



INTERNATIONAL *Chiropractic*

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

PATIENT INFORMATION

Name

Social Security #

Street

Date of Birth _____ Age _____

City, State, and Zip

Telephone (Home) (_____) _____

(Work/Cell) (_____) _____

Email Address _____

Male [] Female []

Single [] Married []

Contact in case of emergency, Name: _____

Telephone # (_____) _____

Name of Parent of Minor Patient (If applicable) _____

INFORM CONSENT

The doctors of International Chiropractic clinic will provide Chiropractic treatment to help relieve my pain and discomfort and to do their best to restore my health to pre-injury status. I understand and agree that the doctors of International Chiropractic clinic have the right to refuse to accept me as a patient at any time before or after treatment begins, if I do not follow the recommendations and comply with the treatment schedules.

Signature

Date



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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 my 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: _____

Patient/ Policy Holder

Date: _____



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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

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

Date



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MALE: PATIENT CONSENT TO X-RAY

I authorize the performance of diagnostic x-ray examination of myself which the doctor may consider necessary or advisable in the course of my examination and treatment.

Signed _____ Date _____

FEMALE: REGARDING POSSIBILITY OF PREGNANCY

This is to certify that, to the best of my knowledge, I am not pregnant, and International Chiropractic has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed _____ Date _____

FEMALE: CONSENT TO X-RAY DURING PREGNANCY

This is to certify that I am or may be pregnant and that International Chiropractic has my permission to perform diagnostic x-ray examination involving my cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be utilized over the lower trunk of my body. I have been advised that certain x-ray examinations, particularly those in involving the pelvis, can be hazardous to an unborn child.

Signed _____ Date _____

CONSENT TO X-RAY A MINOR

I am the parent or legal representative of _____, who is a minor, _____ years of age. I authorize the performance of diagnostic x-ray examination of this child or ward which the doctor may consider necessary or advisable in the course of examination or treatment.

Signed _____ Date _____



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INJURY

If your injury involved LIFTING, complete this section:

From where were you lifting an object?

- | | |
|--|---|
| <input type="checkbox"/> Ground level | <input type="checkbox"/> A surface below ground level |
| <input type="checkbox"/> A surface 1 to 3 feet high | <input type="checkbox"/> A surface 3 to 5 feet high |
| <input type="checkbox"/> A surface above 5 feet high | |

How many pounds was the object you were lifting?

- | | | |
|--|--|--|
| <input type="checkbox"/> 1 to 5 pounds | <input type="checkbox"/> 5 to 10 pounds | <input type="checkbox"/> 10 to 20 pounds |
| <input type="checkbox"/> 20 to 40 pounds | <input type="checkbox"/> 40 to 60 pounds | <input type="checkbox"/> Over 60 pounds |

What position were you in while lifting the object?

- | | |
|--|--|
| <input type="checkbox"/> Back was upright and straight | <input type="checkbox"/> Bent over at the waist |
| <input type="checkbox"/> Twisted to the left side | <input type="checkbox"/> Twisted to the right side |

What type of pain did you feel immediately after the injury?

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Gripping pain | <input type="checkbox"/> Sharp pain | <input type="checkbox"/> Dull pain |
| <input type="checkbox"/> Aches | <input type="checkbox"/> Popping feeling | <input type="checkbox"/> Paralysis |

If your injury involved FALLING, complete this section:

From where did you fall at work?

- | | |
|--|--|
| <input type="checkbox"/> Onto the ground while walking | <input type="checkbox"/> Onto the ground while running |
| <input type="checkbox"/> From 1 to 3 feet high | <input type="checkbox"/> From 3 to 5 feet high |
| <input type="checkbox"/> From 5 to 8 feet high | <input type="checkbox"/> From higher than 8 feet |

What part of your body did you land on?

- | | | | |
|-------------------------------------|--|---|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Right Shoulder | <input type="checkbox"/> Left Shoulder |
| <input type="checkbox"/> Right Arm | <input type="checkbox"/> Left Arm | <input type="checkbox"/> Right Hand | <input type="checkbox"/> Left Hand |
| <input type="checkbox"/> Back | <input type="checkbox"/> Right Buttock | <input type="checkbox"/> Left Buttock | <input type="checkbox"/> Tail Bone |
| <input type="checkbox"/> Right Hip | <input type="checkbox"/> Left Hip | <input type="checkbox"/> Right Leg | <input type="checkbox"/> Left Leg |
| <input type="checkbox"/> Right Knee | <input type="checkbox"/> Left Knee | <input type="checkbox"/> Right Foot | <input type="checkbox"/> Left Foot |

What other areas of your body were affected by your falling?

- | | | | |
|-------------------------------------|--|---|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Right Shoulder | <input type="checkbox"/> Left Shoulder |
| <input type="checkbox"/> Right Arm | <input type="checkbox"/> Left Arm | <input type="checkbox"/> Right Hand | <input type="checkbox"/> Left Hand |
| <input type="checkbox"/> Back | <input type="checkbox"/> Right Buttock | <input type="checkbox"/> Left Buttock | <input type="checkbox"/> Tail Bone |
| <input type="checkbox"/> Right Hip | <input type="checkbox"/> Left Hip | <input type="checkbox"/> Right Leg | <input type="checkbox"/> Left Leg |
| <input type="checkbox"/> Right Knee | <input type="checkbox"/> Left Knee | <input type="checkbox"/> Right Foot | <input type="checkbox"/> Left Foot |

Other related injury:

- | | |
|---|--|
| <input type="checkbox"/> Raised up from bending over | <input type="checkbox"/> Twisted at the waist |
| <input type="checkbox"/> Wrist injury from repetitive use | <input type="checkbox"/> Wrist injury from pulling |

Please Describe ALL injuries in your own words
