FORGEY
CHIROPRACTIC

601 E 22nd St Vancouver WA 98663
360-573-5500

PERSONAL INFORMATION

First Name: _____ M.I. _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Age: _____

Home Phone: _____ Cell Phone: _____ Preferred Number: ☐Home Phone ☐Cell Phone

Email: _____

Address: _____

City/State/Zip: _____

Referred By: _____ ☐ Website ☐ Google ☐ Insurance ☐ Attorney ☐ Family/Friend

EMPLOYER

Occupation: _____

Company name: _____ Phone: _____

EMERGENCY CONTACTS

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Are staff authorized to speak with these people regarding medical information including scheduling? ☐ Yes ☐ No

Are staff authorized to speak with these people regarding account information including financial ? ☐ Yes ☐ No

INSURANCE

Please provide insurance card(s) at time of visit if using insurance

Type of Insurance: ☐ Health Insurance ☐ No Insurance ☐ Workers Comp. ☐Auto Insurance - DOI: _____

Primary Insurance Carrier: _____ Claim #: _____

ID/Policy #: _____ Group #: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Birthdate: _____ Employer: _____

Is patient covered by another insurance? ☐ Yes ☐ No ☐ Health Insurance ☐ At-Fault Auto Insurance

Secondary Insurance Carrier: _____ Group #: _____

ID/Policy/Claim #: _____ Policy Holder's Birthdate: _____

Name of Policy Holder: _____ Relationship to Patient: _____

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Patient Name: _____ Date: _____

REASON FOR VISIT

Please describe what brings you in today: _____

_____

_____

How long have you had this condition?_____ Has this happened before?_____

What seemed to be the initial cause? _____

Onset: ☐ Gradual ☐ Sudden ☐ Other: _____ Is it getting worse? ☐ Yes ☐ No ☐ Unknown

Frequency of pain daily: ☐ 0-25% of day ☐ 25-50% of day ☐ 50-75% of day ☐ 75-100% of day

Activities that make the symptoms better: _____

Activities that make the symptoms worse: _____

Have you seen a chiropractor before? ☐ Yes ☐ No If yes, how long ago? _____

For what reason? _____

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what reason? _____

Date of last physical exam: _____ Where: _____

Please mark areas of pain:

Using the scale below, please rate your level of pain today from zero to ten:

0 1 2 3 4 5 6 7 8 9 10

Using the body chart to the right, indicate the region(s) of your complaint using the following symbols:

A - Aching

B - Burning

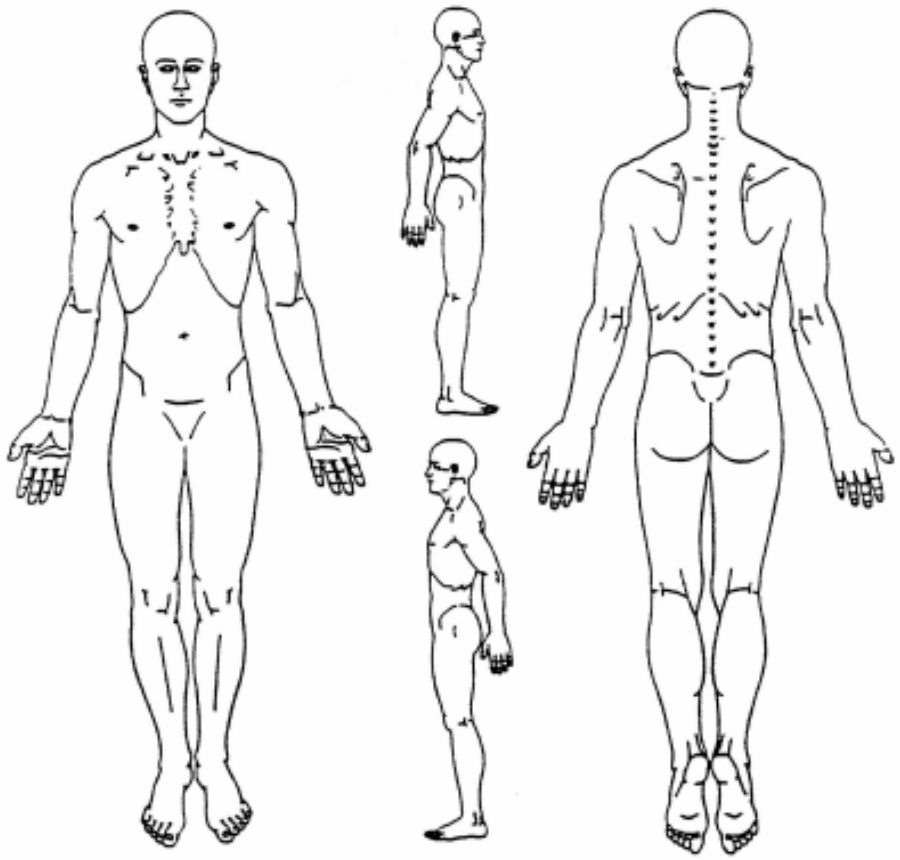
N - Numbness

X - Tingling

S - Stabbing/sharp

T - Tightness

O - Other



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PERSONAL HEALTH HISTORY O = Occasional F = Frequent C = Constant

