EASTSIDE spine & injury
CHIROPRACTIC • MASSAGE

PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other chiropractic rehabilitative programs. This often allows our patients to achieve superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

_____

Patient Signature

_____

Today's Date

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. By signing below **I acknowledge that the Notice of Privacy Practices has either been offered to me or received by me.**

Patient or Guardian's Signature X_____ Date:_____

Female Patients Only – non-pregnancy verification for xrays

To the best of my knowledge I certify that I am NOT pregnant. Should I become pregnant during the course of treatment I will provide that information to the Doctor.

Patient Signature X_____ Date:_____

Consent to Treat a Minor

I authorize the Doctor and whomever he may designate as assistants to examine and administer chiropractic care as deemed necessary to treat my child.

Parent or Guardian's Signature X_____ Date:_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractic with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care including various modes of physical therapy (exercises, traction, massage therapy) as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from ALL providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:_____

Parent or Guardian: _____ Signature: _____ Date:_____

Witness Name: _____ Signature: _____ Date:_____

Eastside Spine & Injury – Financial Policies

Thank you for selecting us as your chiropractor. The following information describes our financial policies. Our primary goal is that you receive the optimal treatments needed to restore and maintain your health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask one of our office managers.

1. We accept the following forms of payment: Cash, Check, Visa, MasterCard, Care Credit (Care Credit use is reserved for long-term financing of large treatment fees)

2. Payment is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist.

3. Chiropractic insurance is a contract between you and your insurance company. Patients should realize that professional services are rendered to a person, and not to any insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to the doctor. Ultimately the patient is responsible for all unpaid balances. On your behalf, we will help in filing your claim, handling insurance queries, processing follow-ups, and lost claims, etc. Please understand that we provide an estimate of your fees which is a **guideline** from which to work until final payment is received from your insurance company and your **exact** share of the bill is known. If you direct the insurance company to pay their share of the cost directly to this office, we will give you credit for this anticipated amount. Your insurance company will **not** be billed for services rendered until treatment has been completed. Often these payments are not received for 2 to 4 months after being submitted for payment.

4. All x-rays taken in this office are referred to a radiology specialist for interpretation/analysis and a Radiology Consulting fee of $40-60 will be charged to you for this service.

5. Any pre-payments for health services are 100% refundable if those services are not rendered.

6. We do our best to provide you with an accurate estimate of your treatment costs. Ultimately, your final treatment costs will depend on how your insurance claims are processed and what services are rendered. Any "over-payments" or "under-payments" will be reconciled accordingly after all insurance claims have processed and you have concluded your active treatment program.

7. Balances older than 90 days may be subject to additional collection fees and interest charges of 1% per month. (per RCW 19.52) Returned checks may be subject to an additional $25 non-sufficient fund fee. (per RCW 62A.3-515 & 520)

8. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account.

PATIENT RESPONSIBILITY: I authorize treatment of the patient named above and agree to pay for all fees for such treatment. I hereby authorize the clinic to receive all benefits to which my dependents or I are entitled to under my health insurance plan. I also authorize the healthcare provider or insurance company to release any information required to process the claim. In addition, I will not withhold or delay payment if my insurance company denies payment of any charges. I acknowledge my responsibility for payment of the service from Dr. Ryan Coogan in accordance with his regular fees and terms. I accept financial responsibility for all services not covered by my insurance and authorize payment to be made directly to the doctor by my insurance company.
I have reviewed and acknowledge my understanding of the office financial policies and procedures.

Signature:_____ Date:_____

Eastside Spine & Injury

About You

Full Name:_____ Date:_____

Address:_____City:_____ State:_____ Zip:_____

Cell Ph: (____)_____ Work Ph: (____)_____ Home Ph: (____)_____

Email:_____ Birthdate:___/___/___ Age:_____

Marital Status: □ M□ S □ D □ W Gender: □ M □ F □ Other _____ □ Prefer not to say

Family Doctor:_____ City:_____ Phone #:_____

I give permission for Eastside Spine & Injury to send a brief progress report to my physician: ☐ Please Initial

