ALLEN FAMILY CHIROPRACTIC

Dr. Nickolas Allen, DC
4206 W. 24th Ave. #A102, Kennewick, WA 99338
P: 509-591-4481 F: 509-591-4480

PATIENT INFORMATION

Name: _____ **Date:** _____
Last **First** **Middle**

Address: _____
City **State** **Zip Code**

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Employer: _____ **Job Title:** _____

Birth date: _____ **Sex: M F** **Spouse Name:** _____

Primary Care Physician & location:_____

Emergency Contact Name and Phone No.: _____

Email: _____
(This is for newsletters and promotions that go out from time to time and will not be given to anyone else.)

INSURANCE INFORMATION

Auto Accident: ☐**Yes** ☐**No** **If Yes, Claim No.:** _____ **Date of Injury:** _____

Work Related: ☐**Yes** ☐**No** **If Yes, Claim No.:** _____ **Date of Injury:** _____

Insured Name: _____ **Relationship to above:** _____

Primary Insurance: _____ **ID No.:** _____ **Group ID:** _____

Secondary Insurance: _____ **ID No.:** _____ **Group ID:** _____

CONSENT FOR PAYMENT

I authorize my insurance company to make payment directly to Nickolas Allen, DC in an amount equal to their contracted fee for treatment. I authorize Nickolas Allen, DC/ to release any information pertinent to any insurance company, adjustor attorney to facilitate collection by signing this agreement. I authorize Nickolas Allen, DC to examine any and all healthcare records pertaining to any injury or condition I am seen for. In the case of an auto accident or third party accident, I assign Nickolas Allen, DC any and all insurance benefits, settlement or judgment proceeds due to them, which are or shall become payable to me as a result of my injuries. I agree to see that all charges incurred with Nickolas Allen, DC are fully paid in the amount equal to their fee for treatment. I grant them an irrevocable lien on those benefits or proceeds for their fees. I am aware that I am solely responsible for paying Nickolas Allen, DC for all treatment and services rendered at their office. I understand that at any time they may demand full or partial payment of those services.

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

If Minor, Parent's Signature: _____ **Date:** _____

MEDICARE/MEDICAID DISCLAIMER

To our Medicare patients, we accept assignment on all Medicare patients and chiropractic adjustments are a covered service. Exams for chiropractic are a non-covered service with Medicare. Routine maintenance visits are a non-covered service with Medicare. Rehab therapies are not cover. Medicare will not pay for products sold by a chiropractor. Charges not covered by Medicare or your supplemental insurance may become your responsibility. By signing below you attest that you have read and understand the above.

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

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TREATMENT CONSENT

Name: _____ Date: _____
Last First Middle

TREATMENT DISCLOSURE INFORMATION

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objectives and the methods 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 and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that 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 subluxation. This occurs when one or more of the 24 vertebra in the spinal column, or one of the other joints throughout the body, become misaligned and/or do not move properly. This causes an unhealthy change to 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 a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce subluxations. Our chiropractic method of correction is by specific adjustments to the spine or extremities, including the jaw, arms, and legs. Adjustments are done by hand where the doctor will put pressure on the specific segments of the spine, or other joint, to adjust them into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another healthcare provider.

Chiropractic care, including adjustments and rehab therapies, has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

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

Signature: _____ Date: _____

CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission form my child to receive chiropractic care.

_____

Print Name Signature Date

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HIPAA NOTICE OF PRIVACY PRACTICES

Name: _____ **Date:** _____
Last **First** **Middle**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name

For fast communication it is sometimes beneficial for us to speak with a family member. If you would like to allow access to your information for a family member please fill out and sign below for each individual that will have access to your health information. This is generally used for scheduling

Name: _____ D.O.B.: _____ Relation: _____

Name: _____ D.O.B.: _____ Relation: _____

Your Signature: _____ Date: _____

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PERSONAL HEALTH HISTORY

Patient's Name _____ **DOB** _____ **Date** _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

O F C

Muscle / Joint
- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Arm/Leg pain, stiffness
- ☐ ☐ ☐ Neck pain, stiffness
- ☐ ☐ ☐ Pain between shoulders

General
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness, depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

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

Genitourinary
- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Lack of kidney control
- ☐ ☐ ☐ Kidney infection
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Prostate trouble
- ☐ ☐ ☐ Pus in urine

