



Date: _____

First Name: _____

Last Name: _____

Middle Initial: _____

MAJOR COMPLAINT INFORMATION

What is your major complaint(s)? _____

When did symptom(s) begin? _____

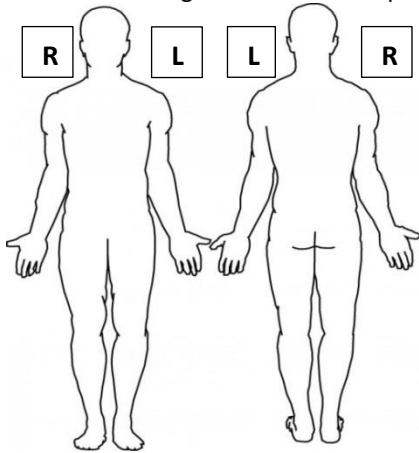
Have you experienced these symptoms before? Circle YES or NO When? _____

Are symptoms due to an auto accident or work injury? Circle YES or NO

Please circle if you have reported accident to: Auto Insurance or Employer

PAIN DIAGRAM

Using the symbols in the Pain Index, mark the areas on the diagram below where you are experiencing pain, followed by a number from 0 to 10 indicating the extent of the pain. (0 being no pain, 10 being the worst possible pain)



PAIN INDEX

- ~ Spasm
Δ Aching/Dull
* Numbness/Tingling
Burning
\ Sharp/Stabbing
T Throbbing
R Radiating

If this is an injury, describe what happened:

Blank lines for describing an injury.

On a scale of 0 through 10, how do you feel now? (0 being no pain, 10 being the worst pain)

Scale from 0 to 10 with a line for marking the current pain level.

Check all that apply:

Symptoms:

- come & go
are constant
came on gradually
came on suddenly

Symptoms have persisted for:

- days
weeks
months
years

Symptoms are worse in:

- AM
midday
PM

Symptoms are better in:

- AM
midday
PM

Do you have "pins & needles" in arms or legs? If yes, please specify: _____

What activities make symptoms worse? _____

What activities make symptoms better? _____

HEADACHES

Do you get headaches? If yes, how often? _____

Nausea, vomiting, or visual disturbances? ___ yes ___ no

When was your last eye exam? ___ 1-6 mo. ___ 7-12 mo. ___ years ___ never

Abnormal blood pressure? ___ yes ___ no ___ high ___ low

Do you have jaw problems? ___ yes ___ no



DAILY ACTIVITIES AFFECTED BY CONDITION

Please circle all that apply:

- coughing or sneezing, walking short distances, sleeping, kneeling, stooping, lying on back, bending over forward, getting out of car, climbing, pushing, gripping, dressing self, lying flat on stomach, turning over in bed, balancing, pulling, reaching, sex activity, lying on side w/ knees bent, standing > 1 hr., sitting, holding baby, lifting, bathing, bending forward to brush teeth, carrying bag/backpack, driving, exercise, other (please specify): _____

Have you consulted a doctor for this condition? If yes, please provide doctor's name: _____

Date consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? ___ yes ___ no If yes, how so? _____

How do you sleep? ___ On stomach ___ on back ___ on side ___ other (please explain: _____)

Do you sleep with a pillow? ___ yes ___ no If yes, how many? ___

Do you wear a heel lift or orthotic (circle one)? ___ yes ___ no If yes: ___ right ___ left

OTHER HEALTH HISTORY

Date of last physical exam? _____ Reason for exam? _____ Date of most recent x-rays? _____

List all medications you are taking now, including over-the-counter, and reason(s) for taking them:

Table with 3 columns: Medicine, Dosage/Frequency, Reason for taking medicine

Please list all known allergies: _____

Have you ever been hospitalized or had surgery? ___ yes ___ no If yes, please list below:

Date: _____ Reason: _____ Date: _____ Reason: _____

Date: _____ Reason: _____ Date: _____ Reason: _____

Do you have a family physician? ___ yes ___ no If yes, physician's name: _____

Physician's phone #: _____ City and state of physician's practice: _____

Have you ever received chiropractic care? ___ yes ___ no If yes, date last seen: _____

Have you ever had a concussion? ___ yes ___ no If yes, please explain: _____

Have you ever had any broken bones? ___ yes ___ no If yes, please explain: _____

Have you ever had any accidents resulting in serious injury? If yes, please explain: _____

