CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Audubon Park Wellness
2909 West Northwest Blvd
Spokane, WA 99205
Office 509-327-4049
audubonparkwellness.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Gender
○ Male ○ Female

Your Last Name

Your Social Security Number

Your First Name | Your Middle Name (or Initial) | Birth Date (MM/DD/YYYY) | Age

Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Address

City | State/Province | ZIP/Postal Code | Home Phone | Spouse's Name

Email Address | Cell Phone | Child's Name and Age

Emergency Contact | Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer

May we contact you at work?
○ Yes ○ No

Address

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

City | State/Province | ZIP/Postal Code | Work Phone

Insurance Carrier | Policy Number | Primary Care Provider's Name

Insured's Last Name | Birth Date (MM/DD/YYYY)

Who carries this policy?
○ Self ○ Spouse ○ Parent

First Name | Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

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1. **The symptom(s) that have prompted me to seek care today include:** _____

_____

2. **And are the result of (darken circle):** ◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

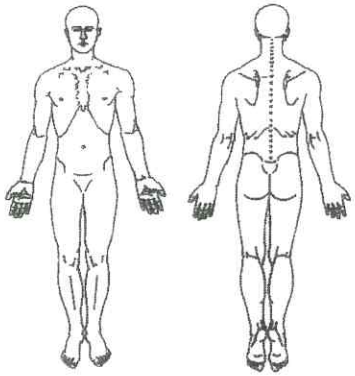
3. **Onset** (When did you first notice your current symptoms?)
_____

4. **Intensity** (How extreme are your current symptoms?)
0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10
Absent Uncomfortable Agonizing

5. **Duration and Timing** (When did it start and how often do you feel it?)
◯ Constant ◯ Comes and goes. How Often? _____
_____

6. **Quality of symptoms** (What does it feel like?)
◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other _____

7. **Location** (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
_____

9. **Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. **Prior interventions** (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other _____
◯ Physical therapy ◯ Massage _____

11. **What else should Audubon Park Wellness know about your current condition?** _____
_____

12. **How does your current condition interfere with your:**
Work or career: _____
Recreational activities: _____
Household responsibilities: _____
Personal relationships: _____

13. **Review of Systems**
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have			
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders	NONE ○
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture	Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness	NONE ○
																		Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising	NONE ○
																		Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia	NONE ○
																		Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea	NONE ○
																		Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste	NONE ○
																		Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash	NONE ○
																		Initials ____

Patient name

Patient Number
(office use only)

Consultation Notes

Doctor's Initials

Audubon Park Wellness

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(Continued from previous page)

h. Endocrine

Had Have ○ ○ Thyroid issues | Had Have ○ ○ Immune disorders | Had Have ○ ○ Hypoglycemia | Had Have ○ ○ Frequent infection | Had Have ○ ○ Swollen glands | Had Have ○ ○ Low energy | NONE ○ Initials ____

i. Genitourinary

Had Have ○ ○ Kidney stones | Had Have ○ ○ Infertility | Had Have ○ ○ Bedwetting | Had Have ○ ○ Prostate issues | Had Have ○ ○ Erectile dysfunction | Had Have ○ ○ PMS symptoms | NONE ○ Initials ____

j. Constitutional

Had Have ○ ○ Fainting | Had Have ○ ○ Low libido | Had Have ○ ○ Poor appetite | Had Have ○ ○ Fatigue | Had Have ○ ○ Sudden weight gain/loss (circle one) | Had Have ○ ○ Weakness | NONE ○ Initials ____

Patient name

Patient Number (office use only)

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			_____
○	○	Chicken pox			_____
○	○	Diabetes			_____
○	○	Epilepsy			_____
○	○	Glaucoma			_____
○	○	Goiter			_____
○	○	Gout			_____
○	○	Heart disease			_____
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: _____

○ ○ Medications (prescription and over-the-counter):

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Audubon Park Wellness about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

19. Are there any other hereditary health issues that you know about? _____

_____

20. Social History

Tell Audubon Park Wellness about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? _____
Coffee use	○ Daily	○ Weekly	How much? _____
Tobacco use	○ Daily	○ Weekly	How much? _____
Exercising	○ Daily	○ Weekly	How much? _____
Pain relievers	○ Daily	○ Weekly	How much? _____
Soft drinks	○ Daily	○ Weekly	How much? _____
Water intake	○ Daily	○ Weekly	How much? _____
Hobbies: _____			

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Doctor's Initials

Audubon Park Wellness

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21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____ **Hours**

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

_____ Signature

_____ Date (MM/DD/YYYY)

Consultation Notes

Patient name _____

Patient Number (office use only) _____

Doctor's Initials _____

Audubon Park Wellness

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HIPAA NOTICE OF PRIVACY PRACTICES
SUMMARY AND DISCLOSURE

Audubon Park Chiropractic

Effective Date:_____

Our HIPAA Notice of Privacy Practices describes the privacy practices of Audubon Park 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 and services.
-As permitted or required by the law.
-For certain activities when the law requires it, such as: public health, reporting of 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; workers' 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 an Office Manager by calling (509) 327-4049, sending a letter to our office address, or by e-mailing twochiros@comcast.net

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

❑ Please do not release my information to anyone unless required to do so by law.

