



# INTERNATIONAL *Chiropractic*

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

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## 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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CAR ACCIDENT INFORMATION

Date of Accident \_\_\_\_\_

Time of Accident \_\_\_\_\_ am pm

Please describe the accident in your own words: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you the: Driver Front Passenger  
Rear Passenger Pedestrian (not in car)  
How many people were in the car? \_\_\_\_\_

Street Name \_\_\_\_\_  
City/State \_\_\_\_\_

Make and model of the car you were in: \_\_\_\_\_

Were you wearing seatbelt?  
Full lap and shoulder Lap only  
Shoulder only No seatbelt

What position were your vehicle headrest in?  
Lowest position Middle position  
Highest position No headrest

Was vehicle equipped with airbags? Yes No  
If yes, did it inflate properly? Yes No

What was your vehicle doing just prior to accident?  
Going Straight Slowing down to a stop  
At a complete stop Increasing speed  
Merging into traffic Changing lanes  
Speed traveling? \_\_\_\_\_ mph

Who hit who?  
You were struck by another car  
You struck another car  
You struck a stationary object

What was your vehicles point of impact?  
Front Rear Right side Left side  
Right front Left front Right rear Left rear

Make and model of the other car: \_\_\_\_\_

What was the other vehicle doing just prior to accident?  
Going Straight Slowing down to a stop  
At a complete stop Increasing speed  
Merging into traffic Changing lanes  
Speed traveling? \_\_\_\_\_ mph

What was the other vehicles point of impact?  
Front Rear Right side Left side  
Right front Left front Right rear Left rear

Were you prepared for the impact?  
Came as complete surprise  
Aware but not braced for collision  
Aware and braced for collision  
Position of your head and neck prior to the impact:  
Straight forward Tilted forward  
Rotated to the left Rotated to the right  
Turned around Toward rear view mirror

That happened to your body at the moment of impact?  
Tensed for impact Whipped forward/backward  
Body torqued and twisted Body thrown over seat  
Body thrown from vehicle Body pinned in vehicle  
Body thrown from side to side Cut and bruised  
Did any part of your body hit anything in the vehicle?  
Yes No If yes, explain \_\_\_\_\_

What was your mental/emotional state immediately following the accident?  
Unconscious Shaken up  
Disoriented Shaken up & Disoriented

Did you receive medical attention at the scene of the accident? Yes No

Did you go to the hospital? Yes No  
When did you go? Immediately after accident  
Next day 2 days or more after accident

Name of hospital and treatment received \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did the police come to the accident site? Yes No  
Was a police report filed? Yes No  
Was a traffic violation issued? Yes No  
If yes, to whom? \_\_\_\_\_

How much does it cost to fix the car? \$ \_\_\_\_\_  
What is damage of your car? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Damage of the other car? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_