

Absolute Chiropractic & Wellness Center

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PATIENT INFORMATION

Name: _____ Date: _____
(First) (M.I.) (Last)

Sex: ___M ___F Marital status: (circle) single married divorced partnered widowed

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Please **Circle** best # to call

Email: _____

Occupation: _____ Employer: _____

Referred by: _____ Name of Spouse: _____

Emergency Contact: _____
(Name) (Phone) (Relationship to Patient)

FINANCIAL INFORMATION

Financial Category:

___ Personal/Group Insurance ___ Auto Insurance ___ Labor & Industries ___ Cash ___ Other: _____

Insurance Company: _____

Insured Name: _____ Insured DOB: _____

Policy #: _____ Group #: _____ Co-Pay Amount: \$ _____

Deductible Amount: \$ _____ Deductible Remaining: \$ _____

Visit Limits - Chiropractic: # _____ Massage: # _____ Physical Therapy: # _____ Acupuncture: # _____

Insurance Company Address: _____

_____ Phone: _____

Name: _____

Date: _____

HEALTH HISTORY

Purpose of Visit: (circle)

Is this your 1st time seeing this type of practitioner?

Chiropractic

___Y ___N

Massage

___Y ___N

Physical Rehabilitation

___Y ___N

Acupuncture

___Y ___N

Main Complaint: _____

When did this condition begin? _____ How did this condition begin? _____

Do you have any prior history of this problem? ___Y ___N

If Yes, please explain: _____

Is this condition injury related? ___Y ___N If Yes, is it: ___ Work related? ___ Motor vehicle collision related?

Other injury- Please describe: _____

Other doctors/practitioners seen for this condition: _____

What makes this complaint **worse**? _____

What makes the complaint **better**? _____

Pain Intensity (circle the #)	None		Minimal Discomfort/ache/stiff			Slight to Moderate Hurts/sore/bearable			Severe Sharp/intense pain		
	0	1	2	3	4	5	6	7	8	9	10
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck discomfort	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back discomfort	0	1	2	3	4	5	6	7	8	9	10
Low Back discomfort	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot symptoms	0	1	2	3	4	5	6	7	8	9	10
Other:	0	1	2	3	4	5	6	7	8	9	10

Pain Frequency	None	Occasional			Intermittent			Frequent		Constant	
		10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Neck	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid Back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Other:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Do you get headaches? ___Y ___N How frequently? _____

How many hours does your typical headache last? _____

Do you get migraines? ___Y ___N How frequently? _____

How many hours does your typical migraine last? _____

What is/are the cause(s) of your migraines? _____

Name: _____ Date: _____

Please check symptoms with which your pain has been associated:

- Numbness, tingling or pain into your shoulder, upper arm, lower arm, or hand/fingers? **Circle areas.**
- Numbness, tingling or pain into your hip/buttock, groin, front of thigh, back of thigh, knee, calf, shin, or foot/toes? **Circle areas.**
- Increased low back pain with coughing, sneezing, or bearing down to have a bowel movement
- Excessive fatigue-malaise
- Weight loss
- Low grade fever
- Bowel or bladder disorders (such as urinary or bowel incontinence or difficulty urinating or having bowel movements)
- Ovarian pain
- Kidney pain/painful urination
- Night pain or night time sweats
- Abdominal pain
- Balance problems
- Flu/cold
- Inflammation
- Infection
- Contagious disease

Allergies: _____

Food sensitivities: _____

Describe any allergic/sensitivity reactions: _____

Date of last physical exam and results: _____

Job description: _____

Have you been able to work? ___Y ___N

Recreational activities/hobbies: _____

Do you exercise? ___Y ___N If Yes, please describe: _____

Do you, or have you, smoke cigarettes or use tobacco products? ___Y ___N If Yes, for how long? _____

Medications and reason taken: _____

Vitamins, minerals, or other supplements: _____

Name: _____ Date: _____

Past Surgeries

Date

Reason for surgery

Past Accidents, Falls or Injuries

Date

Description of injury

Past Fractures/broken bones

Date

Description/location of fracture

Health problems of relatives: _____

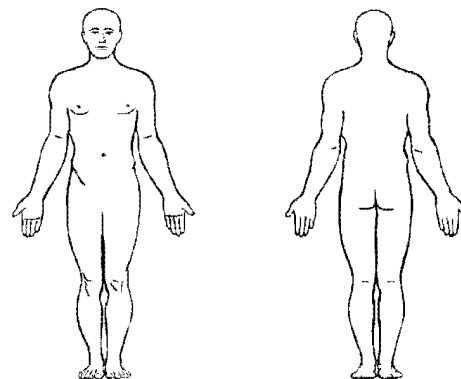
Other health related concerns or comments: _____

WOMEN: Are you pregnant? ___ Y ___ N If so, how far along are you? _____

Please list any pregnancy complications or restrictions? _____

Please indicate on the drawing where you experience the following:

pain (P), aches (A), numbness (N), swelling (S)



Please check any of the following that currently affect you or that you have experienced.

