**CONFIDENTIAL PATIENT INFORMATION**

Name: ______________________________________________ Marital Status (M S D W) Age: ____Birth Date:______/______/_______

Height: ________ Weight: ________ Sex (F M) Race: _______________ **Phone (H):** ___________________**(W)**:__________________

Spouse's Name: ___________________Children: ______________________________

Address (Street, City, State, Zip): ______________________________________________________

**Medical Doctor:**____________________________________

**EmailAddress:**________________________________________________________________**Cell#**:______________________________

Occupation: ______________________________ How Long: ________ Employer:_____________________________________

**Referred by**: ________________________________________Previous Chiropractic Care:______________________________________

**ACCIDENTS:** Please describe, give date, injuries, broken bones, fractures, treatment

Automobile:_____________________________________________________________________________________________

Occupational:___________________________________________________________________________________________

Recreational:___________________________________________________________________________________________

Childhood:______________________________________________________________________________________________

Operations/Surgeries (type/date): _______________________________________________________________________

X-Rays (date, where taken, of what, findings)_____________________________________________________________

**PRESENT COMPLAINT:** ______________________________________________ How Long?: ____________ Is it constant?:_______

How did it occur?: ______________________________________ What relieves it?: ____________________________________________

**Please circle the symptoms you have noticed:**

| | | | |
|---|---|---|---|
| Headache | Dizziness/Faintness | Eye/Vision Problems | Cold Feet |
| Neck Pain/Stiff | Loss of Smell | Arm/Shoulder Pain | Chest/Rib Pain |
| Upper Back Pain | Loss of Taste | Pins/Needles Arms | Problems Breathing |
| Low Back Pain | Problems Sleeping | Finger Numbness | Coughing |
| Pressure in Head | Fever/Chills | Cold Hands | Stomach Upset |
| Loss of Balance | Fatigue/Depression | Leg/Hip Pain | Bowel Problems |
| EarAche/Ringing | Nervousness | Pins/Needles Toes | Indigestion |
| Irritability | Stress/Tension | Numbness in Toes | Urination Problems |

Symptoms not listed above:

_____________________________________________________________________________________________

Other doctors seen for this condition:

_____________________________________________________________________________________

What medications are you taking:

________________________________________________________________________________________

**Please circle any in your family history**:

Heart disease — Diabetes — Arthritis — Cancer — Back problems

**Health Questions:**

Do you smoke? _____ Drink alcoholic beverages? _____ Eat a well-balanced diet?______Sleep 6-8 hours? _____Daily Exercise?_____

NO SYMPTOMS EXTREME SYMPTOMS

1_________________________________________________________________10 **Place an "X" on the line above to indicate the level of the problem**.

**Patient or Guardian's Signature:** ______________________________________________________**Date:** ________________________

201 W. North River Dr (suite 170) Spokane WA, 99201 • Phone 315-8758 • Fax 315-8944 • www.MySpokaneChiro.com

**INFORMED CONSENT**

PATIENT NAME ___________________________________________

Clinic Name: 180° Chiropractic Wellness Center,LLC
Doctor's Name: Dr. Joshua Ebert

At this office, our goal is simple! Our main purpose is to locate, analyze and correct vertebral subluxations for health, wellness and maintenance care.

I understand that chiropractic care is given to correct misalignments of the spine called SUBLUXATIONS. One of the benefits of a chiropractic adjustment is that you MAY feel better but this is not the GOAL of an adjustment. The goal of an adjustment is to correct SUBLUXATIONS, thereby removing possible interference to the nervous system allowing the body to heal itself. As a result, WE DO NOT TREAT PAIN/ DISEASE AND/OR MEDICAL NECESSITY; we remove subluxations so that the body is able to function properly and be better enabled to heal itself.

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as" Spinal Adjustment." As the joints in your spine are moved, you may experience a "pop" sound as part of the process. This is said to be built up pressure in the joint being released similar to popping your knuckles.

There are certain side effects that can occur as a result of a spinal manipulation. These include, but are not limited to: dizziness, nausea, muscle strain and swelling. In rare cases, complications include disc and vertebral injury, fractures, strains and dislocations. The most common symptom or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these symptoms/complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays in office or referral out of office. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE ____________________

____________________
Printed Name

____________________
Signature

____________________
Signature of Parent or Guardian (if a minor)

201 W. North River Dr (suite 170) Spokane WA, 99201 • Phone 315-8758 • Fax 315-8944 • www.MySpokaneChiro.com

| **Office Use Only** |
|---|
| ☐ 1 |
| ☐ 4-5 |
| ☐ >5 |

Patient #:_______________

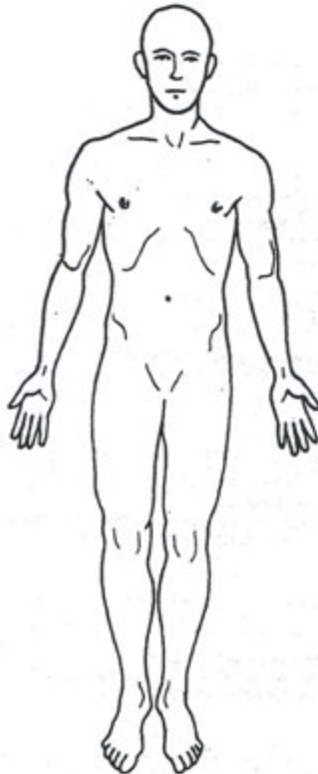
# Pain Drawing

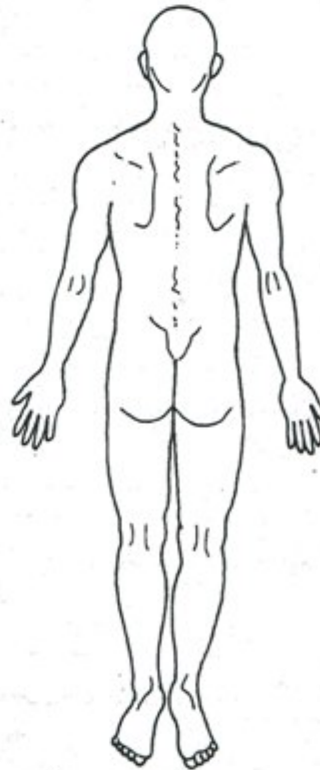
Name:______________________________ Date:______________________

Date of Birth:_________________________ Examiner:___________________

***Please read carefully:***
*Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.*

| | | |
|---|---|---|
| Ache = A | Numbness =N | Pins & Needles = PN |
| Burning = B | Stabbing = S | Throbbing = T |





# Financial Policy for 180 Chiropractic Wellness Center,LLC

At our office, we want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered our business procedures to keep our fees reduced.

Please read over these procedures below to understand how our office functions, and to decide if you wish to participate. If you have any questions, please ask so there is no confusion moving forward?

We are treating subluxations for the sole purpose of wellness/maintenance. This is not covered by most if not all insurance companies.

You may choose to submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by this office.

We take no responsibility for non-payment by insurance companies for services rendered at our office.

Our office will not respond to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. However, patients may have a copy of their records and the original x-rays at any time they request.

No balances can be kept or run by patients at any time. All adjustment visits are paid immediately prior to the service being rendered. All initial visits and if applicable, x-rays are paid for upon completion of these services.

Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

I have read, understand and agree to all terms.

I understand that I am under no obligation to receive or continue care.

Print your name___________________________________ Sign your name_____________________________

Today's Date______