Vital Chiropractic Center

Patient Name: _____
(Last) (First) (MI)
Address:_____
(City) (State) (Zip)
Home Ph. (_____)_____-_____ Work Ph (_____)_____-_____ ext_____ Cell:_____
Email:_____
Sex: M F DOB____/____/____ SSN _____-_____-_____ Status: M S W D Number of children_____
Occupation: _____ Employer: _____
Spouse's Name:_____ Whom should we thank for referring you?_____

Please complete the following with as much information as possible.

_____
How long have you had this condition?_____ Have you had similar problems in the past? Y N
What activities aggravate your condition? _____
What relieves it?_____
Is it worse/ better in the AM/ PM? Is it constant: Y N How long does it last:_____
Does the pain radiate: _____ Where to:
_____
Do you have any other complaints?_____
_____
_____
What do you like to do that your condition(s) prevent you from doing? _____
_____

Is the condition interfering with: Work Sleep Daily Routine
Is it progressively getting worse:_____ How long since you felt well?_____
Is this condition due to an auto accident? Y N If yes please fill out the auto accident form.
Is this condition due to a work injury? Y N If yes please fill out the work injury form.

OTHER DOCTORS SEEN FOR THIS CONDITION: MD DC DO DDS
Doctor's Name: _____ Diagnosis: _____
Were x-rays taken: Y N Treatment: _____ Medication: _____
Physical therapy: _____ Results: _____
Length of time under care: _____ Were you off work: Y N
Have you had any surgeries? Y N If yes,
list:_____
Are you taking any medication? Y N If yes,
list:_____
Do you have any other illnesses? Y N If yes, list:_____

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health concerns you may have about your:

Children _____
Spouse _____
Mother/father _____
Siblings _____
Others _____

"Health is complete physical, mental and social well-being and not merely the absence of disease and infirmity"

Webster's Dictionary

IMPORTANT: Please check all that apply to you.

HEAD:
___Headache
___Sinus (allergy)

HEAD:
___ Headache
___Sinus (allergy)
___Entire head
___Back of head
___Forehead
___Temples
___Migraine
___Head feel heavy
___Loss of memory
___Light-headed
___Fainting
___Light bothers eyes
___Blurred vision
___Double vision
___Loss of vision
___Loss of balance
___Loss of taste
___Loss of hearing
___Dizziness
___Pain in ears
___Ringing or noises in ears

NECK:
___Pain in neck
___Neck pain with movement
___Forward
___Backward
___Turning (L) (R)
___Bending (L) (R)
___Pinched nerve in neck
___Neck feels out of place
___Muscle spasms in neck
___Grinding sounds in neck
___Popping sounds in neck
___Arthritis in neck

SHOULDERS:
___Pain in joint (L) (R)
___Pain across shoulders
___Bursitis (L) (R)
___Arthritis (L) (R)
___Can't raise arm
___Above shoulder level
___Over head
___Tension in shoulders
___Pinched nerve in shoulder (L) (R)
___Muscle spasms in shoulder

ARMS AND HANDS:
___Pain in arm
___Tennis elbow
___Pain in hands/fingers (L) (R)
___Pins and needles sensation(L) (R)
___Numbness (L) (R)
___Hands cold
___Loss of grip strength
___Sore/swollen joints in fingers
___Arthritis in fingers

MIDBACK:
___Mid-back pain
___Location
___Pain between shoulder blades
___Sharp stabbing
___Dull ache
___Muscle spasms
___Pain in Kidney area

CHEST:
___Chest pain
___Shortness of breath
___Rib pain
___Breast pain
___Dimpled orange peel breast
___Irregular heartbeat

ABDOMEN:
___Nervous stomach
___Foods can't eat_____
___Nausea
___Gas
___Constipation
___Diarrhea
___Hemorrhoids

LOW BACK:
___Lower back pain
___Upper lumbar
___Lower lumbar
___
___Low back pain is worse when
___Working
___Lifting
___Stooping
___Standing
___Sitting
___Bending
___Coughing
___Lying down
___Walking
___Pain relieved when_____
___Slipped disc
___Low back feels out of place
___Muscle spasms
___Arthritis

HIPS, LEGS, & FEET
___Pain in buttocks (L) (R)
___Pain in hip joint (L) (R)
___Pain down leg (L) (R)
___Knee pain (L) (R)
___Outside
___Inside
___Leg cramps
___Feet cramps
___Pins and needles in legs
___Numbness in legs/feet
___Swelling in legs/feet

WOMEN ONLY:
___Breast Implants
___Menstrual pain
___Cramping
___Irregularity
___Cycle _____Days
___Birth control _____type
___Hysterectomy
___Tumors/Cancer_____
___Discharge
___Menopause _____
___Abortions
___Are you pregnant (indicate first day of last menstrual cycle _____)

MEN ONLY:
___Penile Implants
___Urinary frequency
___Difficulty starting
___Night urination
___Prostate swelling