Have you ever had professional clinical massage? ___ yes ___ no

Do you have a massage therapist you see regularly? ___ yes ___ no

Do you see or have you ever seen a medical specialist? ___ yes ___ no If yes, what specialty? _____

Medical specialist's name: _____ City and state of specialist's practice: _____

How often do you exercise? _____

What type(s) of physical exercise do you enjoy or prefer? _____



ADDITIONAL COMPLAINTS

Check any of the following disease(s) you have or have ever had:

- | | | | | |
|--|---------------------------------------|--|--------------------------------------|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Addiction | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Eczema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> AIDS | <input type="checkbox"/> Gout |

REVIEW OF SYSTEMS

Check any of the following you now have or have had in the past:

F = frequently O = occasionally N = never

<p>Head/Ears/Eyes/Nose/Throat</p> <input type="checkbox"/> blurred vision <input type="checkbox"/> floaters in vision <input type="checkbox"/> hearing loss <input type="checkbox"/> ringing in ears <input type="checkbox"/> loss of taste <input type="checkbox"/> loss of smell <input type="checkbox"/> glaucoma <input type="checkbox"/> ear infection <input type="checkbox"/> sinusitis <input type="checkbox"/> postnasal drip <input type="checkbox"/> nasal polyps <input type="checkbox"/> strep throat <input type="checkbox"/> Mononucleosis <input type="checkbox"/> dental issues	<p>Neurological</p> <input type="checkbox"/> dizziness <input type="checkbox"/> balance difficulty <input type="checkbox"/> blurred vision <input type="checkbox"/> loss of concentration <input type="checkbox"/> depression/confusion <input type="checkbox"/> anxiety/nervousness <input type="checkbox"/> sleep disturbance <input type="checkbox"/> fatigue/energy loss <input type="checkbox"/> fainting <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson's <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Chronic pain <input type="checkbox"/> Mood disorders <input type="checkbox"/> Other: _____	<p>Gastro-Intestinal</p> <input type="checkbox"/> ulcer <input type="checkbox"/> anorexia/bulimia <input type="checkbox"/> food sensitivities <input type="checkbox"/> indigestion <input type="checkbox"/> unusual appetite <input type="checkbox"/> excessive thirst <input type="checkbox"/> frequent urination <input type="checkbox"/> vomiting <input type="checkbox"/> constipation <input type="checkbox"/> sudden weight change <input type="checkbox"/> hemorrhoids <input type="checkbox"/> liver issues <input type="checkbox"/> abdominal cramps <input type="checkbox"/> gas/bloating <input type="checkbox"/> heartburn <input type="checkbox"/> black bloody stool <input type="checkbox"/> diverticulitis/-osis <input type="checkbox"/> gall bladder disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Celiac <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Irritable Bowel Syndrome	<p>Musculoskeletal</p> <input type="checkbox"/> headache <input type="checkbox"/> neck pain <input type="checkbox"/> pain between shoulders <input type="checkbox"/> arm pain/tingling/numb <input type="checkbox"/> mid back pain <input type="checkbox"/> low back pain <input type="checkbox"/> hip pain <input type="checkbox"/> leg pain/tingling/numb <input type="checkbox"/> walking problems <input type="checkbox"/> chewing difficulty
<p>Cardiovascular</p> <input type="checkbox"/> poor circulation <input type="checkbox"/> chest pain <input type="checkbox"/> shortness of breath <input type="checkbox"/> irregular blood pressure <input type="checkbox"/> irregular heart beat <input type="checkbox"/> heart problems <input type="checkbox"/> lung issues/congestion <input type="checkbox"/> varicose veins <input type="checkbox"/> ankle swelling	<p>Genitourinary</p> <input type="checkbox"/> kidney stones <input type="checkbox"/> prostate issues <input type="checkbox"/> erectile dysfunction <input type="checkbox"/> bedwetting <input type="checkbox"/> PMS symptoms <input type="checkbox"/> infertility <input type="checkbox"/> urinary tract infection <input type="checkbox"/> yeast infection <input type="checkbox"/> abnormal PAP <input type="checkbox"/> sexually transmitted disease <input type="checkbox"/> decreased libido <input type="checkbox"/> menstrual cramping <input type="checkbox"/> menstrual irregularity <input type="checkbox"/> vaginal pain	<p>Family History Has your: <i>Grandmother, Grandfather, Father, Mother, Sister, Brother, Daughter, or Son ever had:</i></p> <input type="checkbox"/> cancer <input type="checkbox"/> heart disease <input type="checkbox"/> stroke <input type="checkbox"/> arthritis <input type="checkbox"/> osteoporosis <input type="checkbox"/> high cholesterol Other (please explain): _____	<p>Habits:</p> Do you smoke? _____ _y _n How many per day? _____ Do you drink alcohol? _____ _y _n How much per day? _____ Do you consume caffeine? _____ _y _n How much per day: _____ List vitamins/supplements: _____ Water intake: _____ ounces per day How old is your bed? _____ Sleep quality? _____ Rate your stress level: <input type="radio"/> Stress free <input type="radio"/> Low stress <input type="radio"/> Moderate stress <input type="radio"/> High stress <input type="radio"/> The worst possible stress Stress factors: <i>Check all that apply.</i> <input type="radio"/> Relationship <input type="radio"/> Family <input type="radio"/> Work <input type="radio"/> School <input type="radio"/> Other: _____ _____
<p>Integumentary</p> <input type="checkbox"/> dry skin <input type="checkbox"/> psoriasis <input type="checkbox"/> eczema <input type="checkbox"/> acne	<p>Constitutional</p> <input type="checkbox"/> poor appetite <input type="checkbox"/> weakness <input type="checkbox"/> sudden weight change <input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> night sweats <input type="checkbox"/> fainting <input type="checkbox"/> difficulty losing weight	<p>Endocrine</p> <input type="checkbox"/> thyroid issues <input type="checkbox"/> hypoglycemia <input type="checkbox"/> low energy <input type="checkbox"/> swollen glands <input type="checkbox"/> polycystic ovarian syndrome	



