6951 Martin Luther King Jr. Way S., #101
Seattle, WA 98118
(206) 721-7200

PATIENT INFORMATION

## Patient

Last Name: ___________________________ First Name: _________________________ Middle: ________
Date of Birth: ____ / ____ / ____ Age: _______ SS#: __________________________________
Gender: M / F Marital Status: Single / Married
Home Address: ______________________________________________________________________________
City: _______________________________________ State: __________________ Zip:_____________
Home Phone #: ________________________________ Cell / Work Phone #:_________________________
Email Address: _____________________________________________________

## Emergency Contact

Last Name: ___________________________ First Name: ________________________ Middle: _________
Home Phone #: ______________________________ Cell / Work Phone #: __________________________
Relation to Patient: ____________________________________________________________________

## Payment Method ☐Cash ☐Check ☐Visa ☐Mastercard ☐Insurance

## Insurance

Insurance Company: ________________________________________________________________________
Insured's Name: _________________________________ ID/Policy #/Claim #: ______________________
Insurance Phone #: ________________________________

Insurance Company: ________________________________________________________________________
Insured's Name: _________________________________ ID/Policy #/Claim #: ______________________
Insurance Phone #: ________________________________

## Responsible Party Complete this section if you are not the patient but are responsible for the bill.

Responsible Party: ____________________________________ Relationship to Patient: ______________
Home Address: ______________________________________________________________________________
City: ____________________________________________ State: _______________ Zip: __________
Home Phone #: _______________________________ Cell / Work Phone #:__________________________

## Signature (Patient, Parent, Legal Guardian or Responsible Party)

I request services X ____________________________________________________________________

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ASSIGNMENT OF INSURANCE BENEFITS

SIGNATURE ON FILE

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this clinic chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The clinic will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to m account.

I hereby authorize payment directly to International Chiropractic.
I authorize International Chiropractic to act as my agent in helping me to obtain payment from the Insurance Company.
I understand that I am financially responsible to the charges not covered by this assignment.
I authorize the doctor, attorney, or insurance company to release any information required for this claim.
I permit a copy of this authorization to be used in place of the original.

Name: ________________________________

Signature: ______________________________ Date: __________
Patient/ Policy Holder

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# INFORMED CONSENT

## CHIROPRACTIC

Chiropractic is a health care system that promotes health by working with the body naturally. Chiropractic believes that the body has its own innate healing capability to heal itself, if the body is allowed to express itself in its optimal environment, by being free from subluxation. A subluxation is a minor misalignment or malfunction of the joints of the body to the extent that it puts pressure on the surrounding tissues, especially the nerve tissues, and causes problem where ever the nerves travel to, resulting in either over stimulation or under stimulation. Either condition causes an alteration in the normal function of the body, thus resulting in a loss of health. Many things in our daily life can cause subluxation in the body; it may be due to birth process, aging, injury, physical or emotional trauma, stress, chemical imbalance, activity of daily living, etc. Chiropractic corrects the subluxation by giving an adjustment. An adjustment involves the use of controlled force by hand or instrument. Other modalities may be given to help facilitate the healing of the body, to reduce the interferences in the body and restore the normal function. When the body is functioning at its optimum, then you will be healthy.

## INFORMED CONSENT FOR CHIROPRACTIC CARE

I give International Chiropractic permission and authority to care for my condition in accordance with the chiropractic tests, diagnosis and analysis. Chiropractic treatment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, illnesses, or pathologies may render the patient susceptible to injury. I promise to inform International Chiropractic any time I feel my well-being is threatened or compromised. It is my responsibility to let the doctor know all the health condition I am suffering from. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. International Chiropractic will not give a chiropractic treatment, or health care, if he/she is aware that such care may be contraindicated. I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by International Chiropractic and other members of my health care team. I agree to participate in the self care program we select.

## RESULTS

The results of chiropractic care depends on many variables; such as the status of your condition (acute or chronic), how traumatic is your condition, and your overall health. You should notice great improvement within two weeks into your care. In most cases there is a more gradual, but quite satisfactory response.

## RETRACING

On rare occasion, especially when your body is fragile, retracing occurs before “true” healing can take place. Retracing is the release and healing of unresolved problems. After the correction, old injuries, old distortions, old subluxations and old symptoms (both physical and emotional) may resurface while the body is going through the unwinding process of healing.

Patients may report of having "cleansing" symptoms such as diarrhea, pus, mucus, headache, generalized ache and pain, fever, etc. as toxins leave the body. These symptoms may take the form of emotional releases, old memories coming up or unusual dreams.

It is very important, especially at this time, to maintain regular treatment schedule to facilitate the healing process.

