# Lifestyle Chiropractic

*New Patient Intake*
*Personal Information*

Patient Name: _____ Date: _____

Address_____City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth_____ Age_____

Social Security #_____

Occupation_____
Employer_____

How did you hear about us? : _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

1. **Reasons for seeking chiropractic care:**

Primary reason:
_____

Secondary reason:
_____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**
_____
_____
_____

3. **Past Health History:**

   A. **Please indicate if you have a history of any of the following:**
   □ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
   □ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
   □ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other _____
   □ None of the above

   B. **Recent Injury or Trauma:**
   _____

   **Have you ever broken any bones? Which?**
   _____

4. **Emergency Contact:**

   A. **Name of Emergency Contact:** _____ **Relationship:** _____

   B. **Phone Number of Emergency Contact:**_____

# HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

**Use and Disclosures of Protected Health Information:**
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____
Signature of Patient of Representative

_____
Printed Name

_____
Date

**Patient Name:** _____ **Date:** _____

**NEW PATIENT HISTORY FORM**

***Please start at the top of your body and work your way down (e.g. headache, neck pain, etc.)***

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? _____
  - How did the symptom begin? _____
- What makes the symptom worse? please describe: _____
- What makes the symptom better? please describe: _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? _____
  - How did the symptom begin? _____
- What makes the symptom worse? please describe: _____
- What makes the symptom better? please describe: _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? _____
  - How did the symptom begin? _____
- What makes the symptom worse? please describe: _____
- What makes the symptom better? please describe: _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

**Financial Policies**

1) Payment is expected at the time of the visit, including co-payments and deductible amounts.
2) The patient is always responsible for payment for his/her care. An insurance contract is between the patient and insurance company.
3) Insurance coverage is never guaranteed. If there are any problems between you and the insurance company, you may choose to assist us in billing by filing a dispute with the insurance company directly. Your signature below assigns assignment to Lifestyle Chiropractic for collections of payment.
4) We may send an account balance to collections if we deem necessary. Any additional collection fees incurred are the responsibility of the patient.
5) Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding our coverage in way way implies or guarantees that your care here will be covered by your insurance company, and you will be responsible for paying your account, regardless of coverage.
6) Please feel free to ask our office manager questions about your account.

**Professional Fee Schedule**

Consultation.....No charge
Chiropractic Examination.....$75 - $175
Chiropractic Office Visits (averages).....$35 - $60
Chiropractic X-ray studies (averages).....$70 - $210
Massage Therapy.....$95 - $128

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Lifestyle Chiropractic for services performed.

By signing below, I state that I understand the policies as explained herein.

Patient or Guardian Signature: _____
Date: _____

Lifestyle Chiropractic

# Graston and Cupping Information and Consent

**Please answer the following questions. Read the statements concerning Graston Technique® and sign below. If you have any questions, please speak with your clinician.**

| | | | |
|---|---|---|---|
| **1.** | Do you bruise easily? | YES | NO |
| **2.** | Do you bleed for a long period of time after you cut yourself? | YES | NO |
| **3.** | Are you taking blood thinners or anticoagulants? | YES | NO |
| **4.** | Do you take aspirin on a regular basis? | YES | NO |
| **5.** | Do you take cortisone on a regular basis? | YES | NO |
| **6.** | Have you ever had inflamed veins or blood clots? | YES | NO |
| **7.** | Do you have surgical Implants In your body? | YES | NO |
| **8.** | Do you have diabetes or kidney disease? | YES | NO |
| **9.** | Do you currently have any infections? | YES | NO |
| **10.** | Do you have uncontrolled high blood pressure? | YES | NO |

Graston Technique® (GT) is an instrument-assisted variation of traditional cross fiber or transverse friction massage. The GT instruments consist of six stainless steel instruments of various sizes and contours. GT is a form of treatment used to "break up" or "soften" scar tissue, thus allowing for the return of normal function in the area being treated. On the other hand, Cupping Therapy is an ancient form of alternative medicine in which special cups are put on the skin to create suction. The suction helps to facilitate healing with blood flow and also allows the return of normal function in the area being treated. These two techniques may produce the following:

1. Local discomfort during the treatment.
2. Reddening of the skin.
3. Superficial tissue bruising.
4. Post treatment soreness.

