Downey Chiropractic Center
14777 NE 40th Street
Bellevue, WA 98007

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: ( )	Offspring: ( )
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____

CONFIDENTIAL CASE HISTORY FILE

Downey Chiropractic Center P.S.
14777 NE 40th St, #102, Bellevue WA 98007
425.883.2543 FAX 425.867.1109

Date: _____

Full Legal Name: _____ Name you prefer: _____

Address: _____ City/State/Zip _____

Phone: (home) (___) _____ (work) (___) _____ (cell) _____

Birth date: _____ Age:___Sex:___ SS#: _____ Marital Status: S M W D Sep

Spouse's Name: _____ # Children _____ Years of Education _____

Emergency Contact: _____ Phone: (___) _____

Your Employer: _____ Phone: (___) _____

Employer's Address: _____ City/State/Zip _____

Job title: _____ Supervisor Name: _____

e-mail address: _____ Referred by: _____

MEDICAL HISTORY (please be complete)

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any auto accident injuries (include dates): _____

List any on the job injuries (include dates): _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):

_____

List all current over-the-counter and prescription medications used (include reason used):

_____

_____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.)

_____

Have you been under a physician's care in the past year? ☐ no ☐ yes (reason) _____

When was your last physical examination? _____ Dr: _____

Have you ever been under chiropractic care? ☐no ☐yes (describe) _____

If female, is there a possibility that you are pregnant? ☐ no ☐ yes

Do you smoke/use tobacco? ☐ no ☐ yes Exercise habits? ☐never ☐occasional ☐ frequent

Check any of the following symptoms you have noticed: (▨ = Previously, ☐ = Now)

▨ ☐ Headaches	▨ ☐ Low back pain	▨ ☐ Sensitive to light or sound
▨ ☐ Dizziness or light-headed	▨ ☐ Leg/foot numbness/tingling	▨ ☐ Visual or hearing disturbance
▨ ☐ Jaw pain, clicking, or locking	▨ ☐ Leg/foot fatigue/weakness	▨ ☐ Memory loss/problems
▨ ☐ Pain or difficulty swallowing	▨ ☐ Leg pain with walking	▨ ☐ Irritability or depression
▨ ☐ Neck pain or stiffness	▨ ☐ Abdominal pain	▨ ☐ Fatigue or loss of energy
▨ ☐ Shoulder pain	▨ ☐ Nausea or vomiting	▨ ☐ Fainting or convulsions
▨ ☐ Mid back pain	▨ ☐ Diarrhea or constipation	▨ ☐ Trouble with balance or coordination
▨ ☐ Chest pain or cough	▨ ☐ Blood in urine or stool	▨ ☐ Sleep disturbances/problems
▨ ☐ Pain/trouble breathing	▨ ☐ Difficulty or pain w/ urination	▨ ☐ Rashes (face, body, limbs)
▨ ☐ Arm/hand numbness/tingling	▨ ☐ Difficulty with sexual function	▨ ☐ Joint pain or swelling
▨ ☐ Arm/hand fatigue/weakness	▨ ☐ Abnormal menstrual periods	▨ ☐ Pain with exertion (activity, climbing stairs, etc.)

HAVE YOU HAD *ANY* OF THE FOLLOWING:	*NOW:*		*EVER:*
	☐ Pain worse at night	☐ Recent bacterial infection (30 days)	☐ History of cancer
	☐ Constant pain	☐ Loss of bowel or bladder control	☐ History of IV drug use
	☐ Unexplained weight loss	☐ Urinary discharge	☐ History of blood transfusion
		☐ Recent surgery (30 days)	

Information about your current condition/complaints

Downey Chiropractic Center P.S.
14777 NE 40th St, #102, Bellevue WA 98007
425.883.2543 FAX 425.867.1109

What is your primary complaint/problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

How did your symptoms first begin? _____

Pain is: ☐ Constant ☐ Intermittent Is your condition getting worse? _____

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. _____
2. _____
3. _____

Have you had: ☐ Xray ☐ MRI or CAT Scan ☐ EMG ☐ Bone Scan ☐ Blood Work

Who is your family medical doctor: _____

List all home remedies tried for this problem: _____

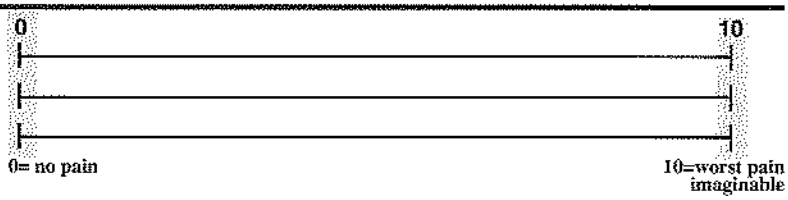
Is your condition worse at certain times of the day or night? _____