O F C

Eye, Ear, Nose and Throat
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Crossed eyes
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental decay
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noise
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Nose bleeds
- ☐ ☐ ☐ Sinus infection
- ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ Tonsillitis

Gastrointestinal
- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Bloated abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Gallbladder trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Intestinal worms
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over stomach
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

O F C

Skin
- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin eruptions (rash)
- ☐ ☐ ☐ Varicose veins

Pain or numbness in
- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hand
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tailbone
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

Respiratory
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing
- ☐ ☐ ☐ Asthma

Women only
- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excess menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Lumps in breast
- ☐ ☐ ☐ Menopause
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal discharge

Are you pregnant? ☐Yes ☐No
If yes, how many months?____
How many children do you have?____

Check any of the following conditions you currently have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diptheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

FAMILY HEALTH HISTORY: Information about your immediate family members' health conditions will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

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Patient's Name _____ **DOB** _____ **Date** _____

HEALTH HISTORY:

List any surgeries you have had, and the year you had them: _____

_____

_____

List any mental or emotional disorders you have, or have had: _____

_____

_____

List any medications you are taking, and what you take them for: _____

_____

_____

_____

Have you had any serious illness or injury/accidents in the past:_____

_____

_____

Your job description:_____

Work schedule:_____

Hobbies & Recreational activities:_____

Do you exercise, briefly describe: _____

Do you or have you ever smoked tobacco: No Yes

Do you drink alcohol: No Yes

Do you or have you ever used recreational drugs: No Yes

Describe your diet: _____

Have you broken any bones: _____

_____

Have you had any images (X-ray, MRI, CT, ultrasound) taken recently: _____

_____

Do you take any vitamins or supplements: _____

_____

Allergies: _____

Have you ever been seen by a chiropractor before: No Yes

CURRENT SYMPTOMS

Symptom #1:

Where are your symptoms? _____ Does it ever radiate? _____

How long have you noticed it? _____ Has it gotten: SAME BETTER WORSE

Describe the quality of pain: Sharp dull achy burning throbbing stabbing deep nagging shooting stinging other: _____

How bad is the pain (0 = No pain to 10 = worst pain imaginable): 0 1 2 3 4 5 6 7 8 9 10

What percent of day are symptoms present: 0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

What activity is noticeably affected? _____

What makes the symptom better: _____

What makes the symptom worse: _____

Have you received any treatment for this episode prior to today:_____

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Patient's Name _____ **DOB** _____ **Date** _____

CURRENT SYMPTOMS

Symptom #2:

Where are your symptoms? _____ Does it ever radiate? _____

How long have you noticed it? _____ Has it gotten: SAME BETTER WORSE

Describe the quality of pain: Sharp dull achy burning throbbing stabbing deep nagging shooting stinging other: _____

How bad is the pain (0 = No pain to 10 = worst pain imaginable): 0 1 2 3 4 5 6 7 8 9 10

What percent of day are symptoms present: 0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

What activity is noticeably affected? _____

What makes the symptom better: _____

What makes the symptom worse: _____

Have you received any treatment for this episode prior to today:_____

Symptom #3:

Where are your symptoms? _____ Does it ever radiate? _____

How long have you noticed it? _____ Has it gotten: SAME BETTER WORSE

Describe the quality of pain: Sharp dull achy burning throbbing stabbing deep nagging shooting stinging other: _____

How bad is the pain (0 = No pain to 10 = worst pain imaginable): 0 1 2 3 4 5 6 7 8 9 10

What percent of day are symptoms present: 0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

What activity is noticeably affected? _____

What makes the symptom better: _____

What makes the symptom worse: _____

Have you received any treatment for this episode prior to today:_____

Symptom #4:

Where are your symptoms? _____ Does it ever radiate? _____

How long have you noticed it? _____ Has it gotten: SAME BETTER WORSE

Describe the quality of pain: Sharp dull achy burning throbbing stabbing deep nagging shooting stinging other: _____

How bad is the pain (0 = No pain to 10 = worst pain imaginable): 0 1 2 3 4 5 6 7 8 9 10

What percent of day are symptoms present: 0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

What activity is noticeably affected? _____

What makes the symptom better: _____

What makes the symptom worse: _____

Have you received any treatment for this episode prior to today:_____

Please mark your areas of pain on the figures below.