Name:_____ **Date:** ___/___/___ **File #:**_____

1) Describe current complaints:

2) Describe how your problem began

3) When did your problem begin (specific date if possible):_____

4) Check appropriate boxes:
   a) Symptoms ❑ come and go ❑ came on gradually ❑ came on suddenly
   b) Symptoms have persisted for: ❑ days ❑ weeks ❑ months ❑ years
   c) Symptoms began as a result of: ❑ a car accident ❑ a work related incident ❑ a sports or play injury ❑ other:

5) Please describe the character of your current pain (you may check more than one box): ❑ Sharp/Stabbing ❑ Sharp/dull ❑ Aches ❑ Dull ❑ Soreness ❑ Weakness ❑ Throbbing ❑ Numbness ❑ Shooting ❑ Gripping/Constricting ❑ Burning ❑ Tingling

6) How often are the complaints present? ❑ Constant (76-100%) ❑ Frequent (51-75%) ❑ Occasional (26-50%) ❑ Intermittent (25% or less)

7) How bad is your discomfort? Please circle a number: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable pain)

8) Since your discomfort began, is the discomfort: ❑ Increasing ❑ Decreasing ❑ No change

9) What activities make your discomfort worse?

10) Please list the names of doctors you have seen for your present discomfort:

11) Are you currently taking any medication (perscription or over the counter) for your discomfort (please list):

12) Are you taking any home remedies for your discomfort?

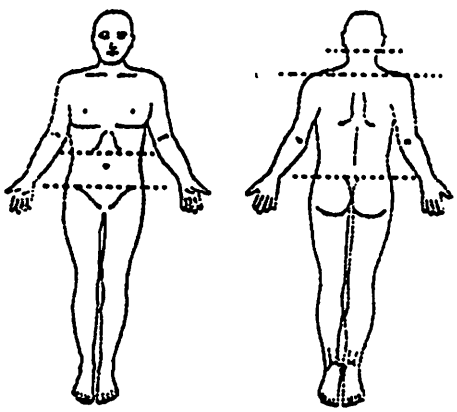
13) At what time of the day is your discomfort worse?
    At what time of the day is your discomfort better?

14) Is your discomfort interfering with: ❑ Work ❑ Sleep ❑ Daily routine ❑ Other:

15) Please list other accidents, disabilities, or pre-existing conditions and date of injury:

16) Please shade areas of discomfort:

(P) = Pain
(T) = Tenderness



17) Other symptoms:
- ❑ Headaches
- ❑ Vision problems
- ❑ Confusion
- ❑ Convulsions/Seizures
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Paralysis
- ❑ Fatigue
- ❑ Sleeping problems
- ❑ Recurring illness
- ❑ Muscle spasm
- ❑ Numbness
- ❑ Neck pain / stiffness
- ❑ Back pain / stiffness
- ❑ Nervousness
- ❑ Tension
- ❑ Irritability
- ❑ Chest Pain
- ❑ Tingling in fingers/feet
- ❑ Shortness of breath
- ❑ Memory loss
- ❑ Ears ringing/buzzing
- ❑ Fever
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Diarrhea

General Pain Disability Index Questionnaire

2950 N. Seventh St. Suite 200 • Phoenix, AZ 85014 • 800.598.0224 • phone 602.224.0220 • fax 602.224.0230 • www.activator.com