Occupation:_____ Employer:_____

Emergency Contact:_____ Emergency Ph:(____)_____

How did you find us? □ Internet/Website □ Location □ Other health care provider(name)_____

□ Community Event (screening, seminar, health fair, massage event) □ Family/Friend (name)_____

Experience with Chiropractic

Have you seen a chiropractor before? □ Yes □ No Who?_____ Last Visit:_____

Reason for visits:_____

How did you respond to treatment?_____

Did your previous chiropractor take xrays to evaluate your spine? □ Yes □ No

Were "after" xrays taken at the end of treatment to assess your progress? □ Yes □ No

Did you receive "adjustments"? □ Yes □ No Exercises? □ Yes □ No Rehab Traction? □ Yes □ No

Are you aware of any of your poor posture habits? □ Yes □ No

Explain:_____

Trauma History

Most spinal health problems (subluxations) are the result of the cumulative effects of past and current traumas. The following questions will help us develop a comprehensive history of your spinal health traumas.

Have you been involved in any motor vehicle accidents (car, motorcycle, boat, etc…)? □ Yes □ No

Explain:_____

Have you been involved with any of the following sports? □ Gymnastics □ Soccer □ Football □ Martial Arts □ Wrestling □ Basketball □ Cheerleading/Dance □ Baseball/Softball □ Volleyball □ Rugby □ Boxing □ Skiing/Snowboarding - Other high impact or contact sports:_____

Do your job or daily activities require any sustained/repetitive postures, positions, or activities: □ Yes □ No

Explain:_____

History of sitting at a desk/computer for extended periods of time (school, work, leisure)? □ Yes □ No

Explain:_____

How many hours per day do you currently spend? ____sitting (driving, desk/computer, leisure) ____ standing

Social History

Do you smoke? ___ yes ___ no # ___ per day/week

Do you drink? ___ yes ___ no # ___ per day/week

Exercise level? ___ none ___ minimal ___ moderate ___ frequent

Past Medical History

HOSPITALIZATIONS

TYPE	DATE
1.	
2.	
3.	

SURGERIES

TYPE	DATE
1.	
2.	
3.	

INJURIES

TYPE	DATE
1.	
2.	
3.	

Family History?

□ Heart Disease
□ Cancer
□ Stroke
□ Diabetes

Allergies

1._____
2._____
3._____
4._____

General Health History

Please check any of the conditions below that currently (C) affect you or that you have experienced in the past (P):

MUSCULOSKELETAL

___fibromyalgia
___gout
___osteoarthritis
___rheumatoid arthritis
___osteoporosis
___cysts
___bursitis
___bone/joint disease
___scoliosis
___fractures
___stiff/painful joints
___low back/hip/leg pain
___neck/shoulder/arm pain
___headache
___muscle pain
___disc bulge/herniation

RESPIRATORY

___pneumonia
___asthma
___difficulty breathing
___sinus problems
___emphysema

CIRCULATORY

___anemia
___hemophilia
___low blood pressure
___high blood pressure
___raynaud's
___varicose veins
___blood clots
___diabetes
___heart condition
___heart attack
___stroke
___thrombosis/embolism

DIGESTIVE

___ulcers
___irritable bowel syndrome
___colitis
___gallstones
___hepatitis
___crohn's disease
___gas/bloating
___indigestion
___constipation/diarrhea

