New Patient Application Form

Welcome, we are grateful you are here.

“Because quality of life means everything.”

You have created a great opportunity for yourself. Thank you for choosing Fidalgo Island Chiropractic Clinic for your health care needs. We value your decision.

We think this is a great place and if there is anything you need to have a better experience, please do not hesitate to tell us. We are here to serve you.

Paperwork is always tedious but please take a few moments to complete a few important documents about you, your goals, and how you are currently experiencing life. Your information will help guide the doctor toward an accurate diagnosis and treatment plan for you.

At your reserved appointment, you can expect to be here approximately an hour. You will meet one on one with the doctor, who will perform a focused examination and order any additional tests (like X-Rays). You may also receive a treatment today, if the doctor sees fit.

At Fidalgo Island Chiropractic Clinic we aim to enhance your quality of life. Because quality of life means everything. Offering Chiropractic, Rehabilitation, Massage Therapy, Lifestyle Medicine and Nutrition, we are at your service for your successful journey back to your optimal health.

Please complete the following:

★ Personal intake form
★ Privacy protection—your rights, records and disclosure.
★ Consent – give the go ahead to begin enhancing your quality of life.
★ SF-36 questionnaire - [https://www.rand.org/health/surveys_tools/mos/mos_core_36item_survey_print.html](https://www.rand.org/health/surveys_tools/mos/mos_core_36item_survey_print.html)
★ Low Back Pain Disability - [http://www.rehab.msu.edu/_files/_docs/Oswestry_Low_Back_Disability.pdf](http://www.rehab.msu.edu/_files/_docs/Oswestry_Low_Back_Disability.pdf)
Date: ____________________

Preferred name: ___________________________________________ Birthday: ____________

Address: ______________________ City: __________ State: _____ zip: ______

SSN: _______________ Email: _______________ Occupation: ___________________________

Home phone: ___________ Work phone: ___________ Cell phone: _______________

Who may we thank for referring you? ________________________________

Marital status: single married divorced ~ Gender: male female ~ Pregnant: yes no

Height: ________ Weight: ________ underweight ~ just right ~ overweight

Any unintentional weight loss of 10 lbs or more in the past 3 months? yes no

Reason for office visit: ___________________________ When did it start? ______________

Quality of pain (circle): dull ~ ache ~ sharp ~ stabbing ~ burning ~ other: ____________

What makes it better: ice ~ heat ~ rest ~ stretching ~ other: _______________________

What makes it worse: sitting ~ standing ~ stretching ~ sleeping ~ other: ___________

What type of therapies have you tried for this problem or to improve your quality of life?

dietary modifications ~ fasting ~ herbs ~ vitamins/minerals ~ chiropractic ~

acupuncture ~ massage therapy ~ physical therapy ~ medications ~ other: ______

Current level of stress you are experiencing on a scale of 1-10 (1 being the lowest):

1 ~ 2 ~ 3 ~ 4 ~ 5 ~ 6 ~ 7 ~ 8 ~ 9 ~ 10

Identify the major cause of your stress (chemical, physical, emotional ie. work, family: ________________________________

Have you ever felt that your life was not worth living? Yes or No

Have you wished you could go to sleep and not wake up? Yes or No

Have you had thoughts you would be better off dead or of hurting yourself in some way?

Yes or No

Diagnostic procedures performed for this current complaint (xray, CT, MRI):

____________________________________________________________________________

Primary physician: ______________________________

Are you currently under care for any other healthcare need? __________________________

Current medications (prescription or over-the-counter): ______________________________
Major hospitalizations/surgeries/injuries. list all procedures, complications and dates:
_____________________________________________________________________
_____________________________________________________________________

We protect your privacy

Protecting your personal health information and privacy is important to us. This document describes how information about you may be used and disclosed and how you can get access to this information. Please review this carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures by submitting the request in writing to our staff.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer or medical records for treatment. You may inspect and receive copies of your health records. We will supply your records within thirty (30) days of your request. There may be a reasonable cost-based fee for photocopying, postage, and preparation. We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may periodically contact you for appointment reminders, announcements, electronic-mail (e-mail) newsletters, newsletters, text messaging and to inform you about Fidalgo Island Chiropractic Clinic and its team members. Medicare and Medicaid Consent to Release Information (if applicable to you): By initiating or participating in care with Fidalgo Island Chiropractic Clinic you certify that the information given by you in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct and true.

You further authorize any holder of medical or other information about you to release to the Social Security Administration, or its intermediary carriers, any information needed for your Medicare claim. Our practice is required to abide by this notice. We have the right to change this notice at any time, and any revisions will be prominently displayed in
a clearly visible location within our office. You may file a complaint about privacy violations by contacting our Director of Financial Services in writing that explains the context of the violation, and submitting it to: Fidalgo Island Chiropractic Clinic 601 O Ave. Anacortes, WA 98221. The effective date of this Notice of Information Practices is November 01, 2013.

Consent for care

I voluntarily consent to receiving and participating in my care that the doctor recommends for me, including all treatment and diagnostic procedures. I understand that I am under the care and supervision of an attending chiropractic physician in the state of Washington and it is the responsibility of the Fidalgo Island Chiropractic Clinic team to carry-out their instructions. I further acknowledge that by initiating and participating in care with Fidalgo Island Chiropractic Clinic, I have been informed of and understand all of the risks (which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains), benefits, and reasonable alternatives to the care prescribed to and elected by me.

Consent for minor child: I consent to have my minor child receive and participate in care, including all treatment and diagnostic procedures, such as X-Ray radiography. I understand that the care and supervision of care is provided by an attending chiropractic physician of Washington, and it is the responsibility of the Fidalgo Island Chiropractic Clinic team to carry-out their instructions. I further acknowledge that by having my child initiate and participate in care with Fidalgo Island Chiropractic Clinic, I have been informed of and understand all of the risks (which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains), benefits, and reasonable alternatives to the care prescribed to and elected by me for my child.

Patient/Authorized representative initials:____________ date:___________________
Pregnancy notice (for women only, please check one): I understand that it is important for my providers to know my pregnancy status. I also understand the “28 day rule” which defines that radiological examination, if so justified, can be carried throughout the cycle until a period is missed. If there is a missed period, a female should be considered pregnant unless proved otherwise. In such a situation, every care should be taken to explore other methods of getting needed information by using non-radiological examinations.

To the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time. Date of last menstrual period was:___________
I am currently pregnant, or suspect I am pregnant: yes ~ no
Release of information: You grant consent to Fidalgo Island Chiropractic Clinic team to use and disclose your protected health information for the purposes of treatment, payments, and healthcare operations. Our “we protect your privacy” (Notice of Privacy Practices) document provides detailed information about how we may use this information, and you agree that you have read and fully understand the practices and provisions noted within this document.

Results: My care with Fidalgo Island Chiropractic Clinic team involves clinical judgments and decisions made by the providing doctor. The decisions made by Fidalgo Island Chiropractic Clinic team are based on facts and information about me and are decisions given to provide care that is within my best interest toward an active healthy lifestyle. I understand that my decisions primarily influence my results, and just as with any health and wellness care, my results are neither guaranteed nor implied.

The signatures below confirm that the above document has been reviewed and fully understood. I sign this document without reservation, question, or concern.

Patient’s printed name:____________________________________

Patient or authorized signature:___________________________ date:________________

Relationship to patient (if authorized signature):___________________________

Fidalgo Island Chiropractic Clinic witness signature:_________________________