**CUPPING:**

- I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.
- Information has been provided to me about Cupping Therapy. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations.
- It has been explained to me that there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my Health History Intake Form, to avoid any complications.
- It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation from my body.
- I also understand that this reaction is not bruising, but due to cellular debris, pathogenic factors and stagnation being drawn to the surface to be clear away by my circulatory systems.
- I further understand that the discolorations will dissipate from a few hours to as long as 2 weeks in some cases and in relation to my after-care activities.
- I understand that the first time I experience Cupping, my body's immune system can temporarily react to this release as it might with the flu - producing flu-like effects like nausea, headache, aches, that will subside in time with rest and water. Water helps to dilute the intensity of the release.
- I understand that Cupping Therapy modalities should not be combined with aggressive ex-foliation, 4 hours after shaving, after sunburn or when I'm hungry or thirsty.
- I understand that I should avoid exposure to cold, wet, and/or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 4 - 6 hours. I understand that exposure to such extremes can produce undesirable effects and I should avoid such situations.

**All components of Cupping and Graston Techniques® have been explained to me. I understand the risks of the procedure and I give me full consent for treatment.**

**Print name:**_____

**Signature**_____ **Date**_____

**7010 Woodlawn Ave**
**Seattle, WA 98115**
**www.mylifestylechiropractic.com**

**P: (206) 517-5433**
**F: (206) 517-5533**
**email: admin@mylifestylechiropractic.com**

# Lifestyle Chiropractic

## *Massage/Sports Cancellation Policy*

These policies are in place to help protect the Massage/Sports Therapist against unexpected fluctuations in income and inability to perform their job effectively due to no fault of their own.
All cancellation fees will be paid directly to the Therapist.
We appreciate your understanding.

_____ Minimum 24 hours' notice is required to cancel or reschedule a scheduled massage/sports therapy appointment. Failure to do so will result in a late cancellation fee of $35 for massage and $15 for PT.

_____ Weekend massage appointments require any changes or cancellations be made before 3 pm on Friday.

_____ Acceptable forms of cancellation are in person, over the phone, voice mail, or email.

_____ While we will do our best to ensure you receive reminders for your massages, ultimately it is your responsibility to be aware of your scheduled appointments.

_____ Being more than 15 minutes late for a massage/sports therapy appointment will result in the appointment being canceled. The $35 or $15 fee will be applied.

Lifestyle Chiropractic requires a valid credit card on file OR $35 massage/$15 PT cash retainer before scheduling any massage therapy appointments. Using gift certificates does not require this but may result in voiding the certificate in case of a late cancellation.

I, _____, hereby authorize Lifestyle Chiropractic to initiate debit/credit card charges and/or corrections to previous debit/credit card charges to my account with the financial institution identified by me, on this form for payment in the amount of $35 for massage or $15 for PT, for any late cancellations or missed sports therapy/massage appointments. The authorization is to remain in effect indefinitely and may be withdrawn by me at any time by request.

**CREDIT CARD #**: _____ exp: _____/_____
(card # will be securely destroyed after being entered in our secure, encrypted billing system.)

CVV:_____

Card Holder Name:_____Signature:_____

(as it appears on the card)

Date:_____

Visa® MasterCard® Amex Discover®

Card Holder Billing Address:

_____

_____

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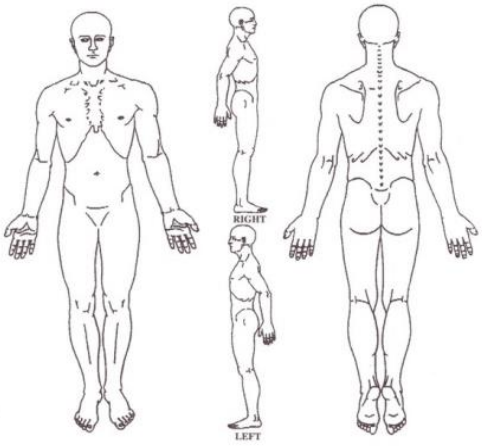
**F: (206) 517-5533**
**email: admin@mylifestylechiropractic.com**