SKIN

___rashes/warts/moles
___eczema/dermatitis
___psoriasis
___fungal infections
___herpes/cold sores

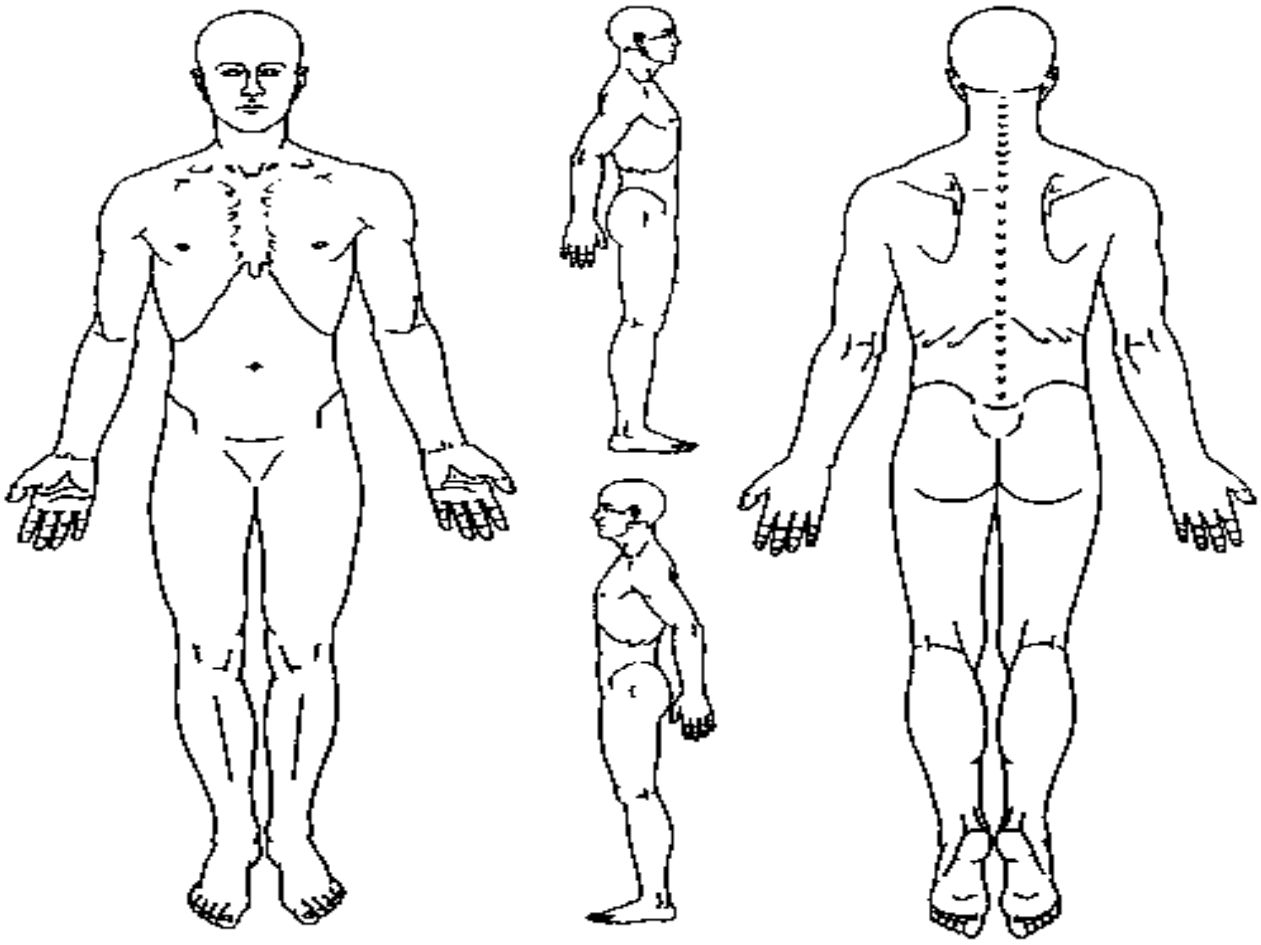
NERVOUS SYSTEM

___multiple sclerosis
___parkinson's disease
___bell's palsy
___spinal cord injury
___paralysis
___trigeminal neuralgia
___seizures

OTHER

___cancer
___urinary/kidney disease
___immune system
___liver disease
___anxiety/panic attacks
___chronic fatigue syndrome
___eyes/ears/nose/throat

Please mark all of the areas on the diagram below where you have complaints



A = Ache X = Burning 000 = Numbness/tingling
S = Stiffness /// = Stabbing

Current Complaints

Please answer the following questions regarding your present complaint(s): please check all that apply

□ Poor posture □ Neck Pain □ Headaches □Upper back pain □ Arm Pain □ Mid-back Pain □ Low-back Pain
□ Leg Pain □ Hip Pain □ Pain and tension across the shoulders □ Numbness/tingling in arms/hands
□ Numbness/tingling in legs/feet □ Dizziness □ Jaw pain/dysfunction □ Shoulder joint pain □ Elbow pain
□ Wrist/Hand pain □ Knee pain □ Ankle/Foot pain □Stiffness in joints Where?_____
□Other:_____

