Northwest Family
CHIROPRACTIC & MASSAGE

Client Registration Form (please complete entire form & please print)

Today's Date: _____ Primary Care Provider:_____ Phone Number: _____

Client Information

Last Name:	First Name:	Middle initial:	single / married / divorced separated / widowed
Is this your legal name? Yes / No	If not, what is your legal name?	Former Name:	
Birth Date:	Age:	Sex: Male / Female	Home Phone #:_____ Cell Phone #: _____
Emergency Contact:	Phone #:		Employer Phone #:

Billing Address:_____
City:_____
State:_____ Zip: _____

Were you referred to this office? Yes / No
If Yes, by whom? _____
You may leave voice mail appointment reminders at:
Home Phone Work Phone Cell Phone

Social Security #_____
Occupation: _____
Email Address_____
You may send email information/appointment reminders to my email address above: Yes / No_____

*Are there any people who you would like to have access to information regarding appointments/billing? Y / N
List:_____

Insurance Information

Person responsible for this bill:_____ Birth Date: _____
Address:_____ City: _____Zip: _____
Home Phone Number: _____ Employer: _____

Are you covered by Medical Insurance? Yes / No
Subscribers Name: _____ Subscribers SS #_____ Birth date: _____
Clients relationship to insurance subscriber: self / spouse / child / domestic partner / other:_____

Primary Insurance: _____ Have you verified your benefits? Yes / No
Group Number: _____ Policy Number: _____ Co Pay: $_____
Secondary Insurance: _____ Subscribers Name: _____
Group Number: _____ Policy Number: _____ Co Pay: $_____

Do you have an open L & I Claim? Yes / No If yes, Claim #_____ Adjuster Phone # _____
If this is Auto Accident do you have Personal Injury Protection? Yes / No / I don't know
Your Auto Insurance Company: _____ Adjuster Phone # _____
Do you have an attorney? Yes / No If yes, Name: _____ Phone # _____

1. I understand that I am responsible for charges not covered or reimbursed by my health plan or similar payer. I agree to pay you directly if my insurer, health plan, employer program or similar benefits program does not pay.
2. I authorize my insurer, health plan, employer program or similar benefits program to release information to you regarding my coverage
3. My right to payment for care, treatment, supplies and other services are hereby assigned to you. This assignment covers any and all benefits under Medicare, other government sponsored programs, insurance, employer programs and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. If my insurer, health plan, employer program or similar benefit program does not accept assignment of benefits, or if payments are made directly to me or my representative I will endorse such payment to you.
4. I understand and authorize release of all health information about me to my insurer, health plan, employer program or similar benefits program identified above to obtain payment for care, treatment, supplies and other services. The above information is true to the best of my knowledge.
5. In the event that any account of mine should need to be turned over to collections, I give my consent to NW Family Chiropractic and any agents acting on it's behalf to communicate with me regarding my accounts through various means such as: 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communication.

Patient/ Guardian Signature: _____ Date: _____

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Confidential Patient Information

Name: _____ Date: _____
Date of birth: _____ Age: _____ Sex: □ Male □ Female
Who is your Primary Care Provider?:_____Phone Number:_____
If patient is under 18 years old who is the legal guardian?:_____

About You

What is the primary reason/complaint that you are seeking Chiropractic care?

_____
When did it begin? _____
What do you think caused this? (car accident or work injury please inform front desk)

_____
Is it getting worse? Yes/No
Specifically, what makes it better? _____
Specifically, what makes it worse? _____
Is the complaint: □Constant □Frequent □ Intermittent □Occasional
Is the complaint worse in the: □Morning □Afternoon □Evening □While sleeping
Is the complaint getting: □Better □Worse □Staying the same
Rate the severity of the complaint (0=no pain / 10=severe pain) 0 1 2 3 4 5 6 7 8 9 10
Do you experience any radiating pain? □ Yes □ No
If yes, where? _____
Do you have increase pain with coughing and sneezing? □ Yes □ No
If yes, where? _____
Are you experiencing any weakness or loss of function? □Yes □No
If yes, where? _____
Describe the pain (please check all that apply):

