# Chiropractic Registration Form

## Patient Information

Your Last Name _____ Your First/Middle Name _____

Address _____

City _____ State _____ Zip _____

Email _____

**Emergency Contact Information:**

Emergency Contact Name _____ Contact Phone Number _____

Emergency Contact Relationship _____

**Employment Information:**

Your Employer _____ Your Work Number _____

Employer's Address _____

Whom may we thank for referring you? _____

Today's Date _____

**Gender** ☐ Male ☐ Female

Social Security Number _____

Birth Date (MM/DD/YYYY) _____ Age _____

Home Phone _____

Cell Phone _____

**Preferred phone number?**

☐ Home ☐ Cell ☐ Work

**Marital Status**

☐ Single ☐ Married

☐ Divorced ☐ Widowed

☐ Separated

Name of Spouse/Partner _____

Primary Care Provider(PCP) _____

PCP Phone Number _____

## Patient Condition

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

_____

2. **And are they the result of:** ☐ **An accident or injury** ☐ Auto ☐ Work ☐ Other _____
   ☐ **A worsening long term problem**
   ☐ **An interest in** ☐ Wellness ☐ Other _____
3. **Onset** (When did you first notice your symptoms?) _____
4. **Intensity** (How extreme are your current symptoms?) **0** ○-○-○-○-○-○-○-○-○-○ **10**

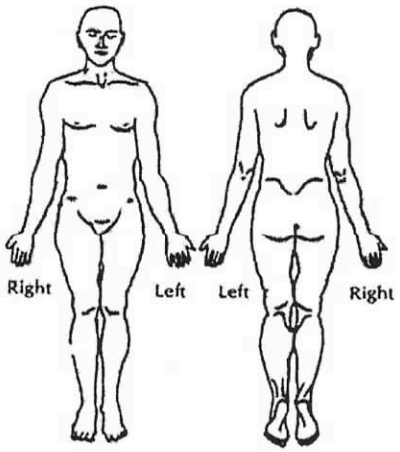
   Absent Uncomfortable Agonizing

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?)

- ☐ Tingling
- ☐ Stiffness
- ☐ Sharp
- ☐ Stabbing
- ☐ Dull
- ☐ Aching
- ☐ Cramps
- ☐ Nagging
- ☐ Throbbing
- ☐ Burning
- ☐ Shooting
- ☐ Other




7. **Location** (Where does it hurt?) On the illustration to the left, mark an X where you continue to experience the symptoms you have selected in number 6.

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?) _____

_____

10. What else should Dr. Dawn know about your current condition?_____

11. **How does your current condition interfere with your:**

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

12. **Have you consulted a chiropractor before?** ☐ Yes ☐ No When? _____ Whom? _____

13. **Treatments:** (Check types of care that you are currently receiving to help your current complaints)

☐ Acupuncture ☐ Homeopath ☐ Massage therapy ☐ Naturopathic care

☐ Primary care doctor ☐ Physical Therapy ☐ Other _____

14. **Review of Symptoms** Chiropractic care focuses on the integrity of your nervous systems, which controls and regulates your entire body. Please darken the box next to any condition you have **Had**, or currently **Have**.

A. **Musculoskeletal**
- ☐ Osteoporosis
- ☐ Knee Injuries
- ☐ Arthritis
- ☐ Foot/ankle pain
- ☐ Scoliosis
- ☐ Shoulder problems
- ☐ Neck pain
- ☐ Elbow/wrist pain
- ☐ Back problems
- ☐ TMJ issues
- ☐ Hip Disorders
- ☐ Poor posture

F. **Integumentary**
- ☐ Skin cancer
- ☐ Psoriasis
- ☐ Hair loss
- ☐ Rash

G. **Constitutional**
- ☐ Fainting
- ☐ Low libido

B. **Neurological**
- ☐ Anxiety
- ☐ Depression
- ☐ Headache
- ☐ Dizziness
- ☐ Pins and needles
- ☐ Numbness

C. **Cardiovascular**
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Angina
- ☐ Excessive bruising
- ☐ Fatigue
- ☐ Sudden weight loss/gain
- ☐ Weakness

