Chiropractic Intake
Plateau Chiropractic Clinic

3707 Providence Point Drive SE, Suite B, Issaquah, WA 98029 – (425) 868-9593

Name _____ Date _____

Phone (C) (H) (W) _____ (C) (H) (W) _____

Address _____ City _____

State _____ Zip _____ Date of Birth _____

E-mail _____

Marital Status: Single Married Divorced Widowed Occupation _____

Who is financially responsible for your care? _____

Emergency Contact Name _____ Phone _____

Were you referred by anyone? Y N If so, who? _____

Please list your current health complaints _____

_____

_____

Are these the result of an auto or work-related injury? Y N If yes, when? _____

Please circle any of the following functions below that aggravate or are aggravated by your condition:

walking step climbing driving working recreating lifting vision

breathing sinus problems concentration hearing sleeping menstrual

bowl movement digestion

Do you experience headaches? Y N If so, what type? tension throbbing sinus migraine

Have you ever been to a Chiropractor before? Y N If so, when? _____

List any major surgeries or operations: _____

List any major accidents or falls: _____

Is there a chance you are pregnant? Y N Have you ever been diagnosed with cancer? Y N

By signing below, I confirm that the above information is true and accurate to the best of my knowledge

Name _____ Date _____

Signature _____

HEALTH HISTORY

What treatment have you already received for your condition? _____ Medications _____ Surgery _____ Physical Therapy_____

_____ Chiropractic Services _____ None _____ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

AIDS/HIV	__ YES ___ NO	Emphysema	__ YES ___ NO	Liver Disease	__ YES ___ NO	Rheumatoid Arthritis	__ YES ___ NO
Alcoholism	__ YES ___ NO	Epilepsy	__ YES ___ NO	Measles	__ YES ___ NO		
Allergy Shots	__ YES ___ NO	Fractures	__ YES ___ NO	Migraines	__ YES ___ NO	Rheumatic Fever	__ YES ___ NO
Anemia	__ YES ___ NO	Glaucoma	__ YES ___ NO	Miscarriage	__ YES ___ NO		
Anorexia	__ YES ___ NO	Goiter	__ YES ___ NO	Mononucleos	__ YES ___ NO	Scarlet Fever	__ YES ___ NO
Appendicitis	__ YES ___ NO	Gonorrhea	__ YES ___ NO	Multiple Sclerosis	__ YES ___ NO	Stroke	__ YES ___ NO
Arthritis	__ YES ___ NO	Gout	__ YES ___ NO			Suicide Attempt	__ YES ___ NO
Asthma	__ YES ___ NO	Heart Disease	__ YES ___ NO	Mumps	__ YES ___ NO		
Bleeding Disorders	__ YES ___ NO	Hepatitis	__ YES ___ NO	Osteoporosis	__ YES ___ NO	Thyroid Problems	__ YES ___ NO
Breast Lump	__ YES ___ NO	Herniated Disk	__ YES ___ NO	Pacemaker	__ YES ___ NO		
Bronchitis	__ YES ___ NO	Hepatitis	__ YES ___ NO	Parkinson's Disease	__ YES ___ NO	Tonsilitis	__ YES ___ NO
Bulimia	__ YES ___ NO	Hernia	__ YES ___ NO	Pinched Nerve	__ YES ___ NO	Tuberculosis	__ YES ___ NO
Cancer	__ YES ___ NO	High Blood Pressure	__ YES ___ NO	Pneumonia	__ YES ___ NO	Tumors	__ YES ___ NO
Cataracts	__ YES ___ NO			Polio	__ YES ___ NO	Typhoid Fever	__ YES ___ NO
Chemical Dependency	__ YES ___ NO	High Cholestrol	__ YES ___ NO	Prostate Problem	__ YES ___ NO	Ulcers	__ YES ___ NO
Chicken Pox	__ YES ___ NO	Kidney Dis	__ YES ___ NO	Prosthesis	__ YES ___ NO	Vaginal Infections	__ YES ___ NO
Diabetes	__ YES ___ NO			Psychiatric	__ YES ___ NO	Whooping Cough	__ YES ___ NO

EXERCISE		WORK ACTIVITY		HABITS			
_____	None	_____	Sitting	_____	Smokin Packs/Day	_____	
_____	Moderate	_____	Standing	_____	Alcohol Drinks/Week	_____	
_____	Daily	_____	Light Labor	_____	Caffein Cups/Day	_____	
_____	Heavy	_____	Heavy Labor	_____	Recreation Drugs	_____	

