Patient Name: _____ DOB: ____/____/____ Today's Provider: _____

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** _____

Mobile Phone _____ **Home Phone** _____

Work Phone _____

Home E-mail _____ **Work E-mail** _____

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

Contact Method *(check one)*

❑ Mobile Phone ❑ Home Phone ❑ Work Phone ❑ Home Email ❑ Work Email

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

How did you hear about our practice? _____

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____
(REQUIRED FOR PERSONAL INJURY)

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	

Patient Name: _____ DOB: ____/____/____ Today's Provider: _____

Today's Date: ____/____/____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never

Exercise Status (Circle one): Daily / Often / Occasionally / Never

Family Medical History(Record on diagnosis in your family history, ex: heart disease, cancer, etc.)				
Diagnosis	**Father**	**Mother**	**Sibling: (_____)**	**Offspring: (_____)**

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Has any doctor diagnosed you with Hypertension presently? (Circle -- Yes or No) If yes, describe:

Has any doctor diagnosed you with Diabetes presently? (Circle – Yes or No)
If yes, what kind? (Circle one) Type I or Type II
If yes to Diabetes, was blood lab-work test for hemoglobin A1c > 9.0%? (Circle one) Yes, No, or Not Sure
If yes, other comments regarding Diabetes:

_____

Briefly list your main health problems:

_____

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

Fearn Natural Health Clinic
19206 SE 1st Street STE 118
Camas, WA 98607
(360) 433-9016
fearnnh@gmail.com

Patient Name: _____ DOB: ____/____/____ Today's Provider: _____

Today's Date: ____/____/____

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
Neck Pain/Stiffness
Sleeping Problems
Back Pain/Stiffness
Nervousness
Tension/Irritability

Numbness in Legs
Numbness in Arms
Numbness in Hands
Numbness in Feet
Dizziness/Balance Loss
Fatigue

Cold Feet
Cold Hands
Loss of Memory
Cold Sweats
Fainting
Fever

Ears Ring/Buzz
Diarrhea
Constipation
Stomach Upset
Depression
Lights Bother Eyes

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(360)433-9016 fearnnh@gmail.com

Patient Name: _____ DOB: ____/____/____ Today's Provider: _____

Today's Date: ____/____/____

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 nervous 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's Signature: _____ Date: _____

PARQ Informed Consent to Chiropractic Adjustments and Massage Therapy

I hereby request and consent to the performance of chiropractic adjustments and/or 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 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. Any risks have been explained to me and I assume responsibility for those risks. I do not expect Dr. Fearn to be able to anticipate and explain all risks and complications, and wish to rely on Dr. Fearn to exercise judgment during the course of the procedure which Dr. Fearn feels at the time, based on the facts then known, is in my best interest. I have completed my health intake form accurately. I authorize Dr. Fearn to release or obtain information pertaining to my condition(s) and/or treatment to/from other medical providers or third party payers. I have read this consent and by signing below I agree to the above-named procedures and was given the opportunity to ask any and all questions/concerns that I have regarding care. 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 Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Children and Minors

I hereby authorize 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: _____ 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's Signature: _____ Date: _____

Print Name: _____

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(360)433-9016 fearnnh@gmail.com

Patient Name: _____ DOB: ____/____/____ Today's Provider: _____

Today's Date: ____/____/____

HIPAA Notice of Privacy Practices for Fearn 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 disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Signature:_____

Print Name: _____ 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.

Patient's Signature:_____

Print Name:_____ Date_____

CANCELATION POLICY

Our staff is here to accommodate you to the best of our ability, however, we ask that you make a point to contact our office at (360)433-9016 as soon as possible if you are not able to make it to your appointment. A 24-hour notice is required as our massage therapists are paid per massage and we would like to try to fill any slots that become available for our other patients. We do send text-reminders the day before asking that you please call or text back if you need to cancel or reschedule. Dr. Fearn does his best to take care of his staff and still pays his therapists if they come into our office even if you no-call/no-show, as often times they may be coming in just for you. I hereby agree to Fearn Natural Health Clinics cancelation policy.

Patient's Signature:_____

Print Name:_____ Date:_____

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