# Welcome

## Patient Information

Date:_____

Name:_____

Address:_____

City:_____

State:_____ Zip:_____

Last 4 of Social Security #: _____

Home Phone:_____

Cell Phone:_____

Text Reminders? Y N Cell Phone Carrier: _____

E-Mail:_____

Sex:_____ Age:_____

Birthday:_____

□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered for ___ Years

Occupation:_____

Patient Employer/School:_____

Employer/School Address:_____

Spouse's Name:_____

Birthday:_____

Spouse's Employer:_____

Emergency Contact:_____

Relationship to patient:_____

Phone Number:_____

Who may we thank for referring you?

_____

## Insurance

Who is responsible for this account?_____

Relationship to patient:_____

Insurance Co:_____

ID#: _____Group #:_____

Is patient covered by additional insurance? □ Yes □ No

Subscribers Name:_____

Birthday:_____ SSN:_____

Relationship to patient:_____

Insurance Co:_____

Group #:_____

Assignment and Release
I certify that I, and/or my dependant(s), have insurance coverage with

_____ and assign directly to

Dr. _____
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian, or Personal Representative

_____
Please print name of Patient, Parent, Guardian, or Personal Representative

_____ _____
Date Relationship to Patient

## Accident Information

Is this condition due to an accident? □ Yes □ No Date_____ Type: □ Auto □ Work □ Home □ Other
To whom have you reported your accident? □ Auto Insurance □ Employer □Workers Comp. □ Other _____

Attorney's Name (if applicable): _____

## Patient Condition

Reason for visit: _____

When did your symptoms appear?:_____ Is the condition getting worse?: □ Yes □ No □ Unknown

Rate the severity of your pain on a scale from 1 (minor pain) to 10 (severe pain) ____ How often do you have this pain?: _____

Is it constant or does it come and go?: _____ Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness
□ Aching □ Shooting □ Burning □ Tingling
□ Cramps □ Stiffness □ Swelling □ Other

Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation
Activities or movements that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

# Health History

What treatment have you already received for your condition? □ Medications □ Surgery □ Physical Therapy □ Chiropractic Services □ None

□ Other: _____

Name and address of other Doctor(s) who have treated you for your condition: _____

Date of last: Physical Exam:_____ Spinal X-Ray:_____ Blood Test:_____

Spinal Exam:_____ Chest X-Ray:_____ Urine Test:_____

Dental X-Ray:_____ MRI; CT-Scan; Bone Scan:_____

Place a mark on 'yes' or 'no' to indicate if you have or have had any of the following:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | □ Yes | □ No | Diabetes | □ Yes | □ No | Liver Disease | □ Yes | □ No | Rheumatic Fever | □ Yes | □ No |
| Alcoholism | □ Yes | □ No | Emphysema | □ Yes | □ No | Measles | □ Yes | □ No | Scarlet Fever | □ Yes | □ No |
| Allergy Shots | □ Yes | □ No | Epilepsy | □ Yes | □ No | Migraines | □ Yes | □ No | STD(s) | □ Yes | □ No |
| Anemia | □ Yes | □ No | Fractures | □ Yes | □ No | Miscarriage | □ Yes | □ No | Anorexia | □ Yes | □ No |
| Glaucoma | □ Yes | □ No | Mononucleosis | □ Yes | □ No | Stroke | □ Yes | □ No | Appendicitis | □ Yes | □ No |
| Goiter | □ Yes | □ No | Multiple Sclerosis | □ Yes | □ No | Suicide Attempt | □ Yes | □ No | Arthritis | □ Yes | □ No |
| Gonorrhea | □ Yes | □ No | Mumps | □ Yes | □ No | Thyroid Issues | □ Yes | □ No | Asthma | □ Yes | □ No |
| Gout | □ Yes | □ No | Osteoporosis | □ Yes | □ No | Tonsillitis | □ Yes | □ No | Bleeding Disorders | □ Yes | □ No |
| Heart Disease | □ Yes | □ No | Pacemaker | □ Yes | □ No | Tuberculosis | □ Yes | □ No | Breast Lump | □ Yes | □ No |
| Hepatitis | □ Yes | □ No | Parkinson's | □ Yes | □ No | Tumors, Growths | □ Yes | □ No | Bronchitis | □ Yes | □ No |
| Hernia | □ Yes | □ No | Pinched Nerve | □ Yes | □ No | Rheumatoid Arthritis | □ Yes | □ No | Typhoid Fever | □ Yes | □ No |
| Herniated Disc | □ Yes | □ No | Pneumonia | □ Yes | □ No | Ulcers | □ Yes | □ No | Psychiatric Care | □ Yes | □ No |
| Herpes | □ Yes | □ No | Polio | □ Yes | □ No | Vaginal Infections | □ Yes | □ No | Cataracts | □ Yes | □ No |
| Chicken Pox | □ Yes | □ No | Kidney Disease | □ Yes | □ No | High Blood Pressure | □ Yes | □ No | Prostate Problem | □ Yes | □ No |
| Prosthesis | □ Yes | □ No | Whooping Cough | □ Yes | □ No | Chemical Dependence | □ Yes | □ No | High Cholesterol | □ Yes | □ No |
| Cancer | □ Yes | □ No | Bulimia | □ Yes | □ No | Other _____ | | | | | |