H. **Sensory**
- ☐ Blurred Vision
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Chronic ear infection

D. **Respiratory**
- ☐ Asthma
- ☐ Apnea
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Pneumonia

E. **Digestive**
- ☐ Anorexia/bulimia
- ☐ Ulcer
- ☐ Food sensitivities
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea

I. **Genitourinary**
- ☐ Kidney stones
- ☐ Infertility
- ☐ Bedwetting
- ☐ Prostate issues
- ☐ Erectile dysfunction
- ☐ PMS symptoms

J. **Illness** (check the illnesses you have had or have)

- ☐ AIDS
- ☐ HIV Positive
- ☐ Alcoholism
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Measles
- ☐ Mental Illness
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ STD
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcer
- ☐ Other _____
- ☐ _____
- ☐ _____

## *Lifestyle/Personal*

15. **Exercise**

- ☐ None
- ☐ Moderate
- ☐ Daily
- _____
- ☐ Heavy

17. **Work Activities**

- ☐ Sitting
- ☐ Standing
- ☐ Light labor
- ☐ Heavy labor

18. **Habits**

- ☐ Water — Cups/Day _____
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine drinks — Cups/Day _____
- ☐ High stress level — Reason _____

19. **Are you pregnant?** ☐ Yes ☐ No Due date _____ OB/GYN name _____

20. **Injuries/Surgeries you have had:**

| | **Description** | **Date** |
|---|---|---|
| Falls | _____ | _____ |
| Head injuries | _____ | _____ |
| Broken bones/dislocations | _____ | _____ |
| Accidents | _____ | _____ |
| Surgeries | _____ | _____ |

21. **Medications**

_____
_____
_____

22. **Allergies**

_____
_____
_____

23. **Vitamins/Herbs/Minerals**

_____
_____
_____

24. **What is the major stressor in your life?** _____

25. **Hours of sleep you average per night?** _____

26. **What is your preferred sleeping position?** _____

27. **Describe your eating habits:**

☐ no breakfast ☐ 2 meals a day ☐ 3 meals a day ☐ snacking between meals

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

_____

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

_____

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

_____ _____

**Patient Signature, Guardian Signature** **Date** (MM/DD/YYYY)

# Bayshore Chiropractic- Policies and Practices

## 840 SE Bayshore Drive, Ste. 101, Oak Harbor WA 98277

### Philosophy of Care

The doctor's intention is to provide you with the highest quality of chiropractic care. The doctor will explain her findings and develop a treatment plan for you. If you have questions about your care, please ask. The doctor's goal is to help patients move and feel better within 3 to 4 visits and will adapt the care provided or make an appropriate referral to another health care provider as appropriate.

### Hours of Operation

Bayshore Chiropractic is open Monday and Thursday from 9AM-6PM, closed for lunch from 12:45-2:00PM and Tuesday and Friday 9AM-5PM, closed for lunch from 12:30-1:30PM. On occasion, the office hours will change to accommodate holidays or the doctor's schedule. Schedule changes will be made available on the office's voicemail.

### Appointment/Cancellation Policy

If you are unable to keep your appointment, you must call 24 hours in advance to cancel. A **$40 cancellation fee** will be charged when appointments are not cancelled within the 24- hour window. A **$40 missed appointment fee** will be charged for each failure to not show for an appointment. Our phone system takes messages 24-hours per day, so please leave a message if you are unable to reach us.

****Reminder calls, texts and emails are a courtesy and do not replace your responsibility to remember your appointment. Please call our office to respond to texts as we cannot receive replies to your texts.**

### Wait List

At times, the schedule will get busy, and it may take a week or two to make an appointment. You are welcome to request being added to our wait list. We call patients in the order in which they were added, however, if a patient does not answer, we have a need to fill an appointment, and reserve the right to move on to the next patient on the wait list. On occasion, if a patient has had a serious accident, the doctor reserves the right to see that patient on an emergency case-by-case basis, we do save a few emergency appointments each day.