EMERGENCY CONTACT

Name: _____ Relation: _____
Phone: _____ Is this a cell phone? _ yes _ no Work Phone: _____
Address: _____ City/State/Zip: _____

INSURANCE INFORMATION

Insurance Company: _____ Phone: _____
Address: _____ City/State/Zip: _____
Insured's Name: _____ Insured's SS#: _____
Group #: _____ Member ID#: _____ Insured's Birth Date: _____
Insured's Employer: _____

PERSONAL INFORMATION

Address: _____ City/State/Zip: _____
Phone: _____ Is this a cell phone? _ yes _ no Work Phone: _____
Email: _____
Date of Birth (mm/dd/yyyy): ___/___/___ Age: _____ Legal Gender (for insurance use): ___ female ___ male
SS#: _____ Driver License #: _____ US State of Issue: _____
Occupation: _____ Circle one: full-time part-time School or Employer's Name: _____
Work or School City/State: _____
How were you referred to our office? [Single Married Partnered Divorced Widowed]

Optional questions:

Gender Identity: ___ female ___ male ___ transgender ___ non-binary ___ other: _____
My preferred pronouns are: ___ she/her ___ he/him ___ them/they ___ other: _____

PLEASE READ, SIGN, AND DATE BELOW

I hereby acknowledge that the information provided above is true and accurate. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Atlas Chiropractic Health 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 Atlas Chiropractic Health Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my financial responsibility. Any dispute between legal parties shall be resolved by binding arbitration. It is not our intention to cause you undue hardship, however we must collect our receivables as efficiently as possible in order to continue our service to the community. Interest of 1% per month will be charged on delinquent accounts. If you discontinue your care, all charges are due immediately.

