Greenreich Family Chiropractic

24837 – 104th Avenue SE, Suite #100 · Kent, WA 98030 · (253) 854-7700

***** Confidential Information *****

If your symptoms are due to an on-the-job injury or a car accident, please tell the receptionist now.

Name (First, Middle, Last)			Today's Date	
Home Phone	Work Phone		Cell Phone	
Street Address	City		State	Zip
Email Address:				
Birthdate	Age	Sex	Height	Weight
Status (Circle) Married Single Widowed Divorced			Social Security No.	
Employer	Occupation			Years
Employer Address	City		State	Zip
Spouse's Name	Spouse's Birthdate		Spouse Phone No.	
Nearest Relative (if not married)	Relationship		Phone No.	
Insured Name (if not yourself)	Relationship		Phone No.	
Insured Birthday	Insured Sex			

List your current major complaints / symptoms in order of the worst to the least painful:

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

Greenreich Family Chiropractic

24837 – 104th Avenue SE, Suite #100 · Kent, WA 98030 · (253) 854-7700

For Doctor's Use Only

Describe the cause of your complaint(s)/symptom(s); for example, fall, accident, lifting on the job injury, unknown, etc:

Allergies to Medications? ( )No ( )Yes, list:

Past Medical History:

a) Have you ever had this problem before? ( )Yes ( )No

b) Were you treated by a Medical Physician for this ailment? ( )Yes ( )No

c) Physician name & location:

d) Type of treatment:

e) Diagnosis:

f) Length of time under care:

Results of care:

g) Have you had any broken bones? ( )Yes ( )No. If so, please list:

h) Have you had any dislocations? ( )Yes ( )No. If so, please list:

i) Please list any past accidents or falls:

j) Date of last physical: Last chiropractic treatment:

k) Have you ever been diagnosed with cancer? ( )Yes ( )No

Any history of cancer in your family? ( )Yes ( )No

l) Have you ever been hospitalized? ( )Yes ( )No If so, why?

m) Have you had any cosmetic surgery? ( )Yes ( )No. If so, please list:

n) Have you had surgery to replace hip, knee, etc? ( )Yes ( )No Please list:

o) List other illnesses and operations:

p) Have you been treated for any other health condition not listed here within the past year?
( )Yes ( )No
Please describe:

Greenreich Family Chiropractic

24837 – 104th Avenue SE, Suite #100 · Kent, WA 98030 · (253) 854-7700

Review of Systems:

	Yes	No
Chest pain		
Change to bladder/bowel habits		
Sore that does not heal		
Unusual bleeding or discharge		
Indigestion / difficulty swallowing		
Slurred speech		
Change in a wart or mole		
Blurred vision		
Losing weight without trying		
Recent loss of consciousness		
Recent experience of double vision		

	Yes	No
Vertigo or dizziness		
Drooping eyelid(s)		
Visual disturbances		
Blood in stool or urine		
Ringing in the ears		
Nausea and/or vomiting		
Nagging cough or hoarseness		
Pass out or faint easily		
Night sweats		
Seeing other doctors for any reason		
Pain in the neck, jaw or face		

What prescriptions or over-the-counter drugs are you currently taking? ( )NONE

Drug	Reason	Frequency	Dosage	Duration	Helping?	Prescription?
					YES NO	YES NO
					YES NO	YES NO
					YES NO	YES NO
					YES NO	YES NO

Please Check All Habits That Apply:

( ) Tobacco No. of Packs/day:	( ) Alcohol No. of Drinks/day:	( ) Coffee No. of Cups/day:	( ) Drugs Describe:

Please Check All Conditions You Have NOW or had in the PAST:

*If you have a condition NOW, place an **N** in the space. If you had the condition BEFORE, place a **B** in the space.*

___ Headache	___ Pins/needles in legs	___ Diabetes	___ Feet Cold	___ Nose bleeds
___ Neck Pain	___ Frequent Urination	___ Hemorrhoids	___ Hands Cold	___ Joint Swelling
___ Sleep Issues	___ Menstrual Problems	___ Loss of Balance	___ Stomach Ache	___ Gout
___ Low-back pain	___ Difficulty Swallowing	___ Fainting	___ Constipation	___ Losing Weight
___ Mid-back pain	___ Blood in Stool or Urine	___ Loss of Smell	___ Cold Sweats	___ Light bothers eye
___ Sciatica	___ Coughing up Blood	___ Loss of Taste	___ Anemia	___ Diarrhea
___ Bed wetting	___ Shortness of Breath	___ Nausea	___ Breast Lumps	___ Ears Ring
___ Arthritis	___ Hi/Low Blood Pressure	___ Fatigue	___ Ulcers	___ Loss of Appetite
___ Sinus Trouble	___ Dizziness	___ Pins/needles in arms	___ Asthma	___ Chest Pain