Acknowledgment of Receipt of this Notice As a patient of Audubon Park 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 Audubon Park 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)

Informed Consent Document

Patient Name: _____

To the patient: It is our goal to help you to the best of our ability. Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

What to Expect

With your permission, your doctor will talk with you about your health history, examine you, consider and order necessary tests based on standards of practice and their clinical experience. They will develop a diagnosis and make recommendations for care. With your consent, they will provide care to the best of their ability.

The nature of the chiropractic adjustment

The primary treatment this office uses as Doctors of Chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you. They may use their hands or a mechanical equipment to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement and slight discomfort. If you feel discomfort with any adjustment, please inform the doctor.

Analysis / Examination / Treatment

As part of the treatment you are requesting today, you are consenting to the following procedure(s):

___ vital signs
___ postural analysis
___ palpation
___ range of motion testing
___basic neurological testing
___ orthopedic testing
___ muscle strength testing
___ radiographic studies
___ spinal manipulative therapy
___ Other (please explain in space below)

(Patient: Initial each procedure you are consenting to)

Risks inherent in chiropractic care

As with any health care procedure, there are certain complications which may arise during chiropractic care. Some patients will feel some stiffness and soreness following the first few days of treatment. Sometimes patients experience headaches. This is usually short-term discomfort that is followed by relief. Disc herniation, pinched nerves, arthritic change and biomechanical issues are very common in patients without symptoms. Complications from chiropractic care rarely include but are not limited to fractures, disc injuries, dislocations, muscle strain, spinal cord injury, rib injury and joint pain.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which is typically checked for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

Patients with arterial dissections may experience neck pain, headache and symptoms. These symptoms may cause them to seek chiropractic care. Such arterial dissections and strokes ae very rare. We will make every reasonable effort to determine if you have a developing dissections or stroke. Biomechanical research reveals that chiropractic care does not cause arterial dissections or stroke.to screen for contraindications to care; however, if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform us.

Please inform us of any risk factors or health issues prior to and during your care:

____ Connective tissue disorder, loose joints, Ehlers-Danlos, Marfan, or Loeys-Diets syndrome? ____Any head or neck trauma? ____ Worst headache of your life? ____ Numbness or loss of sensation? ____ Trouble seeing or blurred vision? ____Dizziness? ____ Difficulty talking, difficulty swallowing? ____ Nausea? ____ Recent infection? ____ Fluoroquinolone medication in the past (Cipro, Leavaquin, Levofloxacin, Noroxin, Avelox, etc..)? ____ Coagulation disorders or medicine? ____ Easy bruising? ____ Poor wound healing? ____ Change in bladder or bowel function? ____ Weakness of face, arm or leg? ____ Difficulty walking? ____ Atrial fibrillation or atrial septal defect? ____ Past history of rib or chest injury or pain? ____ Osteopenia or osteoporosis? ____ Have you been diagnosed with cancer?

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers.
- Hospitalization
- Surgery

Medical and Alternative care: The doctor strongly suggests that you advise your primary medical practitioners that you are seeking chiropractic care for your complaint. Please advise your chiropractor of any hospitalizations, changes in treatment, new tests, medications or surgeries. If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

Underlying medical issues may not be initially apparent or may seem to be a musculoskeletal problem. Heart problems, kidneys, infections, fractures, cancer, etc., can cause spinal pain. Sometimes these problems are very difficult to diagnose early on. Symptoms may be very slight and may not be severe enough to warrant initial testing or referral. It is vital for you to inform the doctor of new and worsening symptoms.

Home care: The doctor may make recommendations for activities of daily living, and home exercises. If the recommendation produces discomfort during or after activities, please stop immediately and discuss your concerns with the doctor.

The risks and dangers attendant to remaining untreated or discontinuing care.

If you decide to discontinue care in our office, please advise the doctors. You may have a more sever condition that is not responding that may require further medical care and they will make medical referrals specific to help you. Remaining untreated may allow the formation of adhesions and reduced mobility which may set up a pain reaction of further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the adjustment and related treatment. I have discussed it with Audubon Park Chiropractic and have had my questions to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ Dated: _____

_____ _____
Patient's Name Doctors Name

_____ _____
Signature Signature

_____
Signature of Parent or Guardian
(If a minor)