Clear Chiropractic Redmond

16701 NE 80th Street Suite 104 | Redmond WA | 98052
www.clearchiroredmond.com | ph. 425-861-3832 | fax 425-861-3808

Date _____

Name FIRST LAST _____ Preferred Name _____

DOB ____/____/____ Phone (Home or Work) _____ Cell _____

Address _____
Number & Street Apt # City State Zip

Primary Email Address _____

☐ Single ☐ Married/Partnered ☐ Other: _____

# of Children ____ Names & ages: _____

Employed? ☐ Yes ☐ No Profession and Employer? _____

Which medical providers/specialists are you currently seeing? _____

Which holistic providers? _____

Previous chiropractic office name: _____

Approximate date of last visit ____/____/____ If Yes, how long did you receive care? _____

Have you ever been told you have any issues in your spine or nervous system? ☐ Yes ☐ No

If yes, what? _____

Whom may we thank for referring you to Dr. Zepeda? _____

If not through a personal or MD referral, how did you find Dr. Zepeda? _____

Please check the box beside any codition that you have or have had.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other

Name: _____ Date: _____

CLEAR CHIROPRACTIC
redmond

Functional Rating Index Neck/Back Problems Only

We are intersted in knowing whether you are having any difficulty at all with the activities listed below because of your Neck and/or Back problem for which you are currently seeking attention.

Please provide an answer for each activity by circling the correct respon

Today, do you or would you have any difficulty at all with:

Activities	0	1	2	3	4
1. **Pain Intensity**	No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
2. **Sleeping**	Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
3. **Personal Care (washing, dressing, etc.)**	No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance
4. **Travel (driving, etc.)**	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain; need 100% assistance
5. **Work**	Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot Work
6. **Recreation**	Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities
7. **Frequency of pain**	No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day
8. **Lifting**	No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
9. **Walking**	No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking
10. **Standing**	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

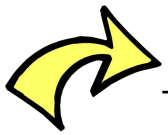
FINANCIAL RESPONSIBILITY

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this 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 office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if CLEAR Chiropractic extends credit to me and I understand that if I suspend or terminate my care, fees for professional services rendered to me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors of CLEAR Chiropractic and whomever they may designate as their assistants to administer treatments as they so deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

_____**Initials**

MASSAGE CANCELLATION POLICY

Our office requires at least 24 hours notice if you need to cancel or change a **massage** appointment. If less than 24 hours notice is given, you will be charged for your appointment in the amount of $45.00. This fee is not covered by your insurance, and is your responsibility to pay immediately. We understand emergencies do occur and in special circumstances this fee may be waived.
I have read and understand the above information.



_____**Initials**

NOTICE OF PRIVACY PRACTICES

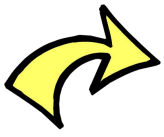
We will never share your personal or private information with others. We may only disclose information about you in the following ways:

- To another health-care provider, hospital or facility if they request it in order to assist them in caring for you.
- To an insurance carrier or employer if they are possibly responsible for payment or reimbursement of services.
- If you are not available to receive an appointment reminder, a message may be left on your answering machine or with a person in your household or at work. We may also send you correspondence by email.

My signature acknowledges I have read these notices, understand it and agree with the policies explained.

Print Name _____ _____

First and Last Name — Date



_____

Signature

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 a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs 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 chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

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 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:_____

Witness Name:_____ Signature:_____
Date:_____