Please discuss any questions or concerns you have with the doctor before signing this statement of policy.
I have read and understand this Informed Consent.

______________________________ ______________

Signature Date
(Signature of parent or guardian if patient is a minor)

INTERNATIONAL Chiropractic

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**General**

current past

_____ ____ headaches
_____ ____ pain
_____ ____ sleep disturbances
_____ ____ fatigue
_____ ____ stress
_____ ____ infectious
_____ ____ fever
_____ ____ sinus
_____ ____ other

**Skin Conditions**

current past

_____ ____ rashes
_____ ____ athlete's foot, warts
_____ ____ other

**Allergies**

current past

_____ ____ scents, oils, lotions
_____ ____ detergents
_____ ____ food
_____ ____ other

**Muscles and Joints**

current past

_____ ____ rheumatoid arthritis
_____ ____ osteoarthritis
_____ ____ osteoporosis
_____ ____ scoliosis
_____ ____ broken bones
_____ ____ spinal problems
_____ ____ disk problems
_____ ____ lupus
_____ ____ TMJ, jaw pain
_____ ____ spasms, cramps
_____ ____ sprains, strains
_____ ____ tendonitis, bursitis
_____ ____ stiff or painful joints
_____ ____ weak or sore muscles
_____ ____ neck, shoulder, arm pain
_____ ____ low back, hip, leg pain
_____ ____ other

**Nervous System**

current past

_____ ____ head injuries, concussions
_____ ____ dizziness, ringing in the ears
_____ ____ loss of memory, confusion
_____ ____ numbness, tingling sciatica, shooting pain
_____ ____ chronic pain
_____ ____ depression
_____ ____ other

**Respiratory, Cardiovascular**

current past

_____ ____ heart disease
_____ ____ blood clots
_____ ____ stroke
_____ ____ lymphadema
_____ ____ high, low blood pressure
_____ ____ irregular heart beat
_____ ____ poor circulation
_____ ____ swollen ankles
_____ ____ varicose veins
_____ ____ chest pain, shortness of breath
_____ ____ asthma
_____ ____ other

**Digestive/Elimination System**

current past

_____ ____ bowel dysfunction
_____ ____ gas, bloating
_____ ____ bladder/kidney dysfunction
_____ ____ abdominal pain
_____ ____ other

**Endocrine System**

current past

_____ ____ thyroid dysfunction
_____ ____ diabetes
_____ ____ other

**Reproductive System**

current past

_____ ____ pregnancy
_____ ____ painful, emotional menses
_____ ____ fibrotic cycsts

**Cancer/Tumors**

current past

_____ ____ benign
_____ ____ malignant

**Habits**

current past

_____ ____ tobacco
_____ ____ alcohol
_____ ____ drugs
_____ ____ coffee
_____ ____ soda
_____ ____ other

Note:

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# PERSONAL QUESTIONNAIRE

Please give 3 reasons why you seek care / what would you like to improve on, list base on priority.

1st ______________________________
2nd ______________________________
3rd ______________________________

What 3 things that you enjoy doing in the past that you are having difficulty doing or can not do

1st ______________________________
2nd ______________________________
3rd ______________________________

*Basically, there are 3 things that determine one's health. These are:*

*1. How you think 2. How you move 3. What you eat/put in your body*

At the present time, how healthy do you consider yourself to be

Less than 50% 60% 70% 80% 90% 100% Other _______ %

How healthy would you like to be, base on your maximum healing potential

Same 60% 70% 80% 90% 100% Other _______ %

What is the time frame you would like to accomplish your maximum healing potential

ASAP 1-month 2-month 3-month 6-month 9-month Other _______

How healthy are the members of your household

Spouse ______ % Age ______
1st Child ______ % Age ______
2nd Child ______ % Age ______
3rd Child ______ % Age ______
4th Child ______ % Age ______
Other ______ % Age ______

______________________________
______________________________

I am interested in: ☐ Treatment ☐ Ionic Detox Foot Bath ☐ Nutrition

I am here for:

☐ Symptom care (when my pain is gone, I would like to end my treatment)
☐ Corrective care (no more pain and continue care until body is stabilized)
☐ Wellness care (no more pain, body is stabilized, continue to come in on regular basis, about once a month, to maintain my health)

Additional Information: ______________________________
______________________________
______________________________
______________________________

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## HEALTH CARE TEAM / MEDICATION / NUTRITION

| Name of doctor, practitioner, or facility you went to see regarding your health within the past 3 years | Reason for visit | Time frame From – To (month/yr) | Phone # |
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| Medication/Nutrition/ Supplement | Reason for taken |
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| List any self-help activity |
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