as long as I want because of moderate neck pain.
☐ I can hardly drive at all because of severe neck pain.
☐ I cannot drive my car at all because of neck pain.

Recreation

☐ I am able to engage in all my recreation activities without neck pain.
☐ I am able to engage in all my usual recreation activities with some neck pain.
☐ I am able to engage in most but not all my usual recreation activities because of neck pain.
☐ I am only able to engage in a few of my usual recreation activities because of neck pain.
☐ I can hardly do any recreation activities because of neck pain.
☐ I cannot do any recreation activities at all.

Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have moderate headaches which come infrequently.
☐ I have moderate headaches which come frequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

PATIENT SIGNATURE:_____ DATE:_____

Back Index

Patient Name:_____

*This questionnaire will give your provider information about how your **back** condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is very severe and does not vary much.

Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal sleep is reduced by less than 25%.
- ☐ Because of pain my normal sleep is reduced by less than 50%.
- ☐ Because of pain my normal sleep is reduced by less than 75%.
- ☐ Pain prevents me from sleeping at all.

Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases pain immediately.

Walking

- ☐ I have no pain while walking.
- ☐ I have some pain while walking but it doesn't increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

Personal Care

- ☐ I do not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it..
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.

Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel except that done while lying down.
- ☐ Pain restricts all forms of travel.

Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

PATIENT SIGNATURE:_____ DATE:_____

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.

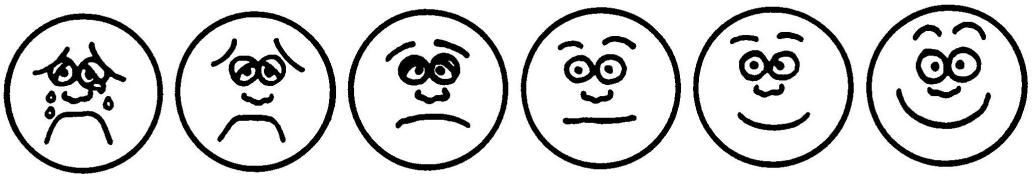
10 MEANS YOU ARE PERFECTLY FINE AND 0 MEANS YOU CAN’T DO IT!!!

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:_____

FAIRWOOD 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:_____