Name (Please Print): _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

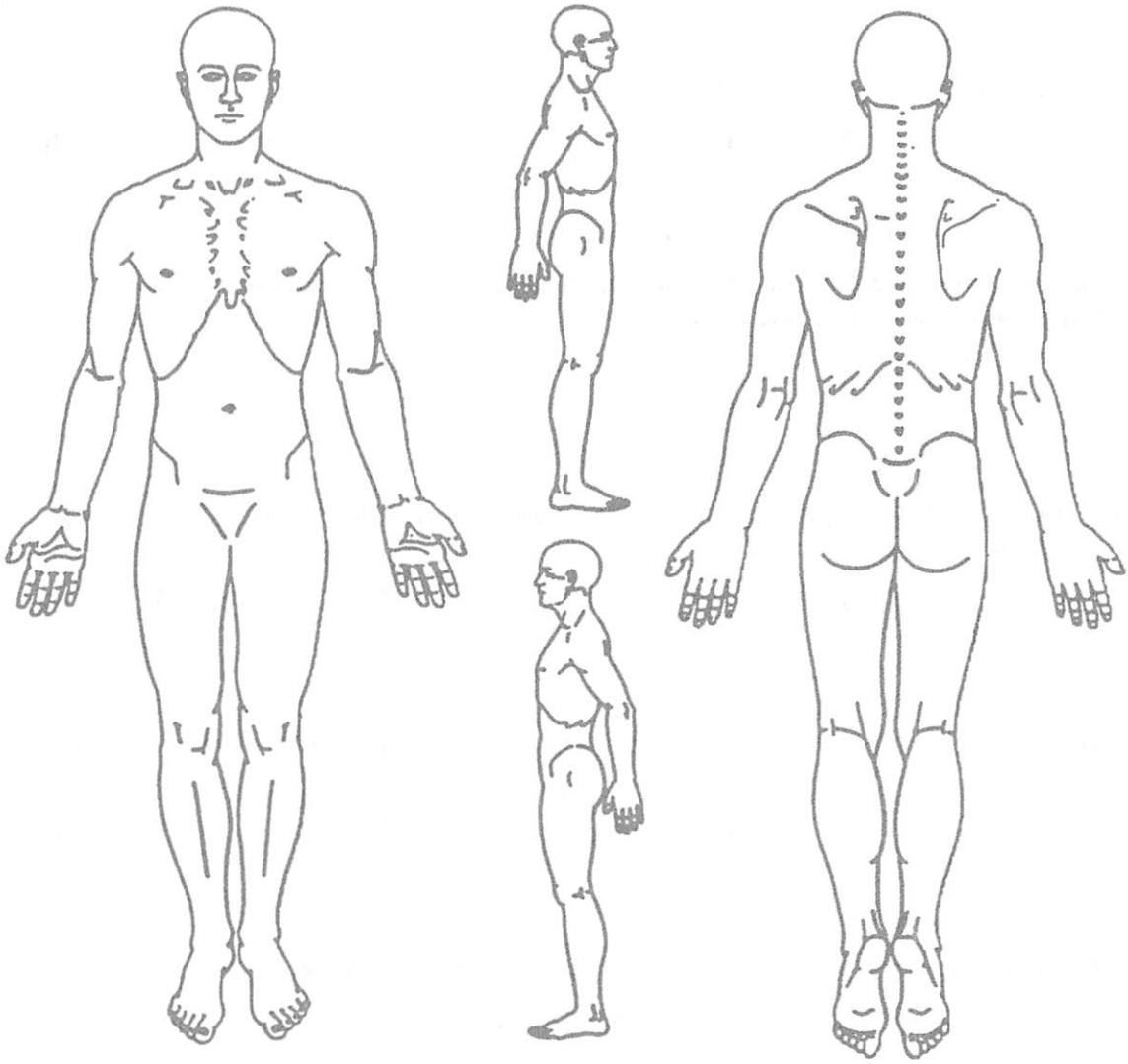
How long have you had this pain? _____ Years _____ Months _____ Weeks

Is this your first episode of this pain? _____ Yes _____ No

Use the letter below to indicate the type and location of your sensations right now

(Please remember to complete both sides of this form)

A = ACHE B = BURNING N = NUMBNESS P = PINS & NEEDLES S = STABBING O = OTHER



over please

FOR DOCTOR'S USE

Chief complaint (other than neck or low back pain): _____

For neck conditions use the Neck Disability Index Questionnaire; for lower back conditions use the Roland-Morris or the Oswestry Low Back Pain Disability Questionnaire.