GENERAL:
___Nervousness
___Irritable
___Depressed
___Fatigue
___Run-down feeling
___Normal sleep _____Hrs
___Loss of sleep
___Loss of weight _____Lbs
___Weigh gain _____Lbs
___Coffee _____cups/day
___Tea _____cups/day
___Cigarettes _____pack/day
___Diabetes
___Hypoglycemia
___Numbness
___Tingling
___Other Please List_____
_____
_____

REMARKS:
_____
_____

Signature:_____ Date:_____

You have made the decision to seek Chiropractic care. People choose Chiropractic care for a variety of reasons. In this office we recognize three phases of care:

1. **Relief Care-** Also know as acute, initial, intensive or symptomatic care. Historically, under this model, people wait until they are sick, then consult a doctor, and then finally discontinue care when they feel better. The patient's goal is to reduce the symptom and disease. Chiropractic provides millions of people a way to regain a symptom free life without the use of high-risk drugs and surgery. It allows the body to heal and repair itself. But here is the difference, once the patient experiences relief, the question must be asked, "Do I discontinue care now that I fell better or do I continue on into Phases 2 and 3 of 'real' health."

2. **Health Care-** An approach that focuses on proper body function. Some call this prevention care, but it's more than just that. Its goal is to keep you healthy by keeping the body functioning correctly and adapting to the environment. This care is centered on the ongoing correction of the vertebral subluxation complex (spinal misalignment causing nervous system interference and damage)

3. **Wellness Care-** In simple terms, this goes beyond getting rid of a disease or prevention. It implies regular family care as a part of your lifestyle. Wellness acknowledges that the human experience is one of growth and development. It promotes development and high performance physically, spiritually, intellectually, emotionally and in ones relationships. To reach full potential, we need a health care system that helps us throughout life. This philosophy, which has always been at the core of chiropractic and anchored by the correction of vertebral subluxation, gives an individual a great opportunity for full health throughout life.

Please indicate which phase of care you are interested in at this time

Relief___ Health ___ Wellness___

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Chiropractor will prepare any necessary reports and forms to assist me in obtaining payment from the insurance company and that any amount authorized will be paid directly to the Chiropractor and be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional service rendered me will be immediately due and payable.

Patients Signature: _____ Date:_____

Guardian or Spouse's Signature: _____ Date:_____

It is our mission at Vital Chiropractic Center to provide a profound health care experience in an open and honest environment. We will strive to work with you, your family and your loved ones to improve the quality of your health and of your lives. Our commitment is to interact with our patients as if they were members of our own family. The body is designed to be healthy and, therefore, it is our job not to tell you what is wrong with you, but, to work with what is right in you!

Vital Chiropractic Center
1332 164th St SW Suite 401 Lynnwood, WA 98037
425-742-7772

Insurance Benefits Questionnaire

Thank you for choosing Vital Chiropractic Center for your health care. It is important that you call to verify your insurance benefits because benefits do change regularly. Please use this form as a guide to make sure that all your benefit information is obtained correctly. It is important to gather as much information from your insurance company to help you understand your insurance coverage.

My Name:_____ Date_____

Eligibility and Benefits ph.# (located on the back of your ins. card) _____

My ID #_____

Name of insurance representative_____

Chiropractic Benefits:

What is the effective date on my plan? _____

Are any of the following providers contracted with my plan?

- Ewen Macaulay D.C Yes/ No
- Belinda Eddy D.C. Yes/ No
- Sue Burrows LMP Yes/ No

  (licensed Massage Practitioner)

What percentage does my plan cover? _____

What is my copay/ co-insurance? _____
(ex: if your plan pays at 90%or 80% you have a co-insurance of 10%or 20%)

Do I have a Deductible? Yes / No

How much is my Deductible? _____

Has any of my deductible been met? Yes / No

How much? _____

Are my x-rays subject to a deductible? Yes/ No

How much? _____

Has any of it been met? _____

How Many Visits do I get a year _____

Do I need a referral from my Primary Care Physician for Chiropractic care?_____

Massage Benefits:

Do I have massage therapy benefits? Yes/ No

What percentage does my plan cover?_____

What is my Copay / Co-insurance? _____

Do I have a Deductible?Yes/ No

Has my Deductible been met? $_____

How may visits or cash limit to I have a year? _____

Do I need a referral/prescription from my Primary Care Physician for Massage? _____

Can my prescription be from my Chiropractor? Yes/ No

Acupuncture Benefits:

Do I have Acupuncture benefits? Yes/ No

What percentage does my plan cover?

What is my Copay / Co-ins.? _____

Do I have a Deductible?Yes/ No

Has my Deductible been met? $_____

How may visits or cash limit to I have a year? _____

Do I need a referral/ prescription from my Primary Care Physician for Acupuncture?_____

Other necessary information I may need to know:

_____

_____

I have called and understood my benefits as they have been presented to me. I am aware that any amount not covered by my insurance company will be my responsibility. If my insurance company pays at a rate less than quoted benefits, I will be responsible for the difference. I also understand that Vital Chiropractic Center does not bill secondary insurance if I have one it is my responsibility to know my benefits and to bill them for additional coverage.

Signed_____ Dated_____

Staff Initials_____

****Please bring this form as well as your insurance card to your first visit.**