For each of the complaints listed above, please describe in more detail using the questions on the next page

MAIN COMPLAINT _____ When did this begin?_____
How did it start? □ slip/fall □ lifting □ nothing specific □ accident/injury □ poor posture habits □ sleeping
Other:_____ Has it? □ improved □ worsened □ remained the same
What makes it worse? □ head/neck movement □ back movement □ general movement/activity □ lifting □ bending
□turning/twisting □ driving □ sitting □ walking □ standing □ running □ cough/sneeze □ poor posture □ sleeping
Other:_____
What makes it better? □ general movement/activity □ inactivity □ exercise □ sitting □ standing □ rest/laying down
□ changing positions □ heat □ ice □ massage □ medications_____
Other:_____
Quality: □ dull/ache □ sharp □ stabbing □ burning □ throbbing □ numbness/tingling □ stiff
Do your symptoms radiate to other areas? □ yes □ no Where?_____
Frequency: □ daily □ several days/week □ several days/month Other:_____
Timing: □ occasional (25% of time) □ intermittent (25-50% of time) □ frequent (50-75% of time) □ constant (>75% of time)
Average pain level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST
Worst pain level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST

COMPLAINT #2 _____ When did this begin?_____
How did it start? □ slip/fall □ lifting □ nothing specific □ accident/injury □ poor posture habits □ sleeping
Other:_____ Has it? □ improved □ worsened □ remained the same
What makes it worse? □ head/neck movement □ back movement □ general movement/activity □ lifting □ bending
□turning/twisting □ driving □ sitting □ walking □ standing □ running □ cough/sneeze □ poor posture □ sleeping
Other:_____
What makes it better? □ general movement/activity □ inactivity □ exercise □ sitting □ standing □ rest/laying down
□ changing positions □ heat □ ice □ massage □ medications_____
Other:_____
Quality: □ dull/ache □ sharp □ stabbing □ burning □ throbbing □ numbness/tingling □ stiff
Do your symptoms radiate to other areas? □ yes □ no Where?_____
Frequency: □ daily □ several days/week □ several days/month Other:_____
Timing: □ occasional (25% of time) □ intermittent (25-50% of time) □ frequent (50-75% of time) □ constant (>75% of time)
Average pain level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST
Worst pain level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST

COMPLAINT #3 _____ When did this begin?_____
How did it start? □ slip/fall □ lifting □ nothing specific □ accident/injury □ poor posture habits □ sleeping
Other:_____ Has it? □ improved □ worsened □ remained the same
What makes it worse? □ head/neck movement □ back movement □ general movement/activity □ lifting □ bending
□turning/twisting □ driving □ sitting □ walking □ standing □ running □ cough/sneeze □ poor posture □ sleeping
Other:_____
What makes it better? □ general movement/activity □ inactivity □ exercise □ sitting □ standing □ rest/laying down
□ changing positions □ heat □ ice □ massage □ medications_____
Other:_____
Quality: □ dull/ache □ sharp □ stabbing □ burning □ throbbing □ numbness/tingling □ stiff
Do your symptoms radiate to other areas? □ yes □ no Where?_____
Frequency: □ daily □ several days/week □ several days/month Other:_____
Timing: □ occasional (25% of time) □ intermittent (25-50% of time) □ frequent (50-75% of time) □ constant (>75% of time)
Average pain level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST
Worst pain level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST

Goals of Care

What are you looking to get out of your care (goals/expectations)?_____

_____

_____

What are your health goals in 10 years (how do you want to feel and what would you like to be able to do?)

_____

_____

_____

We thank you for giving us an opportunity to evaluate your spinal health!

The following are our commitments to you...

We are committed to evaluate you to the best of our ability.

We are committed to clearly explain our findings to you.

We are committed to educate you in your health care options.

We are committed to help you follow through with the care that you choose.

We are committed to help guide you to obtain the level of health that you desire.

Yours in Health,

Dr. Coogan and staff at Eastside Spine & Injury