21651 E. Country Vista Drive, Ste. F • Liberty Lake, WA 99019

DATE: __/__/__

Patient Intake Form

Please complete all sections

Full Name: _____ **Nickname**: _____

Gender: ☐ M ☐ F **Age**: _____ **Date of Birth**: ___ /___ /___

Family Status ☐ S ☐ M ☐ W ☐ D ☐ Sep ☐ P **Number of Children**: _____

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

Home Phone: ( )_____ **Cell**: ( )_____ **Work Phone**: ( )_____

I prefer to be contacted at: ☐ Home ☐ Cell ☐ Work **SSN**: _____

Emergency Contact: _____ **Relationship**: _____

Phone: ( )_____

May we contact you by email and send you updates? ☐ Yes ☐ No **Email**:_____

Employer: _____**Occupation**: _____

Years on the Job: _____

Who referred you to *Barrett Family Chiropractic?* _____

Do you have health insurance? ☐ N/A ☐ Yes ☐ No

Insurance Company: _____ _____

Are you the primary subscriber? ☐ Yes ☐ No

If "No", who is the primary subscriber? _____

DOB of Primary: ___/___ /___

CHIEF COMPLAINT INFORMATION

What is your chief complaint today? *(See Diagram on Page 4)*

_____

When and how did your pain begin? _____

_____

A date is required for Medicare and some insurance policies. Date of onset: ___/___/___

What activities *aggravate* your condition? _____

What activities *improve* your condition? _____

Is your condition getting: ☐ Worse ☐ Better ☐ Staying the same

Are you currently using any home remedies? _____

Have you ever been to a Chiropractor before? ☐ Yes ☐ No
Date of last treatment: ___/___/___ **Name of chiropractor**:_____

List other health care providers you have seen for this condition:

_____

Did you have X-Rays or an MRI or any other imaging performed? ☐ Yes ☐ No
Which body part? _____ **Estimated date of most recent imaging**? _____
Which imaging center performed the testing? _____

PAST MEDICAL HISTORY

Do you have a Primary Care Physician? ☐ Yes ☐ No **Name:** _____

Have you been treated by a physician for any health condition in the past 6 months? ☐ Yes ☐ No

Please describe: _____

Have you ever had any of the following? ☐ Surgery ☐ Fractures ☐ Car Accidents
☐ On-the-job injuries ☐ Serious illness ☐ Cancer ☐ Stroke ☐ Heart attack ☐ TIA

Please describe: _____

Please list your medications: _____
Please list any allergies: _____

PAST FAMILY HISTORY

Do you have a family history of: ☐ Heart Disease ☐ Cancer ☐ Stroke ☐ Diabetes
☐ Arthritis ☐ Back or Disc Problems ☐ Other (please describe): _____
_____
_____

SOCIAL HISTORY

Exercise	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of times per week: _____
Alcohol	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of drinks per week: _____
Coffee	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of cups per day: _____
Smoking	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of packs per day: _____
Water	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of cups per day: _____

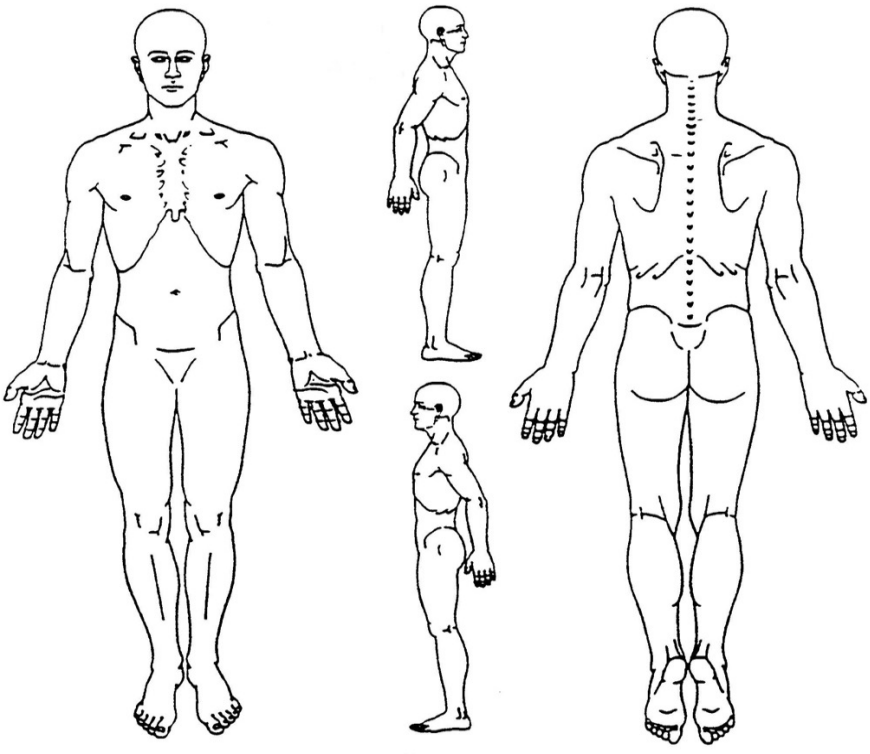
Are there certain activities that you have not been able to do that you would like to be able to return to performing? **Please list**: _____

Patient's Signature: _____ **Date**: _____
(Parent or Guardian Signature if Patient is a Minor)

Patient Name: _____ **Date**: _____
(Please print)

