

# Renaissance Chiropractic Center

4902 Tacoma Mall Blvd., Tacoma, WA 98409 253-473-0300

Name (F) \_\_\_\_\_ (MI) \_\_\_\_\_ (L) \_\_\_\_\_ Preferred Name \_\_\_\_\_ Sex M or F

Mailing Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #'s - Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

E-Mail Address \_\_\_\_\_ May we contact you at work?  no  yes

SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Spouse's SS # \_\_\_\_\_

Minor Children's Names & Ages \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone #'s \_\_\_\_\_

**How did you find out about our office?**  Insurance Company  Doctor  Our Website  Internet

Friend/Family (Please tell us who referred you so we can thank them) \_\_\_\_\_  Other \_\_\_\_\_

## What brings you here? Please check one

**General Health?** \_\_\_\_\_ **Work Injury ?** \_\_\_\_\_ **Auto Accident ?** \_\_\_\_\_ **Other Accident?** \_\_\_\_\_

How long have you had these concerns? \_\_\_\_\_ Is it  getting worse  improving  staying the same

Where is the problem? (part of your body) \_\_\_\_\_

**Please explain injury** (if applicable) \_\_\_\_\_

When did the incident occur? \_\_\_\_\_

Have you been off work for this injury YES / NO FOR HOW LONG? \_\_\_\_\_

If you have been off work, who took you off work? \_\_\_\_\_

Have you received Chiropractic before?  no  yes If yes, please tell us the doctor's name \_\_\_\_\_

Were you pleased with your care?  no  yes If no, please explain \_\_\_\_\_

Are you currently receiving care from other health professionals for these complaints ?  no  yes

Who is your Primary Care Physician (PCP)? \_\_\_\_\_

Do you take any medications?  no  yes If yes, for what conditions? \_\_\_\_\_

Do you take vitamins/herbs/homeopathics ?  no  yes If yes, do you take them for a specific condition? \_\_\_\_\_

**Ladies:** Are you pregnant?  no  yes If yes, what month are you due? \_\_\_\_\_

Date of last menstrual cycle \_\_\_\_\_

# Health History

Please check all of the following that you currently suffering with:

<input type="checkbox"/>	Headache	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Frequent Nausea	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Dental Problems	<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Middle Back Pain	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	Bloody Stools
<input type="checkbox"/>	Lower Back Pain	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	Vomitting	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	Liver Problems
<input type="checkbox"/>	Arm Pain or Tingling	<input type="checkbox"/>	Stuffy Nose	<input type="checkbox"/>	Breast Pain or Lump	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Cramps	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	Leg Pain or Tingling	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	Tingling
<input type="checkbox"/>	Foot Pain or Tingling	<input type="checkbox"/>	Weight Loss or Gain	<input type="checkbox"/>	Bladder Problems	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	Excessive Urination	<input type="checkbox"/>	Cold Extremities
<input type="checkbox"/>	Infectious or Contagious disease	<input type="checkbox"/>	Auto or Work Injury	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	Fights
<input type="checkbox"/>	Falls or Accidents	<input type="checkbox"/>	Dislocations	<input type="checkbox"/>	Spinal Tap	<input type="checkbox"/>	Surgery
<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	Use a Walker or Cane	<input type="checkbox"/>	Extensive Dental Work	<input type="checkbox"/>	Excessive Alcohol use
<input type="checkbox"/>	Sports Injuries	<input type="checkbox"/>	Knocked Unconscious	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Smoking

OTHER:

Please list any Surgeries you have had: \_\_\_\_\_

## What Do You Know About Chiropractic?

In your own words, what do chiropractors do? \_\_\_\_\_

Do you know what spinal nerve stress/subluxation is?  no  yes If yes, please describe \_\_\_\_\_

What would you like to gain from chiropractic care? \_\_\_\_\_

Do you have friends/relatives who see chiropractors?  no  yes

If yes, do they use chiropractic for:  health maintenance/optimization  health problems  both

Are you seeking chiropractic for:  health maintenance/optimization  health problems  both

Please read through each paragraph & initial, sign and date at the bottom of the page.

## \_\_\_\_ Acknowledgement of Receipt of Notice of Privacy Practices:

**RENAISSANCE CHIROPRACTIC CENTER USES PERSONAL INFORMATION ONLY AS RELATED TO PROVIDING CARE AND BILLING PURPOSES IN ACCORDANCE WITH STATE AND FEDERAL PRIVACY GUIDELINES. WE DO NOT SHARE YOUR INFORMATION BEYOND WHAT IS REQUIRED FOR THESE PURPOSES.** I acknowledge that I may request a copy of the Notice of Privacy Practices or I have declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

## \_\_\_\_ Financial Responsibility:

I hereby state that the information on this form is true and correct. I authorize Renaissance Chiropractic Center to examine, take x-rays (if necessary), treat me, and do whatever they deem necessary in accordance with the state statutes, for the care and management of my condition. I understand and agree that health and insurance policies are an arrangement between an insurance carrier and myself. I also understand that Renaissance Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to Renaissance Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered me will be immediately due and payable. **Insurance benefits are based on a "Good faith" quote from your insurance company. However, this is not a guarantee of payment.**

## \_\_\_\_ Terms of Acceptance:

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. Chiropractic has only one goal. 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.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. I, \_\_\_\_\_, have read and fully understand the above statements.

(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I, parent/guardian, give permission for minor's care \_\_\_\_\_