□ Sharp	□Dull	□Throbbing	□Aching	□Numbness	□Shooting
□ Burning	□Tingling	□Cramping	□Stiffness	□Swelling	□Pressure

Are there any other (secondary) complaints? Please list: _____
_____

How does your complaint affect the following aspects of your life:

Length and quality of your sleep: _____
Exercise:_____ _____
Work: _____
Family: _____
Social interaction: _____ _____

Specifically list activities that you are avoiding due to your complaint and your goal for that activity:

Activity:_____ Goal:_____
Activity:_____ Goal:_____
Activity:_____ Goal:_____

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Past/current care information

Have you ever seen a Chiropractor before? □Yes □No

If yes, who: _____

Have you seen any other health care provider for this complaint? □Yes □No

List provider name:_____Phone: _____

List provider name: _____ Phone: _____

List all medication: _____

_____

List all supplements: _____

_____

List any allergies: _____

_____

If female:

Date of menarche (first menstrual cycle): _____

Do you experience symptoms during your cycle: _____

Are you currently pregnant? □Yes □No □ I don't know If Yes Due Date:_____

If pregnant, who is your OB or Midwife?:_____

Are you currently breastfeeding? □Yes □No

Number of pregnancies:_____

If you have been pregnant in the past, how did you deliver? □Vaginally □C-Section □Vbac

Describe any complications during delivery:_____

Do you currently (C) or have you experienced any of these in the past (P):

C/P □Headaches	C/P □Pins & Needles in legs	C/P □Pins & Needles in arms	C/P □Migraines
C/P □Diarrhea	C/P □Constipation	C/P □Neck Pain	C/P □Arthritis
C/P □Loss of balance	C/P □Loss of memory	C/P □Stomach/heartburn	C/P □Stroke
C/P □Upper back pain	C/P □Middle back pain	C/P □Lower back pain	C/P □Muscle weakness
C/P □Leg pain	C/P □Arm pain	C/P □Hip pain	C/P □Difficult urination
C/P □Irritability	C/P □Numbness in hands	C/P □Numbness in feet	C/P □Difficult bowel movement
C/P □Heart Disease	C/P □Cold feet/hands	C/P □Nervousness/Anxiety	C/P □Loss of memory
C/P □Asthma	C/P □Incontinence	C/P □Sudden weight loss	C/P □Vertigo/Dizziness
C/P □PTSD	C/P □Depression	C/P □Ringing in the ears	C/P □Excessive Perspiration

Have you or anyone in your immediate family experienced:

Cancer:	□Self	□mother	□father	□other_____
Heart Disease:	□Self	□mother	□father	□other_____
Arthritis:	□Self	□mother	□father	□other_____
Scoliosis:	□Self	□mother	□father	□other_____
Diabetes:	□Self	□mother	□father	□other_____
Parkinsons:	□Self	□mother	□father	□other_____
Alzheimers:	□Self	□mother	□father	□other_____

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Have you experienced any:

Car accidents: □Yes □No Date:_____
Work related injuries: □Yes □No Date:_____
Hospitalizations: □Yes □No Date:_____
Surgeries: □Yes □No Date:_____

Additional information

Is there anything else in your health history that you would like the doctor to know?_____

Authorization and Informed Consent to Evaluate and Care for Individual:

I, _____ do herby authorize, request, and direct the staff and doctors of Northwest Family Chiropractic & Massage to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary. Chiropractic treatment is one of the safest forms of health care. Still, unexpected problems can occur, such as soreness and stiffness, especially at the start of care. More significant problems, such as fracture of weakened bone or sprain/disc injuries are rare. A stroke following neck manipulation is an extremely rare complication, occurring in less than 1 per million treatments. We screen our clients to insure their safety and refer out to supporting providers when necessary.

Patient/Guardian Signature: _____Date: _____