Dwyer Chiropractic Center
1013 Bridge Street Suite D
Clarkston, WA 99403
(509) 758-9214 Fax (509) 758-9267

Date | Referred By

Name | Social Security #

Address | City, State, Zip

Home Telephone # | Date of Birth Age

Cell Phone # | Email

Occupation | Employer

Employer's Address | Work Phone#

Marital Status: Single Married Divorced Widowed

Guardian/Spouse Name | Guardian/Spouse's SS#

Guardian/Spouse Occupation | Guardian/Spouse's Employer

Name of Nearest Relative | Relative's Telephone #

Statements of Understanding:
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Doctor's Office 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 this Doctor's office will credited to my account on 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 care, any fees for professional services rendered me will be immediately due and payable.

I understand and agree to allow this office to use their PHI (Patient Health Information) for the purpose of treatment, payment, healthcare operations, and coordination of care. I have the right to know how my PHI is going to be used in this office and my rights concerning those records. (If you would like to have more detailed account of our policies and procedures concerning your PHI we encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent.)

I understand and agree to designate the following persons listed below as persons involved with my health care or payment relating to my health care. I understand I am not required to list anyone, and I also understand that I may change this list at any time in writing.

Insurance Company(s):

Spouse: | Name:

Guardian: | Name:

Consent for treatment
I hereby authorize and consent to all treatment and services offered by this clinic may be performed for my dependants or myself. I authorize Dwyer Chiropractic Center to release to my insurance company or companies any and all information they may require to process my claim.

Signature: | Date:

If this is an Auto or Work Accident Injury, please ask for and fill out the accident forms.

Are you experiencing any of the following:

- ☐ Headaches
- ☐ Migraines
- ☐ Neck Pain
- ☐ Neck Stiff
- ☐ Back Pain
- ☐ Pins & Needles in Legs
- ☐ Pins & Needles in Arms
- ☐ Numbness
- ☐ Feet Cold
- ☐ Hands Cold
- ☐ Carpal Tunnel
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Fainting
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Sleeping Problems
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Light Bothers Eyes
- ☐ Loss of Memory
- ☐ Ringing in Ears
- ☐ Fever
- ☐ Cold Sweats
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Stomach Upset
- ☐ Heartburn
- ☐ Digestive Disorders
- ☐ Constipation
- ☐ Chest Pains
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Arthritis
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Hernia
- ☐ Neuritis
- ☐ Anemia
- ☐ Cancer

Have you been under drug and medical care? _____

What medications are you taking? (OTC and Prescription) _____

How much pop do you consume, if any? _____

How much alcohol do you consume, if any? _____

Do you smoke or chew tobacco? Yes_____ No_____ How Much? _____

Choose One:

- ☐ Relief Care - Relief Care is for care of symptomactic relief of pain and discomfort.
- ☐ Corrective Care - Corrective Care is to have the cause of the problem as well as the symptoms corrected and relieved.
- ☐ Not Sure - Check here is you want the Dr. to help you select the type of care appropriate for your condition.

What surgeries have you had? (include dates) _____

Serious Illnesses (include dates) _____

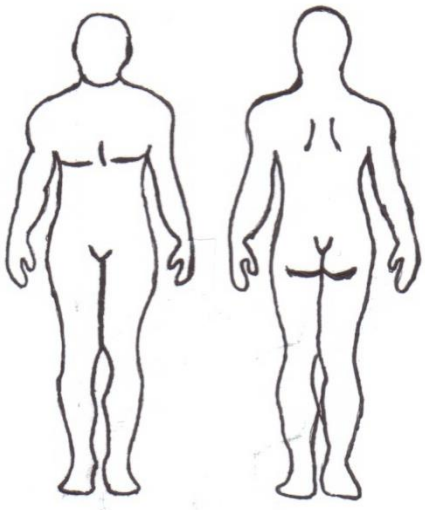
Have you been treated for any health condition by a physician in the last year? Yes_____ No_____

If yes, Describe:

Who is your Primary Care Physician? (PCP): _____

Have you had previous chiropractic care? _____

Please circle on the diagram the area of your discomfort:



Please mark on the pain scales the pain you feel:

MID BACK PAIN
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

NECK-SHOULDER-ARM PAIN
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

LOW BACK AND LEG PAIN
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

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Patient Name: _____ **Consultation History** Date:

Doctors Notes:

1 What is your major symptom? _____

2 Is this a recurrence? ☐ Yes ☐ No

3 When was the first time you noticed this problem? _____

_____

4 How did it originally occur? _____

_____

5 Has it become worse recently?
☐ Yes ☐ No ☐ Same ☐ Better ☐ Gradually Worse
If yes, when and how? _____

6 How frequent is the condition?
☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only
How long does it last?
☐ All Day ☐ Few Hours ☐ Minutes

7 Are there any other conditions or symptoms that may be related to your major symptom?
☐ Yes ☐ No If Yes, Describe _____
Are there other unrelated health problems?
☐ Yes ☐ No If Yes, Describe _____

8 Describe the pain
☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching
☐ Stabbing ☐ Burning ☐ Other _____

9 Is there anything you can do to relieve the problem?
☐ Yes ☐ No If Yes, Describe _____
If No, What have you tried to do that has not helped? _____

10 What makes the problem worse?
☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting
☐ Other _____

11 Have you had any broken bones?
☐ Yes ☐ No If Yes, List and give dates _____

_____

12 List any major accidents you have had other than those that might be mentioned above.

_____

13 To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present?
☐ Yes ☐ No If Yes, Please Explain _____

_____

14 WOMEN ONLY Are you pregnant or is there any possibility you may be pregnant?
☐ Yes ☐ No ☐ Uncertain

15 Remarks: _____

_____

_____

_____

16 Please place an "X" in the line below to indicate your level of problem.

No Symptoms — Extreme Symptoms

0 1 2 3 4 5 6 7 8 9 10

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TERMS OF ACCEPTANCE AND FEE SCHEDULE

Service	**Fees**
Consultation	No Charge
Initial Exam with Computer Scans	$75
X-Rays (per view)	$25-$75
Re-exams	$25
Range of Motion	$25
Adjustment	$43
Extremity Adjustment	$10
PPT Class	$5 per person
Friendly Payment Plans Availiable	
Missed or Cancelled Appointment*	$20

*We require a 24 hour notice to cancel appointments. Any appointment missed due to emergencies will be taken into consideration.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or dissappointment.

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 adjustments 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 impluses, 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 evaluation, 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)