General Pain Disability Index Questionnaire

2950 N. Seventh St. Suite 200 • Phoenix, AZ 85014 • 800.598.0224 • phone 602.224.0220 • fax 602.224.0230 • www.activator.com

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES for each of the six categories of daily living listed. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

1. Family/Home Responsibilities – This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

2. Recreation – This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

3. Social Activity –-This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

4. Occupation – This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as that of a homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

5. Self Care – This category includes activities, which involve personal maintenance and independent daily living such as taking a shower, driving, getting dressed, etc.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

6. Life-Support Activity – This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

TOTAL SCORE:_____ SIGNATURE:_____ DATE:_____

Fox Chiropractic, P.S. *206-522-6339*

Patient's Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home #:_____ Work #:_____ Cell #:_____

Date of Birth:___/___/___ Age:_____ Sex: ❑ F ❑ M SSN:____-____-____

Email address:_____

Marital status: ❑ Single ❑ Married ❑ Widow(er) ❑ Divorced

Employment status: ❑ Full time ❑ Part time ❑ Unemployed
❑ Non-employed ❑ Retired

Student status: ❑ Full time ❑ Part time ❑ Non-student

Your employer:_____ Occupation:_____

Employer's address:_____ City:_____ State:____ Zip:_____

Name and phone number of a friend or relative NOT living with you (emergency contact)_____ Phone:_____

Is this injury employment related? ❑ Yes ❑ No

Other accident ❑ Yes ❑ No If yes, please describe:_____

_____

_____

Have you ever had similar symptoms? ❑ Yes ❑ No If yes, when? ___/___/___

Names of other doctor(s) you have seen for these symptoms:_____

_____

Note: We keep a record of the health care services we provide you. You may ask us to see and copy that record. A fee may be charged for the copies. You may ask us in writing to correct your record, or you may make the corrections. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may get more information about this at our office.

Patient's initials:_____

Please read and sign our policies on the reverse. ➥ OVER

Fox Chiropractic, P.S. *206-522-6339*

Office Policies

1) Please be on time for your appointment. Being late or canceling at the last minute will cause scheduling disruptions which interfere with excellence in care for you and other patients who may be waiting.
2) Please do not wear strong perfume, colognes, etc., to this office, as Dr. Fox treats many people with allergies, and this will impair their progress.
3) Missed appointments may be charged for. In addition, continual cancellation may result in your dismissal as a patient.
4) Personal cleanliness is essential. Please schedule your appointments at a time that will allow you to comply with this. If necessary, carry a clean set of clothes in your car.
5) Children are very welcome here as patients. If you bring children with you for your appointment, you are responsible for their actions at all times.
6) We will work with you to schedule multiple appointments. This will help insure convenient appointment times for you.
7) If you need to spend extra time discussing your health care with Dr. Fox, please let our front desk know so we may schedule your appointment accordingly.
8) Dr. Fox must be notified of any changes in your health care, regardless of significance.

Financial Policies

1) We accept the following forms of payment: Cash, Checks, Visa, and Master Card.
2) Payment is expected at the time of the visit, including co-payments and deductible amounts.
3) We bill primary insurance companies for Initial Intensive Care as a courtesy to you.
4) The patient is always responsible for payment for his/her care. An insurance contract is between the patient and insurance company.
5) Insurance coverage is never guaranteed. If there are any problems between you and the insurance company, you may choose to assist us in billing by filing a dispute with the insurance company directly. Your signature below assigns assignment to Fox Chiropractic, Inc., for collection of payments.
6) Accounts 30 days past due will be charged a 1% service fee, compounded each month.
7) We may send an account balance to collections if we deem necessary. Any additional collection fees incurred are the responsibility of the patient.
8) We do offer a time of service discount when services are paid in full at the time of your visit. This discount will be passed on to your insurance company.
9) In some cases, we may have a contract in effect with your insurance company governing how we handle your account. This contract may prevent us from offering a time of service discount.
10) Please feel free to ask our office manager questions about your account.
11) Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding your coverage in no way implies or guarantees that your care here will be covered by your insurance company, and you will be responsible for paying your account, regardless of coverage.