O F C

Muscle/Joint
- ☐☐☐ Arthritis
- ☐☐☐ Bursitis
- ☐☐☐ Foot trouble
- ☐☐☐ Hernia
- ☐☐☐ Low back pain
- ☐☐☐ Neck pain
- ☐☐☐ Sciatica
- ☐☐☐ Spinal curvature
- ☐☐☐ Swollen joints
- ☐☐☐ Osteopenia
- ☐☐☐ Osteoporosis

General
- ☐☐☐ Allergies
- ☐☐☐ Dizziness
- ☐☐☐ Fainting
- ☐☐☐ Fatigue
- ☐☐☐ Fever
- ☐☐☐ Headache
- ☐☐☐ Migraine
- ☐☐☐ Loss of sleep
- ☐☐☐ Loss of weight

Respiratory
- ☐☐☐ Chest pain
- ☐☐☐ Chronic cough
- ☐☐☐ Difficulty Breathing

O F C

Pain or Numbness in:
- ☐☐☐ Shoulders
- ☐☐☐ Arms
- ☐☐☐ Elbows
- ☐☐☐ Hands
- ☐☐☐ Hips
- ☐☐☐ Legs
- ☐☐☐ Knees
- ☐☐☐ Feet

Skin
- ☐☐☐ Bruise easily
- ☐☐☐ Rash
- ☐☐☐ Varicose veins

Gastrointestinal
- ☐☐☐ Difficult digestion
- ☐☐☐ Nausea
- ☐☐☐ Stomach pain
- ☐☐☐ Vomiting

Cardiovascular
- ☐☐☐ Hardening of arteries
- ☐☐☐ High blood pressure
- ☐☐☐ Low blood pressure
- ☐☐☐ High cholesterol
- ☐☐☐ Poor circulation
- ☐☐☐ Rapid heartbeat
- ☐☐☐ Slow heartbeat
- ☐☐☐ Swelling of ankles

O F C

Eye, Ear, Nose and Throat
- ☐☐☐ Asthma
- ☐☐☐ Colds
- ☐☐☐ Deafness
- ☐☐☐ Earache
- ☐☐☐ Tinnitus
- ☐☐☐ Enlarged glands
- ☐☐☐ Sinus infection
- ☐☐☐ Sore throat

Women Only
- ☐☐☐ Congested breasts
- ☐☐☐ Cramps or backache
- ☐☐☐ Menopause

Are you pregnant?
☐ Yes ☐ No
How many months?____

Check any of the following conditions you have or have had:

Past	Present	
☐	☐	Alcoholism
☐	☐	Appendicitis
☐	☐	Arteriosclerosis
☐	☐	Cancer
☐	☐	Diabetes
☐	☐	Multiple sclerosis
☐	☐	Edema
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Gout
☐	☐	Heart disease
☐	☐	Measles
☐	☐	Mumps
☐	☐	Pacemaker
☐	☐	Pleurisy
☐	☐	Pneumonia
☐	☐	Polio
☐	☐	Rheumatic fever
☐	☐	Scarlet fever
☐	☐	Shingles
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Whooping cough

TRAUMA Broken Bones, Sprains, Strains, Etc. - List and Date: _____
_____

SURGERIES and/or HOSPITALIZATIONS - List and Date: _____
_____

Have you had X-ray, CT scan, MRI or DEXA of your spine in the past 5 years? ☐ Yes ☐ No
List current prescription medications or vitamins: _____
_____
_____

List any known allergies: _____
Please list any other health conditions you have been treated for in the last 10 years: _____
_____

FAMILY HEALTH HISTORY: Information about your immediate family members will give us a better understanding of your total health picture (cancer, high blood pressure, diabetes, stroke, etc.):

_____
_____
_____
_____
_____

HABITS

HABITS	None	Light	Mod	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty Food	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Artificial Sugar	☐	☐	☐	☐

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FINANCIAL POLICY - ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents, have insurance with the named insurance company(s) on page one and assign directly to Forgey Chiropractic all benefits, if any, otherwise payable to me for services rendered. I authorize the release of any information including diagnosis and the records of any treatment rendered to me, or my child, during the period of such care to third party payers and/or other health practioners. I authorize and request my insurance company to pay directly all medical benefits otherwise payable for services.
I agree to pay for services rendered according to Forgey Chiropractic's rates and terms of the physicians or organization furnishing the services. I understand that I am responsible for charges not covered by my insurance which may include non-covered services, deductibles, co-pays and coinsurances. All accounts, including dependents, are due and payable at the time services are rendered unless prior arrangements have been made with Forgey Chiropractic staff.

I authorize the use of this signature on all my insurance submissions and to obtain other medical records and radiographic/CT/MRI images and their corresponding reports.

Signature of Insured: _____ Date:_____
Printed Name: _____ Relationship to Patient: _____

PRIVACY PRACTICES

The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I have been provided with a copy of the Notice of Privacy Practices. I understand the clinic has reserved the right to change the privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me.

Patient Signature: _____ Date: _____

☐ **PRIVATE PAY/CASH:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all charges related to services at the time they are rendered.
Name of person responsible for this account: _____

Patient Signature: _____ Date:_____

CONSENT TO TREAT

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat application, manual traction, therapeutic exercise, cupping, application of tape, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injuries, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with the spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurological impairment, injuries to the spinal discs and fractures. Serious complications are estimated to be in the range of .5 - 2 incidents per million adjustments for adjustments of the neck and 1 per million for adjustments of the low back. Additional information of side effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warrant for specific cure or result. I consent to treatments offered or recommended to me by the doctors at Forgey Chiropractic.

Patient Signature: _____ Date: _____