**NAME:** **DOB:** **DATE:** **TYPE:**

_____
_____
_____
_____
_____
_____
_____
_____

| | | |
|---|---|---|
| Flex/Ext (60/50) | Csp | L_____R_____ |
| Lat Flex (40) | Csp | L_____R_____ |
| Rotation (80) | Csp | L_____R_____ |
| Occiput Fixation | | L_____R_____ |
| Cervical Comp | | L_____R_____ |
| Shoulder Dep. | | L_____R_____ |
| Rib Humping | | L_____R_____ |
| Kemps | | L_____R_____ |
| Becterews | | L_____R_____ |
| Valsalvas | | _____ |
| Scales | | L_____R_____ |
| Flex/Ext (90/30) | Lsp | _____/_____ |
| Lat Flex (40) | Lsp | L_____R_____ |
| Short Leg | | L_____R_____ |
| Nachlas | | L_____R_____ |
| Yeomans | | L_____R_____ |
| Fabere | | L_____R_____ |
| SLR | | L_____R_____ |
| Therm/EMG | | Yes__No__Yes__No__ |

**Palpation/Posture**
X (Tenderness) O (Jt. Fixation) II (Muscle Spasm)




Objective **Exam I**
Height/ H.R. _____'_____"/_____beats/min
B.P. _____/_____

| DTR | R | L |
|---|---|---|
| Bi | | |
| T | | |
| Br | | |
| Pa | | |
| Ach | | |

**Xray**
Csp Curve _____
Lsp Curve _____
C0/C1 angle 1 2 3
Csp WB A P
Lsp WB A P
Scoliosis + -
Spondy _____
Cps DJD _____
Tsp DJD _____
Lsp DJD _____
High Sldr L R
High Hip L R

**Abbreviations**

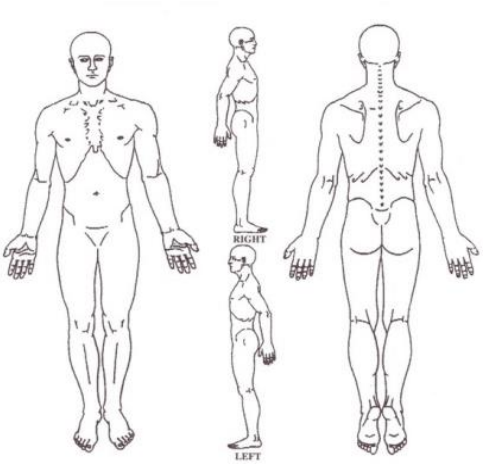
| | |
|---|---|
| L (Left) | 1 (Mild Pain) |
| R (Right) | 2 (Moderate Pain) |
| + (Positive) | 3 (Severe Pain) |
| - (Negative) | T2P (Tender to Palpation) |
| ↓ (Decrease) | |
| ↑ (Increase) | |

**DATE:**

_____
_____
_____
_____
_____
_____
_____
_____

| | | |
|---|---|---|
| Flex/Ext (60/50) | Csp | L_____R_____ |
| Lat Flex (40) | Csp | L_____R_____ |
| Rotation (80) | Csp | L_____R_____ |
| Occiput Fixation | | L_____R_____ |
| Cervical Comp | | L_____R_____ |
| Shoulder Dep. | | L_____R_____ |
| Rib Humping | | L_____R_____ |
| Kemps | | L_____R_____ |
| Becterews | | L_____R_____ |
| Valsalvas | | _____ |
| Scales | | L_____R_____ |
| Flex/Ext (90/30) | Lsp | _____/_____ |
| Lat Flex (40) | Lsp | L_____R_____ |
| Short Leg | | L_____R_____ |
| Nachlas | | L_____R_____ |
| Yeomans | | L_____R_____ |
| Fabere | | L_____R_____ |
| SLR | | L_____R_____ |
| Therm/EMG | | Yes__No__Yes__No__ |

**Palpation/Posture**
X (Tenderness) O (Jt. Fixation) II (Muscle Spasm)




Objective **Exam II**
Height/ H.R. _____'_____"/_____beats/min
B.P. _____/_____

| DTR | R | L |
|---|---|---|
| Bi | | |
| T | | |
| Br | | |
| Pa | | |
| Ach | | |

**Xray**
Csp Curve _____
Lsp Curve _____
C0/C1 angle 1 2 3
Csp WB A P
Lsp WB A P
Scoliosis + -
Spondy _____
Cps DJD _____
Tsp DJD _____
Lsp DJD _____
High Sldr L R
High Hip L R

**Abbreviations**

| | |
|---|---|
| L (Left) | 1 (Mild Pain) |
| R (Right) | 2 (Moderate Pain) |
| + (Positive) | 3 (Severe Pain) |
| - (Negative) | T2P (Tender to Palpation) |
| ↓ (Decrease) | |
| ↑ (Increase) | |