MUSCULOSKELETAL

- Low Back Pain
- Mid Back Pain
- Neck Pain
- Pain between shoulders
- Arm Pain
- Shoulder Pain
- Elbow Pain
- Wrist pain
- Finger Pain
- Hip Pain
- Thigh Pain
- Knee Pain
- Leg Pain
- Foot Pain
- Toe pain
- Ankle pain
- Jaw Pain
- Difficulty Chewing
- Joint Stiffness (Where: _____)
- Joint Swelling (Where: _____)
- Fibromyalgia
- Osteoporosis or Osteopenia
- Arthritis
- Rheumatoid Arthritis
- Postural Deviations
- Headache
- Muscle Weakness or Weak Grip
- Disc bulge/herniation (Where: _____)
- Vertebrae Condition

NERVOUS SYSTEM

- Multiple Sclerosis
- Paralysis
- Spinal Cord Injury
- Stroke
- Seizures/Convulsions
- Numbness/tingling in extremities
- Cold extremities
- Twitching/Ticks
- Fainting
- Depression
- Poor balance/coordination

CIRCULATORY

- Anemia
- Abdominal Aneurysm
- Hemophilia
- High Blood Pressure
- Low Blood Pressure
- Raynaud's Disease
- Varicose Veins
- Hemorrhoids
- Heart Condition/Attack
- Blood Clots/Phlebitis
- Chest Pain
- Irregular heartbeat
- Ankle Swelling
- Light Headedness
- Body too cold
- Body too hot

DIGESTIVE

- Abdominal pain
- Constipation
- Frequent Nausea
- Gall bladder problems
- Liver problems/hepatitis
- Vomiting
- Diarrhea
- Gas/Bloating
- Indigestion/heartburn
- Black or bloody stool
- Excessive thirst
- Excessive appetite

URINARY

- Bladder trouble/infection
- Discolored urine
- Painful urination
- Excessive urination
- Scant urination
- Kidney Problems

RESPIRATORY

- Lung Congestion
- Sinus Congestion/infection
- Asthma
- Difficulty Breathing
- Dizziness
- Lung Condition

SKIN

- Fungal Infections
- Dermatitis/Eczema
- Psoriasis
- Open Wound or Sore
- Rashes
- Warts/Moles
- Athletes Foot
- Ring Worm

OTHER

- Diabetes or Hypoglycemia
- Anxiety/Nervousness
- Muscle Cramping
- Trouble Sleeping
- PMS
- Cancer
- Substance Abuse
- Herpes
- Fatigue
- HIV/AIDS
- Lupus
- Postoperative Situation
- Swelling
- Prosthetics
- Implanted device (ie: pacemaker)
- Joint Replacement
- Transplanted Organ
- Other: _____
- _____
- _____

Name: _____ Date: _____

PATIENT COMPLIANCE FORM

My initials and signature on this document indicates that:

1) I acknowledge that all the information I have given is accurate to the best of my knowledge and is necessary in order to receive the best possible care. I agree and take responsibility for notifying my practitioner if any physical or mental changes occur with my health (ie: injury, illness, pregnancy, etc) to ensure that the most appropriate and effective care continues to be given. _____

2) I understand that if I am here to receive massage therapy, rehabilitation exercises, or acupuncture that massage therapists, athletic trainers, physical therapists, and acupuncturists do not diagnose disease or injury, prescribe medications or manipulate bones. I further understand that the previously mentioned therapies are not a substitute for medical attention or examination. _____

3) I hereby acknowledge that I have read and fully understand the **NOTICE OF PRIVACY PRACTICES** outlining the policies and procedures concerning the privacy of my Patient Health Information and if there is anyone I do not want to receive my medical records, I have informed the center in writing. I agree to allow this wellness center to use my Patient Health Information for the purpose of treatment, payment, healthcare operations and not share my health information with anyone, unless I have signed a Records Release Form. _____

4) If at any time while seeking care at this center I receive treatment from more than one practitioner, I grant permission to those practitioners involved in my care to share my health records and insurance information with one another. My initials and signature below grants permission for the release of my health records to the practitioners within this wellness center coordinating on my care. _____

5) I understand that it is my responsibility to make it to all scheduled appointments and to notify the office/practitioner at least 24 hours in advance if a situation arises that leads to cancellation or rescheduling. I agree to pay the \$50 missed appointment fee (per practitioner seen that day) in the event I miss my appointment or cancel last minute. _____

6) I have read and fully understand this wellness center's **FINANCIAL POLICIES** and know that I am ultimately responsible for any charges incurred at this center. I know that it is my responsibility to pay at the time of service if a cash patient or a co-payment for regular insurance patients. I know that in the event that I am on an injury claim and the claim closes or stops being paid by the insurance company, that I am responsible for payment, which is due at the time of service. **I am aware that not all practitioners at this facility have the same arrangements with insurance companies and that my financial arrangement is per practitioner as verified prior to care.** I authorize the use of this signature on all insurance submissions. _____

7) I have read the **ACUPUNCTURE PATIENT INFORMATION** sheet and hereby acknowledge that I understand the potential risks and side effects of treatment outlined therein. I recognize that no guarantees have been made to me regarding cure or improvement of my condition. _____

INFORMED CONSENT

I give my permission and consent to the general procedure or treatment I will receive and know that if at any time I no longer wish to receive a specific treatment (or an aspect of), I have the right to inform my practitioner. I will ask my practitioner if have any questions concerning the general procedure. _____

Signature: _____ Date: _____