Does your condition interfere with: (yes/no) work _____ sleep _____ normal daily routine _____

Have you had symptoms like this before? ☐ no ☐ yes (describe) _____

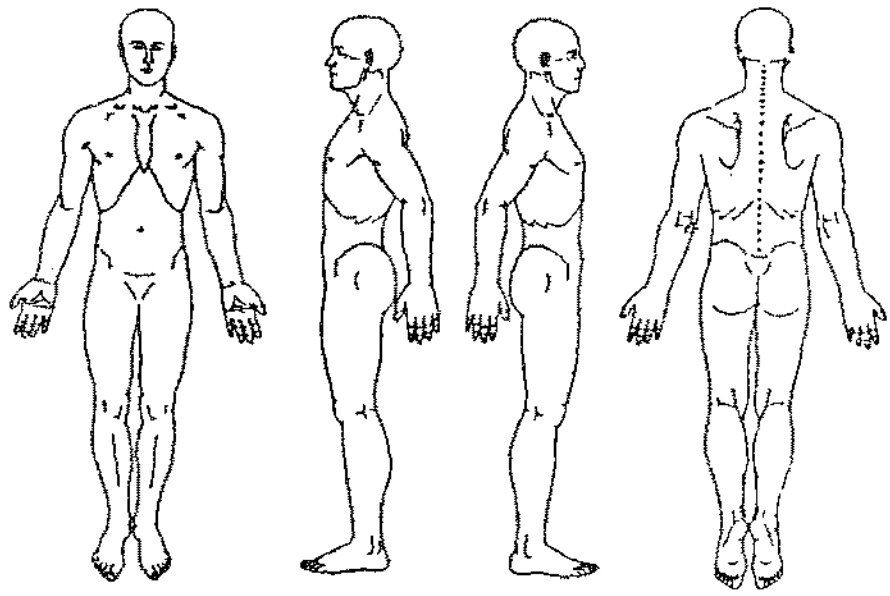
Regarding your main complaint:

How bad is your pain?
(make a slash on all 3 scales)



Draw the area of your symptoms using these symbols:
(mark on the figures)

XXX = ache
✳ = sharp/stab
ooo = numb/tingle
—> = shooting
//// = stiff/tight



Pt. History 3.4
#1.04 SCSI®

NOTICE TO NEW PATIENTS: Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy. I grant permission to the Dr. to use the information in my medical record to assist in the clinical improvement process.

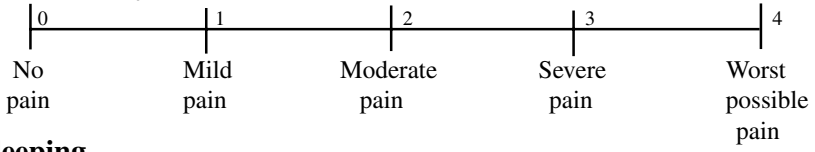
Patient Signature: _____ Date _____

Functional Rating Index

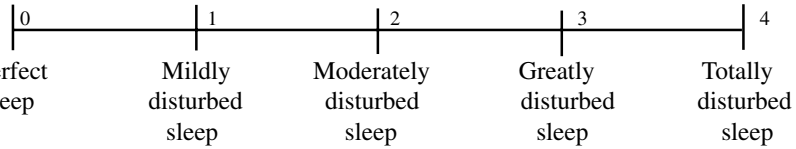
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

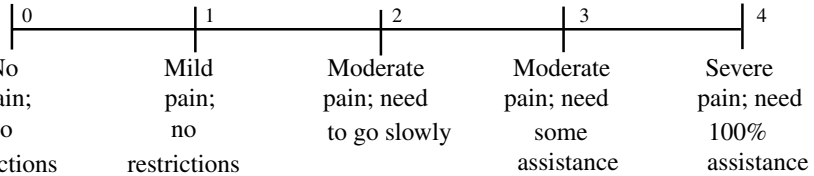
1. Pain Intensity



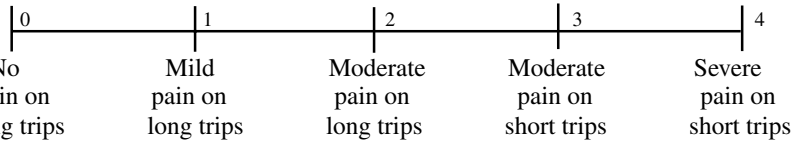
2. Sleeping



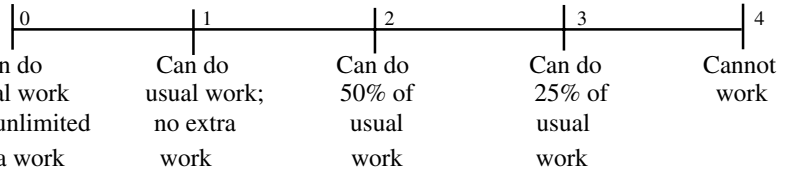
3. Personal Care (washing, dressing, etc.)