Patient Signature: _____ Date: _____

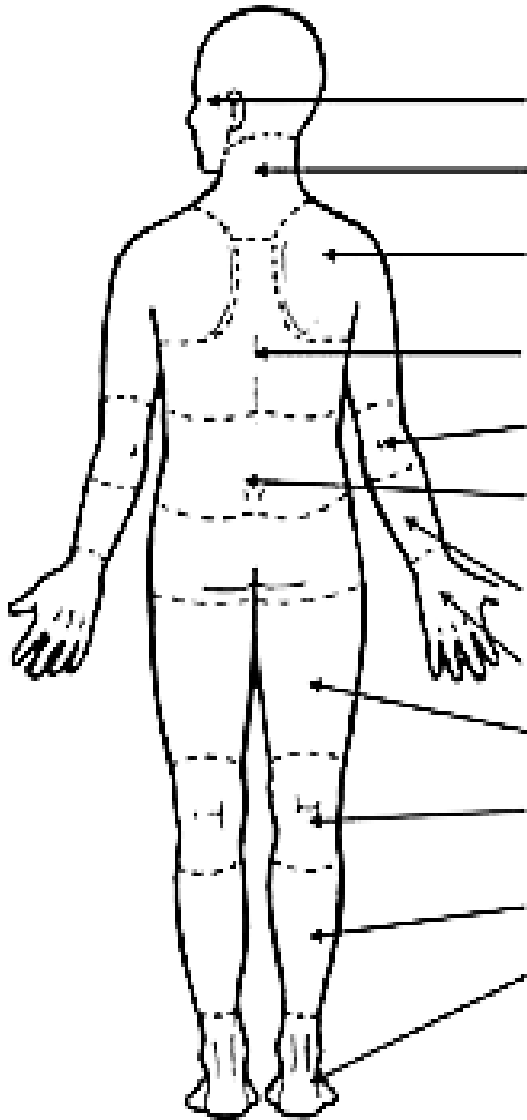
Guardian/Spouse Signature Authorizing Care: _____ Date: _____
Printed Guardian/Spouse Full Name: _____



Functional Pain Index

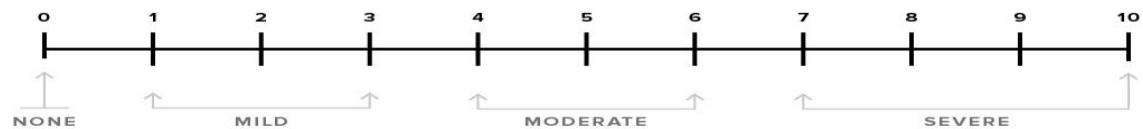
Please check the appropriate box to let us know how you feel TODAY.

Patient Name: _____ Date: _____



Body Part	Right/Left	0	1	2	3	4	5	6	7	8	9	10
<i>BODY-OVERALL</i>												
<i>Head</i>												
<i>Neck</i>	Right/Left											
<i>Shoulders/Chest</i>	Right/Left											
<i>Upper Back</i>	Right/Left											
<i>Elbow</i>	Right/Left											
<i>Lower Back</i>	Right/Left											
<i>Arm</i>	Right/Left											
<i>Wrist/Hand</i>	Right/Left											
<i>Pelvis/Hips</i>	Right/Left											
<i>Thigh</i>	Right/Left											
<i>Knee</i>	Right/Left											
<i>Lower Leg</i>	Right/Left											
<i>Feet/Ankle</i>	Right/Left											

0-10 NUMERIC PAIN RATING SCALE





Insurance Benefits and Financial Responsibility Agreement

Thank you for choosing Atlas Chiropractic Health Center. We appreciate the opportunity to serve you and pledge to provide you with the very best medical care. The following contains information regarding our insurance benefits and financial responsibility policies. It is important that you read and understand this information prior to and during the duration of your treatment with us. Please initial each section.

Commercial Insurance Carriers:

1. As a courtesy, we will verify your benefit eligibility, however, since your insurance coverage is a contract between you and your insurance company, it is important that you understand the terms set forth by them regarding your benefits. **It is your responsibility to contact your carrier prior to treatment if you have any questions or concerns regarding your coverage.**
2. You are responsible for deductibles, co-payments, co-insurance payments or any other patient responsibility determined by your insurance carrier which is not otherwise covered. **You are also responsible for knowing and tracking your total allowed visits per coverage term as well as if a prior authorization is required.**
3. You are responsible for knowing the terms of your insurance policy, including, but not limited to physical and occupational therapy coverage. **You will be responsible for any and all charges in full for the following scenarios:**
 - a. Your health plan requires a prior authorization or referral from a physician before receiving treatment at Atlas Chiropractic Health Center and has not been provided by you
 - b. You receive services in excess of:
 - i. Your referral or authorization
 - ii. Your allowed visits per coverage term
 - c. Your health plan determines that the services you received at Atlas Chiropractic Health Center are not medically necessary and are therefore not covered by your plan
 - d. Your health plan coverage has expired, and you have not provided updated coverage information
4. You are required to provide us with all required information to bill your plan prior to your first appointment. If we are unable to verify your eligibility or benefits by the time of service, you will be considered a self-pay patient. Self-pay visits are expected to be paid in full at the time of service. Once verified information is provided, we will submit your claim and refund you once we have been paid by your carrier. You must notify us as soon as possible regarding any changes to your insurance coverage. Failing to do so could result in unpaid claims, and you will be responsible for the total balance of the unpaid claim. **Atlas Chiropractic Health Center does not accept responsibility for incorrect information provided by you or your insurance carrier regarding your insurance benefits or other plan information.**



Any information we communicate to you has come directly from your carrier. Discrepancies should be addressed directly with them.

