

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:		Date:		
Address:				
	Street	City	State	Zip
Home phone:		Work phone:		
Cell phone:		Email address:		
Best time/place to contact you:				
Date of birth:		Age:		
No. of children:		Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Height:		Weight:		
Driver's license number:				
Marital status: M S W D		Spouse/guardian name:		
Occupation:				
Employer's name & address:				
Spouse's Occupation/Employer:				
Name of person responsible for account:				
Do you have insurance that covers Chiropractic care? Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you have Medicare coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name of Insurance Company:				
Insurance Policy number:		Insurance Company phone number:		
Insurance Company address:				

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

Since the problem started is it: About the same? Getting better? Getting worse?

What have you done for this condition? Was it of benefit?

I do (do not) have a family history of this or similar symptoms (Please explain):

Which activities aggravate your condition? _____

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	<input type="checkbox"/>
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

Is this condition interfering with any of the following:

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
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What lesson(s) have you taken home from your healing process to date?

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Have you ever had x-rays taken?

Area of body:	When?	Where?
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Do you wear orthotics or heel lifts? Yes No

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
Would you take whole food supplements if indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises or stretching would help would you consider adding them to your program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would help you would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) | **M** - Consume this monthly | **O** - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

The type of diet I usually follow is classified as: _____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV (Aids)
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Migraines
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough

Other (please explain) _____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

- 1. Physical stress (falls, accidents, work postures, etc.)
 - a. _____
 - b. _____
 - c. _____

- 2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
 - a. _____
 - b. _____
 - c. _____

- 3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
 - a. _____
 - b. _____
 - c. _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
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On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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Is there anything else which may help to better understand you which has not been discussed?

Why are you here at this point in time?

I consent to a professional and complete chiropractic examination.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by **Dr. Steven B. Noble** and/or other licensed doctor's of chiropractic who now of in the future may practice in, work or associated with, or be employed by **Noble Chiropractic, P.S., currently located at 119 Grand Ave Suite C, Bellingham, WA 98225.**

I have had an opportunity to discuss with Dr. Noble the nature and purpose of chiropractic adjustments and other procedures.

The following points have been explained to me, to my satisfaction, and I have had opportunity to discuss them with Dr. Noble and/or other clinic personnel:

1. Chiropractic care is the science, philosophy and art of locating and correcting spinal and extremity joint dysfunction (aka: subluxation), and as such, is oriented toward improvement of spinal function relative to range-of-motion, muscular and neurologic aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease, or condition as a result of treatment in this clinic. If during the course of a chiropractic examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, a diagnosis or treatment for these findings, we will recommend that you seek the services of a health care provider who specializes in that area.
2. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click".
3. As with the practice of medicine, the practice of chiropractic is not an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.
4. It is not reasonable to expect my chiropractor to be able to anticipate, or explain all possible risks and complications of a given procedure on any particular visit and I wish to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest.
5. An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment.
6. As with any health care procedure there are certain complications which may arise during a chiropractic adjustment, traction, manual therapy" massage therapy, ice or heat. Those complications include, but are not limited to, sprain/strain, dislocation, fractures, disc injuries, or cerebral-vascular accidents (stroke). The most recent studies (Journal of CCA, Vol. 37, No.2, June 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. These complications are extremely rare occurrences.

I have read the above consent, or had it read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided and consent to chiropractic treatment and management on that basis.

Patient's Printed Name

Date

Patient's Signature

Parent/Guardian

NOTICE OF PRIVACY PRACTICE SUMMARY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Noble Sports Chiropractic, P.S., in accordance with applicable federal and state law, is committed to maintaining the privacy of your protected health information (PHI). In other words, the private information about your health condition and the care and treatment you receive from the Practice. We will use and disclose elements of your PHI the following ways:

- Treatment
- Payment
- Health care operations
- When release is required by law, including judicial settings and to health oversight regulatory agencies and law enforcement
- In emergency situations or to avert serious health/safety situations
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in their duties
- To organ, tissue and other donation organizations, upon or proximate to your death, if we have no indication on hand about your donation preferences

Special Cases:

- Appointment reminders, treatment alternatives and other health related benefits and services
- Office newsletter
- Sponsor of your health plan

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your Rights: You have the following rights concerning your PHI:

- **Restrictions:** To request restricted access to all or part of your PHI. To do this, please make the request in writing. We are not required to grant your request
- **Confidential communications:** To receive correspondence of confidential information by alternative means or location. To do this, please make a request in writing
- **Access:** To inspect or receive copies of your PHI. To do this, please submit a request in writing
- **Amendments:** To request changes be made to your PHI. To do this, please submit a request in writing
- **Accounting:** To receive an accounting of the disclosures by us of your PHI in the six years prior to your request. To do this, please submit a request in writing
- **This notice:** To get updates or re-issue of this notice, at your request
- **Complaints:** To complain to your office or the U.S. Department of Health and Human Services if you feel your privacy rights have been violated. To register a complaint with us, please submit your request in writing. The law forbids us from taking retaliatory action against you if you complain

Our duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy contact: To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Dr. Steven B. Noble at Noble Sports Chiropractic, P.S., 119 Grand Ave Suite C, Bellingham, WA 98225.

Effective date: This notice is in effect as of October 1, 2006. A complete copy of the Notice of Privacy Practice is available at the reception desk.

Patient acknowledgement: By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Please Print Name

Signature

Date

Assignment of Benefits in Group Insurance Cases



Welcome to Noble Chiropractic. We are very pleased that you have selected us as your health care provider. We are looking forward to a very healthy relationship and would like to encourage you to visit our website (www.NobleChiropractic.com) for additional information that we may not answer here at the office.

I authorize **Noble Chiropractic** to receive direct payment from my insurance company or attorney for all monies due on my account. If coverage exists, I understand that the primary and secondary carriers will be billed. Any overpayments will be promptly returned to me. In the event that there is no valid coverage or that I have exceeded my annual insurance limit, I will remain responsible for charges incurred. I agree to provide **Noble Chiropractic** with all valid insurance form(s) and billing information within 3 days.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors specific recommendations. A complete list is available at the front desk.

Note: Manipulation is the only covered Chiropractic service by Medicare. Medicare does not cover Nutrition, Cold Laser Therapy, Percussion, Graston, ASERT, Kinesio Tape, etc.

I agree to the above terms and acknowledge that I will remain responsible for any deductible, co-payments or non-covered services. Should I receive any insurance payment(s) or settlements for services rendered, I agree to forward those to **Noble Chiropractic** within 5 days.

A charge of \$25.00 will be assessed for a missed appointment. We require a 24-hour notice for cancellations. A charge of 1.5% interest will be charged for any balance due after 30 days.

Any financial arrangements are to be determined prior to services rendered. I agree to the terms above, and acknowledge that in the event that there is an outstanding balance, which fails to be cured within sixty (60) days, my account with **Noble Chiropractic** will be turned over to collection. I understand that should this happen, I will remain responsible for any and all additional collection fees and/or attorney and court costs.

Signature

Date