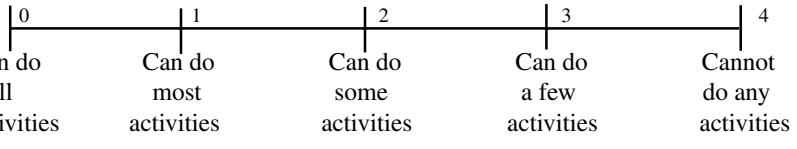
4. Travel (driving, etc.)



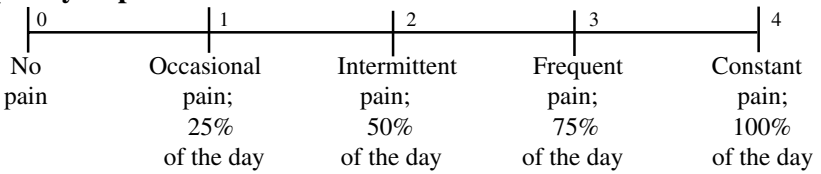
5. Work



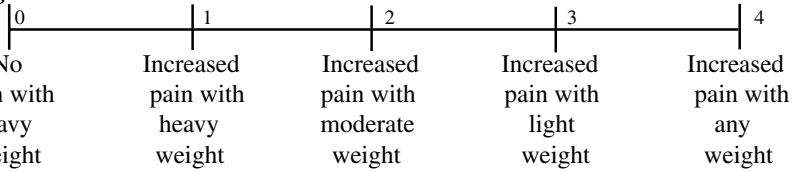
6. Recreation



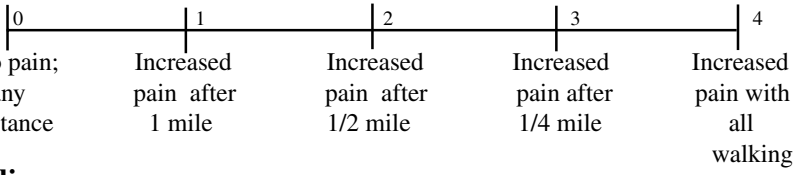
7. Frequency of pain



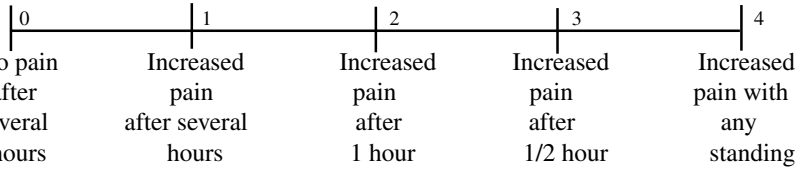
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

Downey Chiropractic Center P.S. 14777 NE 40th. St# 102, Bellevue WA 98007
Voice: 425-883-2543 Fax: 425-867-1109

Informed Consent

Before beginning treatment, it is our office policy to inform you of what to expect, possible complications of chiropractic, as well as complications of other approaches. Remember that all forms of treatment (including non-treatment!) have associated risks. **If you have any questions, please be sure to ask the doctor.**

What to expect

The treatment at our office will consist of manipulation of the joints and soft tissues, using the hands and/or a mechanical instrument. You may feel joint movement, and you may hear joint clicks or other noises. Physical therapy methods, along with therapeutic exercise may also be used.

Chiropractic risks

Chiropractic treatment is one of the safest methods of treating back pain. Still, unexpected problems can occur. Minor, temporary problems, such as soreness and stiffness can occur, especially in the beginning of a treatment plan. More significant problems, such as fracture of weakened bone or sprain/disc injuries are rare. A stroke following neck manipulation is an extremely rare complication, occurring less than 1 per million treatments. Stroke has also been the result of ordinary activities, such as head turning or stargazing.

Other treatments and risks

Medications: Many commonly used medications, such as NSAIDs (e.g. Advil, Aleve) or Tylenol, carry risks of tissue damage, including stomach ulcers or kidney damage. This damage can occur quickly, and may be irreversible. There is a significantly higher risk of developing a serious complication with NSAIDs as opposed to chiropractic. Other medications are habit-forming, and may mask pain to allow further tissue damage.

Surgery: Surgery is the treatment of choice in less than 1% of back pain patients. Your doctor has screened for surgical "red flags", and will refer you for a surgical opinion if indicated. Clinical results of surgery for mechanical back pain have been disappointing, and exposes you to unnecessary hospital and medication risk.

Rest/non-treatment: Bedrest has been shown to increase the likelihood of re-occurrence of back episodes, and make chronic pain more likely. Likewise, non-treatment may cause a permanent mechanical problem to develop, causing future back problems.