Greenreich Family Chiropractic

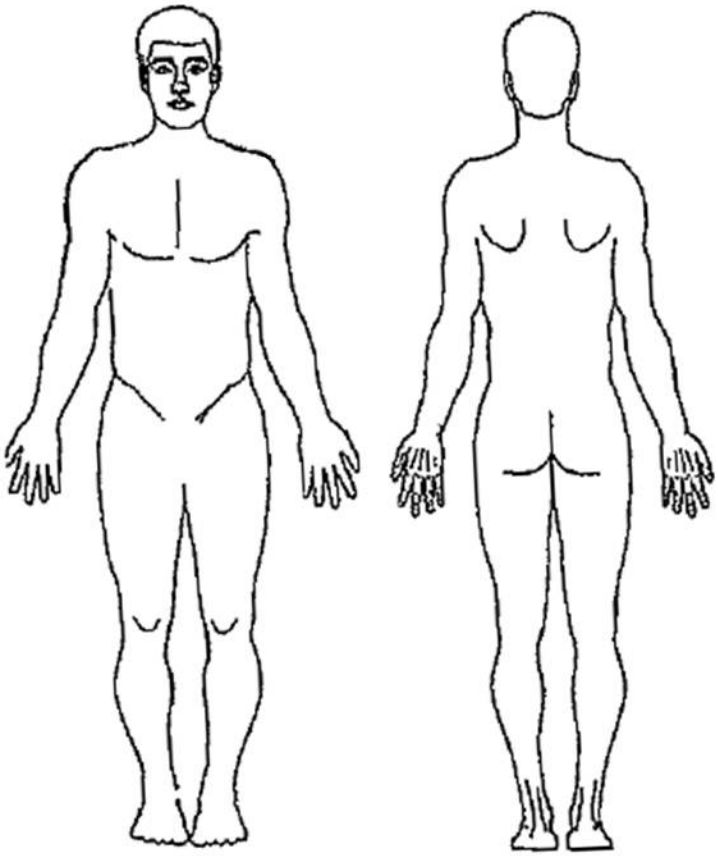
24837 – 104th Avenue SE, Suite #100 · Kent, WA 98030 · (253) 854-7700

Place an X along the line in the following boxes to demonstrate your pain intensity

Neck-Shoulder-Arm Pain	Mid-Back Pain	Low-Back and Leg Pain
On a scale of zero to ten, I rate my discomfort as follows: **(----------)** **0** **10** No Severe Pain Pain	On a scale of zero to ten, I rate my discomfort as follows: **(----------)** **0** **10** No Severe Pain Pain	On a scale of zero to ten, I rate my discomfort as follows: **(----------)** **0** **10** No Severe Pain Pain

Pain Chart

Please circle your area of complaint and add the number on the drawing that most closely describes the sensation you feel. Use arrows to show radiating pain or odd sensations. Fill this out very accurately.



1. Tingling
2. Burning
3. Ache
4. Sharp
5. Throbbing
6. Stabbing
7. Pins & Needles
8. Other
9. Numbness

Greenreich Family Chiropractic

24837 – 104th Avenue SE, Suite #100 · Kent, WA 98030 · (253) 854-7700

INSURANCE PATIENTS

It must be fully understood that the health insurance contract is between you and your insurance carrier, and you are fully responsible for any services not paid by your insurance company. You should also understand that you are financially responsible for non-covered services. By signing below you authorize your chiropractor and this clinic to release any information required by your insurance company.

1. You must pay your co-pay amount per your insurance carrier on the day of treatment
2. Our clinic does NOT guarantee that your insurance will pay. We will make every attempt at the beginning of your care to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill. Exceptions for this are the individual contracting from our doctor with the managed care organizations which they are contracted to.
3. Our clinic will NOT enter into a dispute with your insurance company over a claim. This is YOUR RESPONSIBILITY and OBLIGATION.
4. Our clinic will make every attempt to verify your insurance coverage with your insurance company but we cannot be held accountable for misinformation given to us by your insurance company. Always rely on your insurance plan documentation.
5. It is your responsibility to keep track of any necessary referrals or number of treatment visits allowed by your insurance plan. If you continue to receive treatment outside your referral or insurance limits, you are acknowledging that you are electing to continue treatment at your own expense.
6. Please be advised that there is a $35 service charge on all returned checks.
7. Unless other arrangements have been made, PAYMENT IS EXPECTED AT THE TIME OF SERVICE and charges must be paid in full. We offer many ((what??))

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic care has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The 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: The 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 function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer diagnosis or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination 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 another health care provider. 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 major interference to the expression of the body's innate wisdom. The only method used is specific adjustment to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustment.

I, _____, have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
Signature Date

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____
Signature Date

Consent to Evaluate and Adjust a Minor Child:

I, _____, being the parent or legal guardian of _____, fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.