EASTLAKE CHIROPRACTIC AND MASSAGE CENTER

PATIENT REGISTRATION

Full Name: Mr./Mrs./MS ____

Name you prefer to be called ("Nick Name"): _______________________________

Mailing Address: ____

City:_____________________________ State: _________ Zip Code: __________

E-mail Address: ____

Home Phone: _____________________ Cell Phone:__________________________

Work Phone: _____________________ Occupation: _________________________

Birthday: ________________________ Age: ____________ Sex: M____ F _____

Spouse/Partner's Name: ____

Insurance Company: _______________________ Phone ______________________

Name of Insured: ____

What is your relationship to the insured? Self / Spouse / Dependent / Other

ID # or Social Security # _________________ Group or Claim # _______________

If Accident Related, Adjuster's Name: _______________ Phone: _______________

Whom may we thank for referring you to our office? _________________________

Name of Medical Doctor: ________________________ Phone: ________________

In case of emergency who should we contact? _____________ Phone: __________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Eastlake Chiropractic and Massage Center will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Eastlake Chiropractic and Massage Center will be credited to my account receipt. However, I clearly understand and agree that all services rendered me are charged to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable. I hereby agree that I will be assessed one percent (1%) charge per month on any fee not kept current.

Signature:__________________________________ Date: _____________________

Patient Health Questionnaire

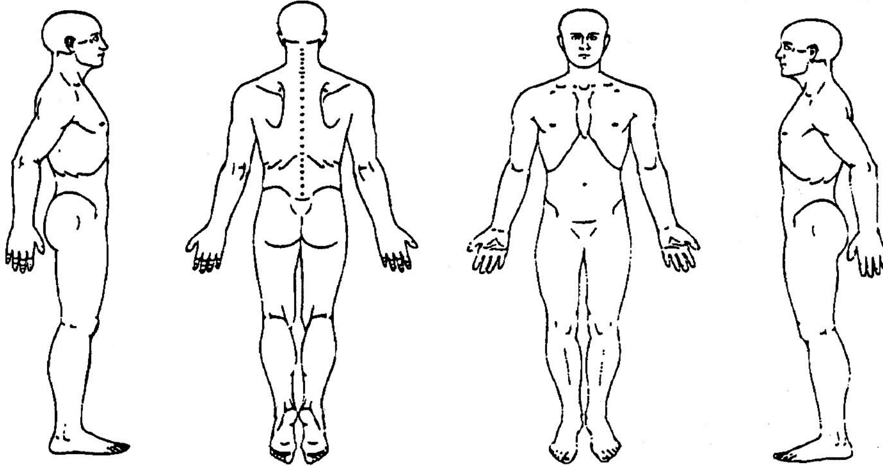
Patient Name ______________________ **Date** __________

When did your symptoms start? __________ **Describe your symptoms and how they began:**

____

____

Indicate on the pictures below where you have pain or other symptoms



How often do you experience your symptoms?
- ○ 1-Constantly (76-100% of day)
- ○ 2-Frequently (51-75% of day)
- ○ 3-Occasionally (26-50% of day)
- ○ 4-Intermittently (0-25% of day)

What describes the nature of your symptoms?
- ○ Sharp
- ○ Shooting
- ○ Dull ache
- ○ Burning
- ○ Numb
- ○ Tingling

How are your symptoms changing?
- ○ 1-Getting Better
- ○ 2-Not Changing
- ○ 3-Getting Worse

What is the intensity of your symptoms at their:

	None									Unbearable
worst	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⓪
best	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⓪

Who have you seen for this episode of your symptoms? ○ No one ○ Other Chiropractor ○ Medical Doctor ○ Physical Therapist ○ Other

When and what treatment? ______________________

Have you had the same or similar symptoms in the past? ○ Yes ○ No

If you have received treatment in the past for the same or similar symptoms, who did you see? ○ This office ○ Other Chiropractor ○ Medical Doctor ○ Physical Therapist ○ Other

What tests have you had for your symptoms? ○ Xrays ○ CT Scan ○ MRI Scan ○ Other

What is your occupation?
____
- ○ 1-Professional/Executive
- ○ 2-White Collar/Secretarial
- ○ 3-Tradesperson
- ○ 4-Laborer
- ○ 5-Homemaker
- ○ 6-FT Student
- ○ 7-Retired
- ○ 8-Other

If you are not retired, a homemaker or a student, what is your current work status?
- ○ 1-Full-time
- ○ 2-Part-time
- ○ 3-Self-employed
- ○ 4-Unemployed
- ○ 5-Employed, off work due to restrictions
- ○ 6-Other

As a result of your symptoms are you restricted in your ability to perform work and/or daily activities? ○ Yes ○ No

Describe your restrictions ______________________

What type of regular exercise do you perform? ○ 1-None ○ 2-Light ○ 3-Moderate ○ 4-Strenuous

What is your height and weight? Height [ ] Feet [ ] Inches Weight [ ] lbs.