Are you pregenant? _____ Yes _____ No Due Date _____

Injuries/Surgeries you have had	Description	Date

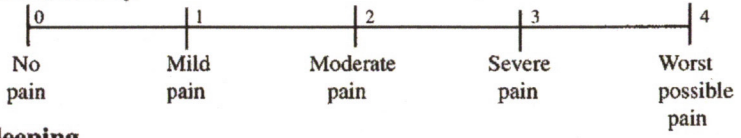
MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

Functional Rating Index

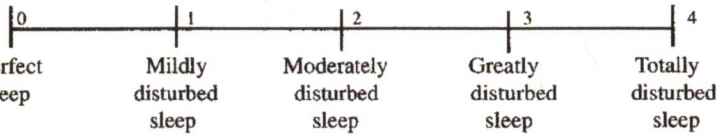
For use with **Neck and/or Back Problems** only.

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.**

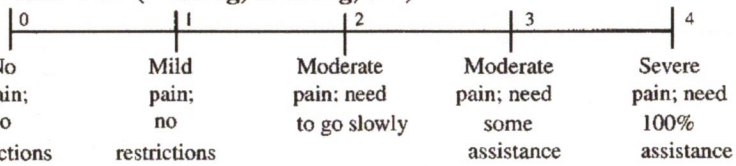
1. Pain Intensity



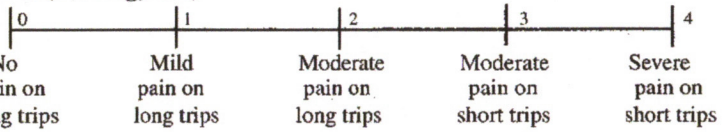
2. Sleeping



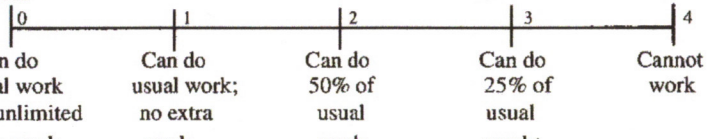
3. Personal Care (washing, dressing, etc.)



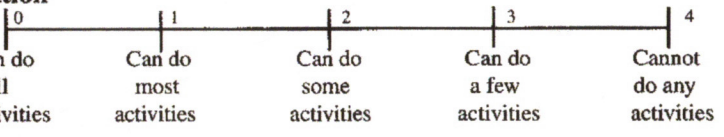
4. Travel (driving, etc.)



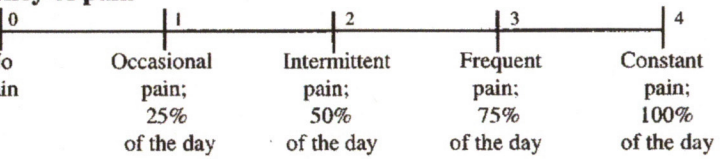
5. Work



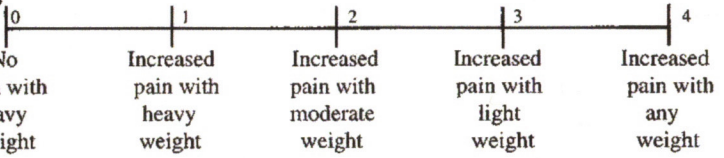
6. Recreation



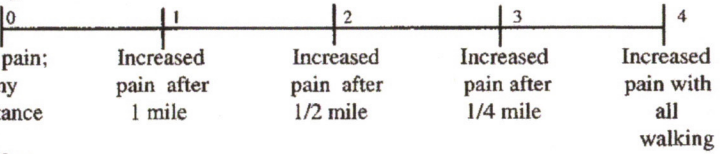
7. Frequency of pain



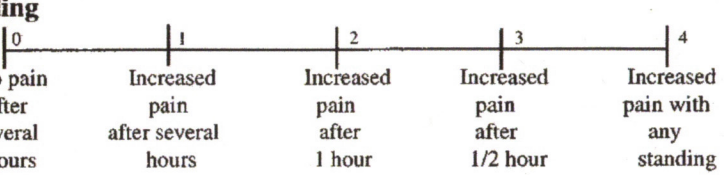
8. Lifting



9. Walking



10. Standing



Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____ _____

Signature **Date**

Plateau Chiropractic
3707 Providence Point Dr. SE, Suite B, Issaquah, WA 98029
P: (425) 868-9593 F: (425) 868-6826

DIRECT ASSIGNEMENT OF BENEFITS & RIGHTS

PATIENT NAME: **DATE:**

In consideration of your undertaking to render care, I agree to the following:

1. RELEASE OF INFORMATION: You are authorized to release an information you deem appropriate concerning my physical condition to any Insurance company, attorney, or adjuster, to process any claim for reimbursement of charges incurred by me at your treatment facility.

2. RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider authority to affix my necessary signature as noted below to obtain medical information from any hospital, medical provider, etc., as it relates to the care being provided by my chiropractic doctor.

3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any Insurance company, which may become obligated to pay me any sums. The Patient(s) grant(s) to the provider a Limited Power of Attorney to receive funds, negotiate any drafts or checks and execute any documents related to payment for services rendered to me.

4. ASSIGNEMNT OF RIGHT TO SUE: In the event, any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve the said claim and you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.

5. RIGHT TO LIEN: I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my injury, including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by you. I also irrevocably instruct my attorney to pay this office in full for services rendered to me for my accident-related injuries form any proceeds or settlements, claims, or judgment regarding said injuries. My legal counsel or successor or any representative is to pay the doctor/clinic before distributing any proceeds to me. I instruct said legal counsel or representative not to attempt to reduce by means of negation my doctor's bill for services that have been provided to me for the accident/injury/illness, which I have agreed to pay in full.

6. RIGHT TO INFORMATION: I irrevocably authorize my attorney, or successor, or legal representative, insurer, or any other party regarding my care or case to release financial information about the proposed settlement, settlement/verdict payment, or amounts owed included, but not limited to other providers or legal representatives, liens, billing amounts, and balances. I also instruct all representative to include all financial information from all facets of my case, including, but not limited to, third-party, uninsured motorists and underinsured motorists.

7. I irrevocably waive the Statute of Limitations regarding my Doctor's right to recover from me directly.

8. I hereby acknowledge that I am receiving (or about to receive) health care services, and I am advised that they are willing to wait for payment for these services, provide there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there is NO insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the Doctor(s) or make other provisions for the protection of the interest of the Doctor(s); or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the Doctor(s) or if I have not engaged the series of an attorney, payment for services rendered by the Doctor(s) will be made on a current basis and my account paid in full immediately. In any event, I hereby promise to pay my bill in full within (10) days from the date of my liability claim is settled or after the passage of three (3) months from the date of my last treatment, which ever comes first.

Plateau Chiropractic
3707 Providence Point Dr. SE, Suite B, Issaquah, WA 98029
P: (425) 868-9593 F: (425) 868-6826

9. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all court costs, attorney's fees, services of process fees, and any reasonable additional costs incurred in order to collect or that are associated with collecting monies due on the patient's account.

10. No Surprise Act: Our fees are derived from the Medical Fees in the United States by the Physicians Medical Information Corporation 2022. They have been geographically modified and are billed at the 75th percentile. A good faith estimated cost for the items and services that would be furnished by this provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services will be provided after my first visit. I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible, out of pocket limit, or be covered. I'm giving up some consumer billing protection under federal law. I may get a bill for the full charge for those services or having to pay out of network cost sharing under my health plan. I irrevocably consent in accident cases to have balances applied towards liens or letters of protection with my attorney. With my signature, I acknowledge that I am consenting of my own free will and not being coerced or pressured.

11. I understand that this document is irrevocable, may not be rescinded, and that my attorney shall not honor any such recession. I hereby instruct that in the even another attorney is substituted in my case, the new attorney honor this lien as inherit to the settlement, judgment, verdict, or any other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as it were executed by him/her. I hereby direct my attorney, on-demand, to provide the status of such litigation to the provider or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact the provider before disbursement of any funds to ascertain any outstanding balances due and owing.

12. I acknowledge that I have been provided a readable copy of the Notice of Privacy Practices (HIPPA).

Dated: _____

Patient Signature: _____

Guardian Signature (if a minor): _____

Doctor's Initials: _____

Plateau Chiropractic

3707 Providence Point Drive SE, Suite B, Issaquah, WA 98029
P: (425) 868-9593 F: (425) 868-6826

Informed Consent Document

PATIENT NAME: _____

To the Patient: 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.

The nature of the chiropractic adjustment

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experience when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, ultrasound, hot / cold therapy, EMS, and radiographic studies.

The risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination 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 the Doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke and / or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all, it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

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

Plateau Chiropractic
3707 Providence Point Drive SE, Suite B, Issaquah, WA 98029
P: (425) 868-9593 F: (425) 868-6826

If you chose 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 discus these with your primary medical physician.

The risk and danger attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I herby request and authorize Dr. Matthews to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son / daughter: _____.
This authorization also extends to all other doctors and office staff member and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child names above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

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

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Matthews and have had my questions answered 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: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian (If a minor)