STRINGER

CHIROPRACTIC & MASSAGE

10303 19TH AVE SE STE B EVERETT, WA 98208 (425) 337-3462

PATIENT HISTORY QUESTIONNAIRE

WHICH SERVICES ARE YOU INTERESTED IN:
CHIROPRACTIC ___ MASSAGE ____ ACUPUNCTURE ____

NAME:____GENDER: _M__F_ DOB: ___ /___ /____
PH#: (___)____________ CELL#: (___)____________ WK: (___)____________ SSN: _____-___-_____
ADDRESS: ____
CITY: _______________________ STATE: ______ ZIP: ____________
EMPLOYER: _________________________ EMPLOYER ADDRESS: ______________________________
MARITAL STATUS: M__S__W__ SPOUSE NAME: __________________ SPOUSE DOB: _________
HOW DID YOU HEAR ABOUT US? _____________________
WHAT COMPLAINTS BRING YOU HERE: ____
____
WHEN/HOW DID IT BEGIN? ____
HAVE YOU RECEIVED PREVIOUS TREATMENT FOR A SIMILAR CONDITION? Y__N___
IF YES, PLEASE PROVIDE NAMES OF PHYSICIANS YOU'VE SEEN AND THEIR CONTACT INFO
____
HAVE YOU HAD ANY SURGERIES? ____
ARE THERE ANY MRI'S OR XRAYS PERTAINING TO THIS CONDITION THAT ARE LESS THAN ONE YEAR OLD? Y__ N__
ARE YOU UNABLE TO WORK BECAUSE OF THIS CONDITION? Y__N__
DO YOU HAVE ANY ONGOING SYMPTOMS FROM PREVIOUS ACCIDENTS OR INJURIES?
Y__N__ DESCRIBE ____
MEDICATIONS YOU ARE PRESENTLY TAKING: ____
FEMALE HISTORY: ARE YOU PREGNANT? Y__N__ DUE DATE: ____________
HAVE YOU HAD PREVIOUS PREGNANCY COMPLICATIONS? ______________________________
FAMILY HISTORY: MOTHER FATHER
PLEASE CIRCLE HEART DISEASE HIGH BLOOD PRESSURE DIABETES CANCER

I HEREBY WITNESS THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE ACCURATELY REPRESENTS MY HEALTH HISTORY AS IT PERTAINS TO THIS CONDITION.

____ _______________
SIGNATURE DATE

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PAIN ASSESSMENT

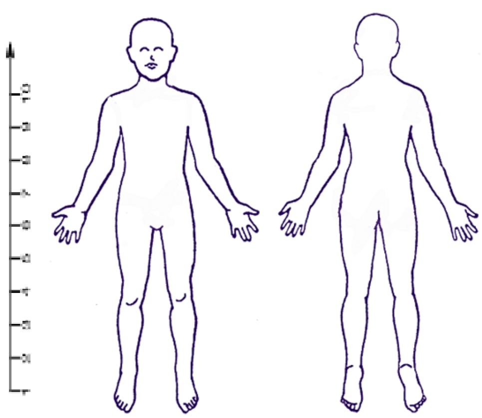
NAME: ____ DATE: __________

WHAT SYMPTOMS BROUGHT YOU INTO THE OFFICE? ____________________________

____

WHEN DID THIS CONDITION.INJURY BEGIN? ____________________

CIRCLE ON THE BODY THE AREAS YOU ARE EXPERIENCING PAIN AND RATE THAT PAIN ON A SCALE OF 1-10. 10 BEING THE MOST PAINFUL.



NEXT TO AREA CIRCLED DESCRIBE PAIN AS:

SHARP DULL ACHY BURNING NEEDLES NUMBNESS

HOW OFTEN ARE YOU EXPERIENCING PAIN?

CONSTANTLY COMES & GOES EACH DAY

DAILY WEEKLY LESS THAN WEEKLY

RE –EXAM SECTION ONLY

WHAT IMPROVEMENT HAVE YOU SEEN IN YOUR CONDITION SINCE STARTING CARE? ____

WHAT MAKES THE SYMPTOMS WORSE: ______________________________

WHAT MAKES THE SYMPTOMS BETTER: ______________________________

PLEASE LIST ANY OTHER COMMENTS OR REMARKS REGARDING YOUR CARE WHICH MAY ASSIST US: ____________________________________

____ ______________

SIGNATURE DATE

DOCTOR’S REMARKS:

____

____

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CURRENT COMPLAINTS

PLEASE CIRCLE ALL THAT APPLY

NAME: ____ DATE: ___________

HEAD & NECK

HEADACHES
MIGRAINES
MEMORY LOSS
DIZZINESS
FAINTING
EYE PAIN
TMJ (JAW PAIN)
LIGHT BOTHERS EYES
BLURRED VISION
STIFF NECK
GRINDING SOUNDS
SORE THROAT
EAR NOISES