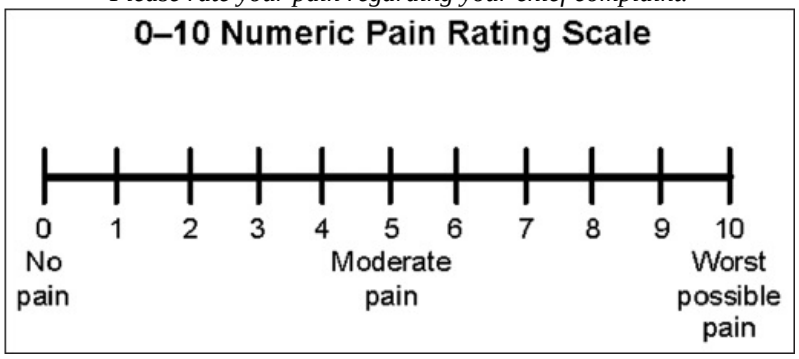
DESCRIBE YOUR CHIEF COMPLAINT TODAY: ☐ Constant ☐ Comes and goes ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Shooting ☐ Symptoms other than above: _____
_____
_____

Mark or circle the area of your symptoms on the drawing and indicate if *painful, numb, tingling* or *aggravated*:



VISUAL ANALOGUE SCALE

Please rate your pain regarding your chief complaint.



Barrett
Family Chiropractic

THE PATIENT – SPECIFIC FUNCTIONAL SCALE
(REQUIRED BY YOUR INSURANCE COMPANY)

NAME:_____
DATE: _____

Please list up to 3 important activities that you are unable to do or are having difficulty with as a result of your discomfort or problem.

	Date	Date	Date	Date	Date
Scoring	1-10	1-10	1-10	1-10	1-10
1._____					
2._____					
3._____					

Scoring Key:

Use the score of 1 if you are UNABLE to do the activity without notable pain / challenge.
Use the score of 10 if you are ABLE to do the activity without any pain / challenge.

Examples of Activities you may write in the first box on this form:

Sitting for a specific period of time	Up or down stairs
Bending	Reading
Lifting a particular amount of weight	Running
Standing in one place for a period of time	Getting in or out of bed
Sleeping	Shopping without a cart
Reaching	A particular sport you like
Pushing	Specific housework
Specific task for work	Specific child care chore

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my treatment, the risks and benefits of my chiropractic treatment, alternatives to my treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that there are some risks to chiropractic treatment including, but not limited to:

- Broken bones
- Dislocations
- Sprains/Strains
- Increased symptoms and pain
- No improvement of symptoms or pain
- Worsening of spinal conditions

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to treatment. I intend for this consent form to cover the entire course of treatment.

To be completed by the patient:

_____

Print name

_____

Signature of Patient

_____

Date signed

To be completed by the patient's representative:

_____

Print name of patient

_____

Print name of patient's representative

_____

Signature of patient's representative

_____

Date Signed

_____

Doctor Signature

_____

Date Signed

HIPAA NOTICE OF PRIVACY PRACTICES
SUMMARY AND DISCLOSURES
BARRETT FAMILY CHIROPRACTIC
Effective Date: January 1, 2016

Our HIPAA Notice of Privacy Practices describes the privacy practices of **Barrett Family Chiropractic**. We respect our legal obligation to keep health information that identifies you private, and by law, we are obligated to provide you a Notice of our privacy practices.

We are required by law to maintain the privacy of your health information, to follow the terms of our Notice that are currently in effect, and if you request, to provide you a copy of our Notice regarding our privacy practices and legal duties in respect of you and the information we collect and maintain regarding your health information. Our Notice also describes your rights regarding your health information and certain obligations that mandate how we use and disclose your health information.

Your Rights —You may:
• Request to inspect any copy of your records.
• Request to amend incomplete or inaccurate information in your records.
• Receive an accounting of certain disclosures of your health information.
• Ask for additional privacy protections (although your request may be declined).
• Ask for confidential communications in a particular manner.
• Receive a paper copy of this Notice.
• File a complaint without penalty.

Use and Disclosures — We will not use or disclose your information unless you tell us to do so or unless the law allows or requires us to do so. We use and disclose your information:
• For treatment, payment, and health care operations.
• Through patient scheduling; to notify family or a close friend you have entrusted with your care; or for notification after benefits or services.
• As permitted or required by the law.
• For certain activities when the law requires it, such as: public health, reporting abuse, neglect, or domestic violence; health oversight; lawsuits and disputes; law enforcement activities; coroner; medical examiner, or funeral director purposes; organ donation; avoidance of a serious threat to health or safety; Worker's Compensation; and National Security.
• With your authorization.

Changes to this Notice — We reserve the right to change this Notice at any time as allowed by law. Updated Notices will be in our office and paper copies will be available upon request.

Complaints — If you believe that we have not properly respected the privacy of your health information, you may file a complaint with our Clinic by contacting our Office Manager by calling 509-319-2310, sending a letter to our office address, or by emailing drsusan@barrettfamilychiro.com.

Please indicate below if we may discuss your health information, appointment scheduling and/or billing with someone you trust:

☐ **Spouse**: _____ ☐ Yes, Health Info ☐ Yes, Billing Info ☐ Yes, Scheduling

☐ **Parent/s or Guardian/s**: _____
☐ Yes, Health Info ☐ Yes, Billing Info ☐ Yes, Scheduling

☐ **Relative/Friend/Other**: _____ **Indicate Relationship**: _____
☐ Yes, Health Info ☐ Yes, Billing Info ☐ Yes, Scheduling

Acknowledgement of Receipt of this Notice

As a patient of **Barrett Family Chiropractic**, I acknowledge that I have received and seen this Notice and understand that I may request a copy of the full HIPAA Notice Privacy Practices for additional information. I understand that **Barrett Family Chiropractic** respects their legal obligation to keep health information private unless required by law. My signature below indicates that I agree to these conditions.

Printed Patient Name: _____

Signature of Patient: _____ **Date**: _____
(Parent or Guardian Signature if Patient is a Minor)