### Financial Policy

Bayshore Chiropractic does not bill individual health insurance companies. Each patient pays out of pocket at time of service. We do on a case-by-case situation take a car accident or L&I patient, in that case we will try to work with that insurance, but will get approval before treatment. Please note that there is a $25 fee for any returned checks. We accept cash, checks, and major credit cards.

### Medicare Patients **Initial Here:**_____

**_Medicare will cover what is considered "medically necessary" manipulation of the spine. Medicare patients will pay the allowable amount considered from Medicare at the time of service. We will bill Medicare and you will be reimbursed from Medicare once your deductible is met. Medicare will not cover the initial exam, the patient is responsible for the exam fee, when performed. Medicare does not cover maintenance or wellness care, medical equipment, retail products, extremity adjustments, taping, exercise or stretching, these services or products are the patient's responsibility at the time of service. The doctor will notify you if they do not believe that Medicare will cover your care for a specific visit.**

### General Risks Associated with Chiropractic Care

**The primary treatment used by Doctors of Chiropractic is the spinal adjustment. The doctor will use various spinal adjusting techniques along with other types of conservative care to treat you. The doctor will use their hands, a mechanical device, or a table with moving parts to mobilize and align restricted joints. That may cause an audible "pop" or "click" much as you experience when you "crack" your knuckles. You may feel or sense movement. This is gas releasing in the joint fluid. As with any health care procedure, there are certain complications in which may arise during a chiropractic adjustment. Those complications may include: fractures, disc injuries, dislocations, stroke and muscle or ligament stain. Some people will feel stiffness and soreness following the first few days of a treatment. Deep tissue massage may result in bruising and soreness. The probability of those risks occurring is rare. Stroke has been the subject of tremendous discussion, but the actual risk is about a one in a million chance of such an outcome. Since even that risk should be avoided the doctor employs tests during the examination designed to identify whether you may be susceptible to injury. The risks associated with remaining untreated are more dangerous than treatment. The formulation of adhesions and reduced spinal mobility sets up a pain reaction which over time complicates the problem, making treatment more difficult and less effective. The voicemail can take messages 24 hours a day. If you are experiencing an emergency, call 911.**

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

**Patient Name**_____ **Signature** _____ **Date**_____

Notice of Effect: January 1, 2021

# NOTICE OF PATIENT PRIVACY SUMMARY

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with notice describing:

## HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND

## HOW YOU CAN ACCESS THIS INFORMATION

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the are that we provide to you, and the related administrative activities supporting your treatment.

Your protected health information may be used and disclosed without your expressed consent or authorization for the purpose of treatment, payment, and health care operations. We may be required or permitted by certain laws to use and disclose your protected health information for other purposes without your consent or authorization. For example, appointment reminders, individuals involved in your care or payment for your care, disaster relief, de-identified information, business associates, personal representative, emergency situations, public health and safety activities, victims of abuse, neglect or domestic violence, health oversight activities, judicial and administrative proceedings, to avert serious threat to health or safety, coroners, medical examiners, funeral directors, organ, eye or tissue donation, workers compensation, special government functions, research, fundraising, and disclosures for law enforcement purposes.

Your specific written permission to use or disclose your information must be obtained for marketing purposes and sale of health information. You, as our patient, have the right to revoke authorization but it must be submitted as a written request to the practice's privacy officer.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated. You also have the right to request your medical records in an electronic format and for those patients that pay out of pocket in full you may restrict the disclosure of Protected Health Information to a health plan for the health care item or service received.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top left -hand side of this pate indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact:

BAYSHORE CHIROPRACTIC PSC

840 SE BAYSHORE DRIVE STE 101

OAK HARBOR, WA 98277

PHONE (360) 675-1066 FAX (360) 769-2278

Patient Name_____ Signature_____ Date _____