5. Billing statements are emailed monthly and can be expected to be received approximately 20-30 days after your insurance has processed a submitted claim. Please add **billing@atlaschirohc.com** to your list of acceptable contacts. **We are not responsible if our emails are sent to you spam or trash boxes.** You must notify us of any errors or objections to your billing statement within 30 days of the statement date, otherwise the information will be considered accurate and any fees and expenses for services provided will be your responsibility.

6. Payment of your account balance is due within 30 days of the statement billing date. Payments can be made online, in person, or via mail. You can conveniently pay by visiting our website or making payment by PayPal, check, cash and all major debit and credit cards are also accepted. It is your responsibility to notify us of any address changes. **Not receiving a bill due to inaccurate information on file is not an excuse for nonpayment.**

7. All self-pay services and co-pays are required to be paid in full at the time of service. All self-pay patients without insurance in accordance with the law will be given a good faith estimate.

Initials _____

Work Injuries/Workers' Compensation/L&I Claims

1. If treatment is part of a workers' compensation/L&I claim it is your responsibility to ensure that your claim is opened and accepting claims for payment of services you will be receiving prior to your initial visit. It is also your responsibility to know how many visits you are allowed and to notify us if you are receiving subsequent care at another location that is also being billed under the same claim. This may affect how many visits will be paid to Atlas Chiropractic Health Center and **we are not responsible for tracking visits that take place outside of our location.** We will do our best to obtain additional authorized visits in a timely manner, however any unauthorized visits are ultimately your responsibility. **It is important that you are regularly communicating with your claim manager so that you are aware of the coverage associated with your claim.**

2. You are responsible for providing us all required information to bill your claim directly. This includes but is not limited to the following:

- a. Claim Number
- b. Carrier name and mailing address if the claim is being paid by a carrier other than the state of Washington.
- c. Date of birth and date of injury
- d. Primary Care Physician in charge of your case
- e. Name and contact information for your claim manager



f. Commercial medical insurance plan information as back up billing source if needed

3. In the event that your claim is denied we will make an attempt to bill your primary commercial medical insurance plan. **If the claim is denied by both parties, you will be billed and required to pay all amounts within 30 days of the statement billing date.**

Initials _____

Auto Accidents/Third-Party Liability Injuries/PIP Claims

1. As a courtesy, we will bill **your** PIP carrier for services. It is your responsibility to ensure that your claim is open and accepting claims for payment of services you will be receiving prior to your initial visit. **Legally we do not have access to information regarding the remaining available funds associated with your claim. It is your responsibility to know when your claim's funds may become exhausted. It is common for us to only become aware that funds have been exhausted after several additional visits have occurred.**

2. You are responsible for providing us all required information to bill your claim directly. This includes but is not limited to:

- a. Name of your carrier
- b. Claim number
- c. Billing address
- d. Name and contact information for your claim manager
- e. Date of birth, date of injury and state where accident took place
- f. Attorney Name and Contact Information (if applicable)
- g. Commercial medical insurance plan information as back up billing source if needed

3. In the event that your funds become exhausted during your course of treatment, we will make an attempt to bill your primary commercial medical insurance plan. **If the claim is denied by both parties, you will be billed and required to pay all amounts within 30 days of the statement billing date.** We will only accept a delay in payment resulting from a settlement with a 3rd party dispute and/or litigation when a letter of protection from an attorney as a guarantee of payment has been signed by both patient and attorney and is on file.

Initials _____

Past Due Balances

Atlas Chiropractic Health Center will work with you to ensure a timely payment of your outstanding balance. In the event that it becomes necessary to begin collection proceedings to collect payment on a delinquent account, you understand that Atlas Chiropractic Health Center has the right to disclose to an outside collection agency all pertinent personal information required to collect payment for services



rendered. You are responsible for all costs associated with any collection efforts. You also understand that information may be reported to a credit reporting agency which may have a negative effect on your credit history.

Initials _____

Acknowledgement

Please sign below acknowledging that you have read and understand the insurance benefits and financial policies stated above.

Signature of Patient/Responsible Party

Date

Printed Name of Patient/Responsible Party

Relationship to Patient