I have read the above, and give my consent to begin chiropractic treatment.

Printed name _____ Date _____

Signature _____

Downey Chiropractic Center, P.S.

14777 N.E. 40th St., Ste #102
Bellevue, WA 98007
Ph: 425/883-2543 Fax: 425/867-1109

Financial Policy and Agreement

Outstanding Patient Service is Our Goal

The goal of our doctors and staff is to make sure you receive the highest quality chiropractic care and service. One step is to make certain that our financial policies are clear and understood by you.

- **Insurance – We Go the Extra Mile**
  If you have insurance we make a good faith effort to estimate your benefits and defer billing you for that amount for up to 60 days. We will take care of completing and filing the appropriate claim forms with your insurance company. We will also track your claim and make sure it is paid in a timely manner. We will follow-up with your insurer when claims are not processed efficiently and attempt to expedite payment. We are also happy to provide your insurance carrier with x-rays or other information they may require. If your insurer denies coverage, or if we otherwise do not receive payment within 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurer and/or your employer and your insurer. **Although we will make every effort to help you obtain your benefits, we cannot force your insurer to pay.**

- **On the Job Injuries (L&I)**
  Please notify your employer of your injury so they may file the necessary forms with your workers compensation carrier. In an accepted claim, industrial insurance pays 100%. If the claim is disallowed or transfer of physician is not approved, industrial insurance does not cover any of the services rendered and the charges for treatment become your responsibility.

- **Motor Vehicle Accidents**
  We bill your insurance company on your Personal Injury Protection (PIP). Notify your insurance company or agent that you are under the care of our physicians. A medical lien is placed on the claim to protect your medical payment benefits. Patients without PIP will need to pay for treatment at the time of service, or have your medical insurance billed until the time of settlement or until the balance is paid in full.

- **Medicare**
  Medicare will cover a portion of visits per year after your deductible has been met. We are happy to bill your co-insurance (secondary) for you. Medicare does not cover exams, x-rays, supplies, or maintenance visits. Payments for services not covered by Medicare are due at the time of service. Please refer to the Medicare Advanced Beneficiary Notice Form.

Patient Responsibility

I acknowledge my responsibility for payment of the services received from Downey Chiropractic Center in accordance with the doctors' regular fees and terms. I understand my responsibility is not modified by whether any third party pays for all, part, or none of the charges. I understand that this account becomes delinquent if not paid within 60 days after billing and at that time a Late Billing Fee of $20.00/mo will be charged until the balance is paid in full. **I also understand that any co-pays and/or any balances on my account are due at the time of treatment and not billed at a later date. Finally, I acknowledge that Downey Chiropractic Center reserves the right to assess a $25.00 fee to my account for any appointments rescheduled, cancelled, or missed with less than 24 hours notice and this fee will not be billed to any insurance or third party billing company.** There is a $25.00 fee for patient record copying.

_____ _____
Patient Name Date

_____
Patient Signature

Downey Chiropractic Center, P.S.

14777 N.E. 40th St., Ste #102
Bellevue, WA 98007
Ph: 425/883-2543 Fax: 425/867-1109

Receipt of Notice of Privacy Practices/ Communication Agreement

Receipt of Notice of Privacy Practices:

By signing below, I acknowledge I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability Accountability Act of 1996 (HIPAA). I understand that official privacy practices policies may change from time to time, and I may request, at any time, a current copy of the Notice of Privacy Practices from Downey Chiropractic Center.

_____
Patient Name

_____ _____
Patient or Parent/Guardian Signature Date

[] The patient was presented with this form and declined to sign. Michael W. Downey, DC_____ _____
Date

[] The patient was presented with this form and declined to sign. Sarah L. Zindt, DC _____ _____
Date

Communication Agreement:

We may need to contact you from time to time to discuss your health, billing questions, or to coordinate your care. By providing us the below information, you are giving us permission to contact you via the phone numbers/e-mail addresses listed and acknowledge that this may result in someone other than yourself learning your personal health information.

_____ _____
Phone Number Alternate Phone Number

_____ _____
E-mail Address Alternate E-mail Address

_____
Patient Name

_____ _____
Patient or Parent/Guardian Signature Date

Credit Card on File Authorization

Please complete this form if you would like ***Downey Chiropractic Center*** to keep your credit card on file for future payments. Your credit card will be charged on the 5th and 20th of each month after charges have been processed by your insurance company. You may elect to provide us with credit card information separately for each payment.

Information to be completed by the card holder:

Cardholder Name: _____

Card Number: _____

Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Expiration Date: _____

Security Code: _____ (3 digit code on back)

Billing Zip Code: _____

E-mail: _____

I, _____, authorize ***Downey Chiropractic Center*** to charge the above credit card account for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder Signature _____ Date_____