SHOULDERS, ARMS

SHOULDER PAIN
FROZEN SHOULDER
PAIN BETWEEN SHOULDERS
DIFFICULTY RAISING ARM
TENNIS ELBOW
NUMBNESS IN ARMS/HANDS/FINGERS
CARPAL TUNNEL SYNDROME
LOSS OF STRENGTH IN ARMS/HANDS
SHORTNESS OF BREATH
RIB BAIN
RAPID HEART BEAT

HIP & LOWER EXTREMITIES

SCIATICA
PAIN IN BUTTOCKS
PAIN IN HIP/SACROILIAC
PAIN IN KNEE JOINT
SWOLLEN ANKLES

UPPER / LOWER

PAINFUL TAILBONE/COCCYX
DIFFICULTY WHEN:
- WORKING
- STANDING
- COUGHING
- STOOPING
- SITTING
- LYING
- BENDING
- LIFTING

FUNCTIONAL & GENERAL

DEPRESSION
FATIGUE
ALLERGIES / ASTHMA
SLEEP DISTURBANCE
NERVOUSNESS
COMMON COLD
CRAMPING / MENSTRUAL PAIN
HOT FLASHES
OSTEOARTHRITIS
FIBROMYALGIA

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EVERETT, WA 98208

INFORMED CONSENT ACKNOWLEDGMENT

I ____________, hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by Dr. Charles J. Stringer, D.C. and/or licensed doctors of chiropractic who may practice in, or be employed by the STRINGER CHIROPRACTIC OFFICE. The following points have been explained to me, to my satisfaction, and I have had the opportunity to discuss them with Dr. Stringer or other clinic personnel:

1. Chiropractic care is the science, philosophy and art of locating and correcting spinal subluxations (misalignments) and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease, or condition as a result of treatment in this office.
2. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" pr "click."
3. It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest.
4. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's judgment and expertise in working with like cases.
5. It is not reasonable to expect the doctor to be able to anticipate, or explain, all possible risks and complications of a given procedure on any particular visit.
6. An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment.
7. As with any health care procedure, there are certain complications that may arise during a chiropractic adjustment. Those complications include, but are not limited to: sprains, strains, dislocations, fractures, disc injuries, CVAs (cerebral-vascular accidents). These complications are rare occurrences.
8. Every spinal exam, spinal adjustment, xray, and all other procedures have a fee for which the patient is ultimately responsible. I understand that it is the policy of this office to obtain an estimate and bill all applicable insurance, but this does not constitute a guarantee of payment. I understand that the insurance portion is an estimate only; actual payment will be determined after the claim is processed by insurance and is subject to change. I also authorize payment of medical benefits to Dr. Stringer or Stringer Chiropractic. Patients are encouraged to ask about the fee for any procedure.

I have read the above consent, or had it read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided and consent to chiropractic treatment and management of my care on that basis.

____ ___________

Signature Date

OFFICE POLICIES:

1. Please be on time for your appointment. Being late or last minute cancellations will cause severe scheduling disruptions, which can interfere with the quality of care you and other patients receive.
2. Please do not wear strong perfumes or colognes. We see many patients with allergies or respiratory problems. Strong scents can impair their progress.
3. Continued cancellations or missed appointments may result in being released from care. If you need to reschedule an appointment, please call within 24 hours of your scheduled appointment.
4. Children are welcome here as patients. If you bring children with you for your appointment, you are responsible for their actions at all times. Our staff will assist you with your well-behaved children.
5. We may schedule you for multiple appointments. This will help ensure convenient appointment time for you, as well as provide you with the highest level of care possible.
6. If you need to spend extra time discussing your health concerns with your doctor, please let our staff know, so we may schedule your next appointment accordingly.
7. Please notify your doctor of any changes in your health status, regardless of the significance.

FINANCIAL POLICIES

1. We accept the following forms of payment: cash, check, debit, credit (MasterCard / Visa)
2. Payment is expected at the time of visit unless other arrangements have been documented.
3. The patient is always responsible for the payment of their care. An insurance contract is between the patient and the insurance company.
4. Insurance coverage is never guaranteed. If there are any problems between the insurance company and the patient, the latter may file a grievance directly with your insurance company. You signature below assigns assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.
5. The Office Manager may approve account balances. Active monthly payments are required. Accounts with balances 30 days past due may be charged a service fee of 12% per year compounded monthly.
6. Any account where no payment has been received for sixty days may be sent to a third party collection agency. Any additional collect fees will be the responsibility of the patient. NSF checks or rejected credit card payments will be charged a $35 service fee per occurrence.
7. We do offer a time of service discount when services are paid in full at the time of the visit
8. We offer financing options for patients that opt for our correctional packages.
9. Please feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care.
10. Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding your coverage in no way guarantee that you care here will be covered by your insurance company, and you will be responsible for your account, regardless of insurance.

By signing below; I acknowledge that I understand the policies as contained herein.

____ ____________

Signature Date