## Exercise

□ None

□ Moderate

□ Daily

□ Heavy

## Work Activity

□ Sitting

□ Standing

□ Light Labor

□ Heavy Labor

## Habits

□ Smoking Packs/Day ___

□ Alcohol Drinks/Week ___

□ Coffee/ Caffeine Cups/Day ___

□ High Stress Level

Reason _____

Are you Pregnant? □ Yes □ No Due Date:_____

| Injuries/ Surgeries you've had: | Description | Date |
|---|---|---|
| Falls | _____ | _____ |
| Head Injuries | _____ | _____ |
| Broken Bones | _____ | _____ |
| Dislocations | _____ | _____ |
| Surgeries | _____ | _____ |

## Medications

_____

_____

_____

Pharmacy Name: _____

Pharmacy Phone: _____

## Allergies

_____

_____

_____

_____

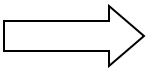
## Vitamins/Herbs/Minerals

_____

_____

_____

_____



**Van Fleet Chiropractic**
**1060 Hudson Longview, WA 98632**
**Phone (360423-2037 Fax (360)423-9320**

## Patients Private Medical Information Policy-HIPPA

I consent to the use or disclosure of my protected health information by Clinton W. Van Fleet D.C. for the purpose of providing treatment to me, obtaining for my health care bills or to conduct health care operations of Clinton W. Van Fleet, D.C.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of practice. Clinton W. Van Fleet, D.C. is not required to agree to the restrictions that I may request. However, if Clinton W. Van Fleet D.C. agrees to a restriction that I request is binding to Clinton W. Van Fleet, D.C.

I have the right to revoke this consent, in writing, at any time, except to the extent that Clinton W. Van Fleet, D.C. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information identifies me.

I understand I have the right to review Clinton W. Van Fleet D.C.'s notice of Privacy Practices prior to signing this document.

The Clinton W. Van Fleet, D.C.'s notice of Privacy Practices has been provided to me. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Clinton W. Van Fleet, D.C.

The notices of Privacy Practices for Clinton W. Van Fleet, D.C. is also provided at 1060 Hudson, Longview, WA 98632. Clinton W. Van Fleet, D.C. reserves the right to change the privacy practices that are described within the notice of Privacy Practices. I may obtain a revised copy by request in the mail or at the time of my next appointment to the office at Van Fleet Chiropractic.

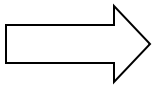
I understand that Clinton W. Van Fleet, D.C. does not offer to diagnose or treat my disease. Clinton W. Van Fleet, D.C. only offers to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter on-chiropractic or unusual findings, Clinton W. Van Fleet, D.C. will advise me. I know that if I desire advice, diagnosis or treatment for those findings, Clinton W. Van Fleet, D.C will recommend that I seek the services of another health care provider.

I, _____have read and fully understand the above statements.

(Print name)

_____ _____

Signature Date



**Van Fleet Chiropractic**
**1060 Hudson Longview, WA 98632**
**Phone (360)423-2037 Fax (360)423-9320**

## Acknowledgment and Understanding

1. I herby authorize Dr. Clinton Van Fleet, D.C. and/or Dr. David Torkko, D.C. to provide chiropractic services to me.
2. I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of
   services rendered to me by this chiropractic office.
3. If this account is assigned to any attorney for collection and or suit, the prevailing party shall be entitled to
   reasonable attorney fees and costs for collection.
4. I herby assign all chiropractic benefits, including major medical benefits in Medicare, private insurance and all
   Other health plans for services rendered by Dr. Clinton W. Van Fleet, D.C. and/or Dr. David Torkko, D.C.
5. I authorize release of my records to third parties requiring them for determination of financial liability.

By signing this application, I affirm under penalty of law that I have given true, complete information.

_____ _____

Patient Signature Date

---

## Consent to Treat

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat/cold application and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however complications may arise. Any procedure intended to help may have complications. While the chance of experiencing complications is small, it is the practice of this clinic is to inform patients about them. These complications include, but are not limited to soreness, inflammation, soft tissue injury, dizziness and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications are available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty of specific cure or result.

_____ _____

Patient Signature Date