By signing below, I state that I understand the policies as explained herein.

Patient or guardian:_____ Date:_____

Witness:_____ Date:_____

Patient Name: _____

Fox Chiropractic, P.S. *206-522-6339*

INFORMED CONSENT TO CHIROPRACTIC CARE

This is an explanation of the chiropractic adjustment, other treatment options, and the risks and benefits of each. The primary treatment used by doctors of chiropractic is the spinal adjustment. I will use that procedure to treat you.

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT.
I will use my hands, a mechanical device called an activator, or other chiropractic instruments, on your body in such a way as to move your joints. This may cause an audible "pop" or "click", called an audible release. You may feel or sense movement.

THE MATERIAL RISKS INHERENT IN A CHIROPRACTIC ADJUSTMENT AND THE PROBABILITY OF SUCH RISKS OCCURRING.
As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. These complications include: fractures, disc injuries, dislocations, muscle strain, costovertebral strains and separations. These usually occur when there is an underlying pathology.

Fractures are rare occurrences and generally result from an underlying weakness in the bone, which I screen for during the examination.

Some types of spinal manipulations in the neck have been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke. The probability of stroke has been the subject of disagreement: One authority states that there is, at most, a one-in-a-million chance of such an outcome. Since even that risk should be avoided, I employ tests during the examination which are designed to identify whether or not you may be at risk.

Other "rare" complications are indeed rare, and low force techniques are utilized, when possible, to help minimize any risk. Some patients will feel some stiffness or soreness following the first few days of treatment.

ADDITIONAL TREATMENTS AVAILABLE IN THIS OFFICE AND ASSOCIATED RISKS.
In addition to the chiropractic adjustment, I may use the following treatments: Nimmo (an adjunctive muscle technique), which may lead to soreness or headache if 2-3 glasses of water are not consumed within one hour of Nimmo treatment. Ice treatment may cause frostbite if not used according to instructions. Exercise instruction may lead to muscle strain and/or joint strain is not performed correctly as directed.

Please sign on the reverse.

· OVER

THE NATURE OF OTHER TREATMENT OPTIONS WHICH ARE NOT AVAILABLE HERE. THE MATERIAL RISKS INHERENT IN SUCH OPTIONS AND THE PROBABILITY OF SUCH RISKS OCCURING INCLUDE:
Self administered care, such as over the counter analgesics and bed rest have large risks. Long term use of over-the-counter medications produce highly undesirable effects, which include (but are not limited to) kidney failure, as described in current medical literature. For some of the risks associated with bed rest, see "Risks of remaining untreated."

Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and pain-killers do have significant risks. Overuse of prescription muscle relaxants and pain-killers produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, the severity of the patient's discomfort, pain tolerance, self-discipline (in not abusing the medication), and proper professional supervision. Medications generally cause significant risks, often with high probabilities of occurrence.

Hospitalization with traction bears the additional risks of exposure to communicable decrease, iatrogenic mishap (doctor-induced illness), and enormous monetary expense. The probability of iatrogenic mishap is low, and exposure to communicable disease is likely; but both events depend upon unknown variables. The risk of great monetary expense is certain.

The risks inherent in surgery include adverse reaction to anesthesia, increased risk of iatrogenic mishap, and all of the risks stated above for hospitalization, plus an extended convalescent period.

THE RISKS AND DANGERS OF REMAINING UNTREATED.
Remaining untreated allows the formation adhesions (internal scar tissue) in the spine and associated muscles and ligaments. This reduces mobility, which then sets up a pain reaction, further limiting the range of motion and restricting normal activities in work and play, and may lead to degeneration of the spine. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN THIS UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read the above explanations of risks. I have had all my questions answered to my satisfaction. By signing below, I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo chiropractic care. Having been informed, I hereby give my consent to chiropractic care.