Patient Signature ______________________ **Date** __________

Functional Rating Index

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

Name:____ Date:________________

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst Possible pain

2. Sleeping

Perfect Sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain; No restrictions	Mild pain; No restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Signature:____ Date:____________________

EASTLAKE CHIROPRACTIC AND MASSAGE CENTER

TERMS OF ACCEPTANCE

I, ____________________ hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by Dr. Lincoln Kamell, Dr. Calvin Mulanax, and /or other licensed doctors of chiropractic who may practice in or by contracted by Eastlake chiropractic and Massage Center.

The following items will, upon my request, e explained to me to my satisfaction, and I will have an opportunity to discuss them with Dr. Kamell, Dr. Mulanax, or other clinic personnel at any time:

1. Chiropractic care is the science, philosophy and art of locating and correcting spinal subluxations (misalignments and /or joints lacking in proper mobility), and, as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. This is tits only goal. There has been no promise, implied or otherwise, to treat or offer cure for any symptom, disease or condition as a result of care in this clinic.
2. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint which may cause an audible “pop” or “click”.
3. It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures which he feels at the time to be in my best interest. If during the course of a chiropractic examination he encounters non-chiropractic or unusual finding, he will advise me. If I desire advice, diagnosis or treatment for those findings, he will recommend the services of a health care provider who specializes in that area.
4. It is not reasonable to expect the doctor to be able to anticipate or explain all possible risks and complications of a given procedure on my particular visit.
5. The chiropractic adjustment is usually beneficial and seldom causes any problem. In rare cases, underlying physical defects, deformities, or pathology may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment if he is aware that such a condition exists. Complications that may arise on an extremely rare basis include sprains/strains, dislocations, fractures, disc injuries, or CVA’s (cerebral-vascular accidents).

I have read the above or have had it read to me. I am comfortable with the information provided. I consent to chiropractic treatment and management on that basis.

Signature:_____________________________________ Date: _____________________

EASTLAKE CHIROPRACTIC AND MASSAGE CENTER

PATIENT CONSENT FORM

Regarding the Use and Disclosure of Protected Health Information

For the purposes of this Consent Form, “Office” shall refer to: Eastlake Chiropractic and Massage Center, PS.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office’s privacy notice entitled, “Our Privacy Practices”. I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time the Office’s privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (Please Print): ____

Signature:____________________________________ Date: _____________________

EASTLAKE CHIROPRACTIC AND MASSAGE CENTER

APPOINTMENT AND FINANCIAL POLICIES

We would like to take the time to welcome you to our office. We appreciate the opportunity to help you in your efforts to regain optimum health. The following is an over view of our office policies.

APPOINTMENT/CANCELATION POLICY

In order to serve all our patients we ask that you call if you are unable to make your appointment or even if you find yourself running late. We will do our best to accommodate you and get you in for your visit as soon as possible. When you fail to notify our office, this leaves a time slot open that could otherwise be used to help someone else.

CANCELATIONS POLICY: We require 24 hours notice if you are unable to keep your appointment. Failure to give ample notice or not show will result in a fee of $50 for massage and $35 for chiropractic. We do understand that there are things we cannot control in life and this policy does not apply to a true emergency.

FINANCIAL POLICY

INSURANCE: Please present your insurance card today. We will contact your insurance company and verify your benefits; however, we strongly recommend that you also call for verification to avoid any confusion. If you have coverage for chiropractic care our office will bill your primary insurance company. After your insurance company has been reached for benefit information a financial payment plan will be presented on your following visit. When applicable, patient co-pays are due at the time of service. If your insurance plan requires a Primary Care Physician (PCP) referral, you must provide this office with a written authorization from your PCP.

CASH: Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance. Payment plans are available. Please ask the office manager.

LABOR & INDUSTRIES: Once we verify that your injury or illness is job-related, we will complete and mail all claim forms directly to the Department of Labor and Industries. All approved costs are paid directly by them. Usually, there are no out of pocket expenses to you. In the event that you are denied coverage by L & I, you will be financially responsible for payment for all services that have been rendered to you. It is important to cooperate with L & I to receive benefits.

PERSONAL INJURY: Please provide us with your car insurance, health insurance, accident report, and name of attorney if applicable. If the claim is a possible third party liability please provide us with the other parties' insurance carrier information. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for care on a cash basis. Patients with Personal Injury Protection (PIP) coverage are not required to pay for care as it is rendered. Patients who are covered by third party insurance will need to check with the front desk to make payment arrangements.

MEDICARE: Please present your Medicare card to reception. There are some treatments that are not covered by Medicare, reception will provide you with a list of those items.

Signature:___________________________________ Date: _________________________