Patient Health History

Today's Date [/ /] **Signature of Patient** ______________________________

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name______________________ **Nick Name**______________________

Last Name ______________________ **Middle Name** ______________**Suffix** ________

Address ____

City______________________ **State**________ **Zip Code** ____________

Primary Phone ______________________**Secondary Phone** ______________________

Mobile Phone ____

Home email ______________________ **Work Email** ______________________

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth [/ /] **Age** ________ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** ______________________

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Employer Name: ______________________ **Occupation:** ______________________

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other_________ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1) ____		**5)** ____	
2) ____		**6)** ____	
3) ____		**7)** ____	
4) ____		**8)** ____	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) ________________ **3)** ________________

2) ________________ **4)** ________________

Briefly list your main health problems: ________________

____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: ________________

____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ________________

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: ______inches **Weight:** __________ pounds **BP:** _______ / ________

Please check the box for “Yes” if you have had any of the following

- ❑ AIDS / HIV
- ❑ Alcoholism
- ❑ Allergy shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding disorders
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical dependency
- ❑ Chicken pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Fracture
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated disk
- ❑ Herpes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple sclerosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Osteopenia
- ❑ Pacemaker
- ❑ Parkinson’s disease
- ❑ Pinched nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate problem
- ❑ Prosthesis
- ❑ Psychiatric care
- ❑ Rheumatoid arthritis
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Sexually transmitted infection
- ❑ Stroke
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Tumors / growths
- ❑ Typhoid fever
- ❑ Ulcers
- ❑ Vaginal infections
- ❑ Whooping cough
- ❑ Other:

Please circle all that apply:

Headache	Numbness in Legs	Cold Feet	Ears Ring/Buzz
Neck Pain/Stiffness	Numbness in Arms	Cold Hands	Diarrhea
Sleeping Problems	Numbness in Hands	Loss of Memory	Constipation
Back Pain/Stiffness	Numbness in Feet	Cold Sweats	Stomach Upset
Nervousness	Dizziness/Balance Loss	Fainting	Depression
Tension/Irritability	Fatigue	Fever	Lights Bother Eyes

Date of Last: Physical exam: ___________ Spinal Exam: ____________ Spinal X Ray:___________

Chest X Ray :____________ MRI,CT Bone Scan:__________ Blood Test:_______

Temporary or Corrective Care?

People go to chiropractors for a variety of reasons. Some simply go for short term pain relief, while others are interested in long term correction of their spine-related problems. Please check the type of care you desire so that we may be guided by your wishes.

☐ Corrective care ☐ Temporary relief care

Terms of Acceptance

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goal – To locate, analyze and correct spinal interference to the nerve system. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

We do not diagnose conditions of disease other than that which relates to vertebral subluxations (spinal misalignments). However, if during the course of a chiropractic spinal exam, we encounter complaints that warrant medical attention, we will recommend that you seek the services of a provider who specializes in that area. We offer no treatment of conditions other than that which relate to vertebral subluxations. Our primary role is to identify subluxations and our primary method of correcting them is through spinal adjustments.

Patient or Guardian's Signature X ____ Date: ______________________

Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of massage therapy, physical therapy and diagnostic x-rays by DR. FEARN and/or other licensed Doctor of Chiropractic or licensed practitioners who now or in the future treat me while employed by, working or associated with or serving as back-up for the DR. FEARN. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the Dr. Fearn to be able to anticipate and explain all risks and complications, and wish to rely on the Dr. Fearn to exercise judgment during the course of the procedure which the Dr. Fearn feels at the time, based on the facts then known, is in my best interest. I have read this consent and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient or Guardian's Signature X ____ Date: ______________________

Children and Minors

I hereby authorize the Dr. Fearn and whomever he may designate as assistants to examine and administer chiropractic care or other therapies as deemed necessary to my child.

Patient or Guardian's Signature X ____ Date: ______________________

Insurance Assignment of Benefits

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to the FEARN NATURAL HEALTH CLINIC at 19206 SE 1st St Ste 118 Camas, WA 98607. If my current policy prohibits direct payment to Dr. Fearn, then I hereby also direct you to make out the check to me and mail it C/O the FEARN NATURAL HEALTH CLINIC at 19206 SE 1st St Ste 118 Camas, WA. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved with this case.

Patient or Guardian's Signature X ____ Date: ______________________

Professional Fee Schedule

I understand & agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of service (excluding work comp and auto victims). It is also understood and agreed the amount paid the Fearn Natural Health Clinic for x-rays is for examination only and the x-ray films will remain the legal property of the Fearn Natural Health Clinic. By signing below I agree to all the terms outlined.

Consultations…… No Charge

Examinations…… $85.00

Spinal Adjustments…… $65.00

Adjunctive Therapies…… $10-$35.00

Massage Therapy…… $35-$85.00

CASH PLANS: You are expected to pay in full for today's services. Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance. We accept Cash, Check, MasterCard, and Visa. Customary monthly payment plans can be created if desired. Please speak with the office manager if you are interested in designing a payment plan that best suits you and your family.

INSURANCE: Unless we are a contracted provider for your insurance, you are expected to pay in full for today's services. Once we have verified your coverage, we will accept assignment and directly bill your insurance company. Until coverage is verified, our policy is for you to pay for services as they are rendered. We also offer monthly payment installments to cover your deductible, co-payments and non-covered care.

WORK / PERSOANL / AUTO INJURY: If a liability claim exists, you do not have to pay for your services as they are rendered. Regardless of fault, if medical coverage is available through an auto or liability policy, it is considered as the primary insurance and Fearn Natural Health Clinic's policy is to bill this coverage first. These policies usually cover 100% of your medical bills. In the event there is no coverage under such a policy, we may accept a lien with an approved attorney representing you. Thereby, we will extend the courtesy of waiting for payment for services rendered, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. You should understand that you are responsible for services, even if you do not receive an insurance settlement.

MEDICARE: Medicare recipients must present their enrollment cards at the onset of care. Spinal manipulation is the ONLY service covered by Medicare. There is no guarantee Medicare will pay for any more than 12 visits. All non-covered services (such as exams and x-rays) must be paid-in-full at the time of service.

TIMES OF HARDSHIP: Your health and wellbeing are of the utmost importance to us here, if you have concerns about the affordability of your care please speak with the office manager. We are more than willing to work with you; there are multiple options that could be discussed to make your treatment more budget friendly.

Signature X ____ Date: ____________________

HIPPA Notice of Privacy Practices for Fear Natural Health Clinic

provided separate from intake

I have read the Privacy Notice and understand my rights contained in the notice.
By way of my signature, I provide FEARN NATURAL HEALTH CLINIC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name:____

Patient's Signature____ Date________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
FEARN NATURAL HEALTH CLINIC

As required by the Privacy Regulations, I hereby acknowledge that I have received or been offered a current copy of FEARN NATURAL HEALTH CLINIC's "NOTICE OF PRIVACY PRACTICES," revision date 12/12/2011.

As required by the Privacy Regulations, Fearn Natural Health Clinic has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that FEARN NATURAL HEALTH CLINIC has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Signature:____ Date_________________________

Print Name:____