Patient's/Guardian's signature:_____ Date:_____

Witness signature:_____ Date:_____

Fox Chiropractic, P.S. *206-522-6339*

Patient Consent for Typical Uses and Disclosure of Protected Health Information

I hereby give my consent for Fox Chiropractic, Inc., to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

With this consent, Fox Chiropractic, Inc., may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Fox Chiropractic, Inc., may mail to my home or any other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements.

With this consent, Fox Chiropractic, Inc., may e-mail to my home or any alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements. I have the right to request that Fox Chiropractic Inc. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting to allow Fox Chiropractic, Inc., to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Fox Chiropractic, Inc., may decline to provide treatment to me.

_____	_____	_____
Patient or legally authorized individual, Signature	Date	Time
_____	_____	
Printed name, if signed on behalf of the patient	Relationship (ie, parent, legal guardian, personal representative, etc.)	

Please read and sign the Notice of Privacy Practices on the reverse. • OVER

Fox Chiropractic, P.S. *206-522-6339*

Notice of Privacy Practices Acknowledgment

We, Fox Chiropractic Inc., keep a record of the healthcare services we provide to you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Dr. Fox at 206-522-6339.

By my signature below I acknowledge receipt of this Notice of Privacy Practices.

_____ _____ _____

Patient or legally authorized individual, Signature Date Time

_____ _____

Printed name, if signed on behalf of patient Relationship (ie., parent legal guardian, personal representative, etc.)

Notations, if any, by staff:

This form will be retained in your medical records.

Fox Chiropractic, P.S. *206-522-6339*

Agreement to Pay for Non-Covered Services

Patient's Name:_____

By signing this document, I agree that it has been explained to me that the services I am about to receive may not be covered by my insurance company. I also agree to pay all or any part of the charges for the services indicated below that my insurance company does not pay for.

- ☒ Initial examination
- ☒ X-rays, or review of supplied X-rays
- ☒ Re-examination
- ☒ Instruction for exercise, daily living, or general health
- ☒ Support purchases (list)_____
- ☒ NIMMO
- ☒ Other (list) Cold laser, massage, spinal adjustments, extremity adjustments

Patient's signature:_____Date:_____

Witness:_____Date:_____

Guardian Signature:_____Date:_____
(if patient is under 18 years of age)

Cancellation Policy

Fox Chiropractic Inc. is here to help as many people as possible reach higher levels of health on the wellness spectrum through chiropractic and massage care. Please schedule your appointments so that you will be able to be on time, so that you may receive the full benefit of your chiropractic or massage appointment. We appreciate being able to give the best possible service to you, our patient, during your appointment time.

Please give us 24 hours notice if you need to reschedule or cancel your appointment, or if you will be more than 10 minutes late for your appointment. This will allow us to schedule another patient from our waiting list.

There will be an immediate $50 charge for any cancellation, no show or if (unable to be seen due to) arriving more than 10 minutes late for your appointment.

Your insurance company may not be billed and you will be personally responsible for this charge. There will be one time grace allowed for one chiropractic visit.

Thank you for your understanding of this policy, so we may assist all of our patients better.

I have read and understand the above policies.

Print name_____

Signature_____Date_____

Chiropractic Order

For Chiropractic Inc. is here to help as many people as possible reach higher levels of health on the wellness spectrum through chiropractic and massage care. Please schedule your appointments so that you will be able to be on time, so that you may receive the full benefit of your chiropractic or massage appointment. We appreciate being able to give the best possible service to your compilation during your appointment time.

Please give us 24 hours notice if you need to reschedule or cancel your appointment, or if you will be more than 10 minutes late for your appointment. This will allow us to schedule another patient from our waiting list.

There will be an immediate $30 charge for any cancellation, no show or if (unable to be seen due to) arriving more than 10 minutes late for your appointment.

Your insurance company may not be billed and you will be personally responsible for this charge. There will be one date grace allowed for one chiropractic visit.

Thank you for your understanding of this policy, so we may assist all of our patients better.

I have read and understand the above policies.

Print name _____

Signature _____ Date _____