BELLTOWN
SPINE & WELLNESS

About You

Date: _____

Name: _____ Cell Phone: _____ Alternate Phone: _____

Address: _____ Apt #_____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender: ☐ Female ☐Male Marital Status: _____

Height:_____ Weight:_____ Email_____

Occupation:_____ Employer: _____ Phone: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

How were you referred to this office? ☐ Google ☐ Yelp ☐ Live/Work Nearby ☐ Current/Former Patient _____

We provide automatic appointment reminders and treatment communication via text and email ☐ Opt Out SMS ☐ Opt Out Email

Experience with Chiropractic

Have you been adjusted by a Chiropractor before? _____ Doctor's Name: _____
Approximate date of last adjustment: _____ Approximate date of last x-ray _____

Reason for this visit

Describe the purpose of this visit: _____

_____

When and/or how did this condition begin? _____
Has the condition: ☐ gotten worse ☐ stayed constant ☐ comes & goes

Has this condition occurred before? ☐ Yes ☐No If yes, please explain: _____

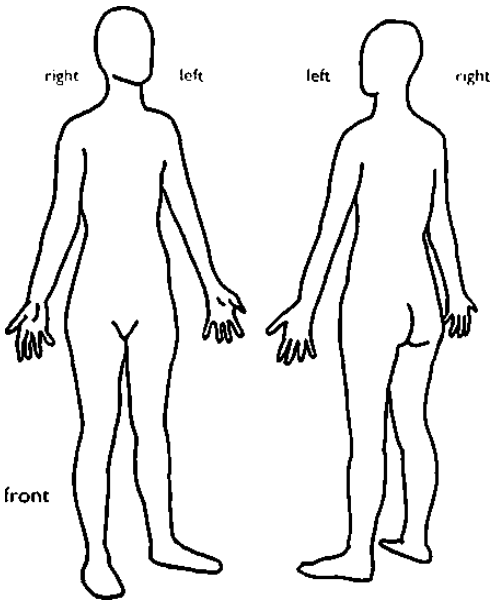
Where do you feel pain?

Please mark the areas on the body forms to the right

What Kind of Pain?

KEY

Stabbing Pain	↗↗↗
Burning	^^^^
Numbness	••••
Pins & Needles	»»»»
Aching	++++



Doctors notes:

Overall intensity of complaint: ☐ minimal ☐ slight ☐ moderate ☐ severe

What aggravates the problem? _____

What relieves the pain? _____

Health History

Have you ever had surgery or have been hospitalized? □ Yes □No If yes, please explain: _____
Have you had any sports injuries? □Yes □No If yes, please explain: _____
What medications and/or supplements are you currently taking? _____
_____
How many glasses of water do you drink per day? _____ How do you sleep? (i.e.: left side, right side, back, stomach): _____
Do you smoke? _____ If yes, how many per day? _____ Do you drink alcohol? _____ If yes, how many per day? _____
Do you drink coffee? _____ If yes, how many per day? _____ Do you exercise? _____ If yes, how often? _____
Are you aware of any poor postural habits? _____
History of diabetes? □ No □ Yes, explain_____ Family history of diabetes? □ No □ Yes, who?_____
History of cancer? □ No □ Yes, explain_____ Family history of cancer? □ No □ Yes, who?_____
History of stroke? □ No □ Yes, explain_____ Family history of stroke? □ No □ Yes, who?_____

Survey of Overall Health

Abnormal postural is the result of trauma or stress to the body that have misaligned the vertebrae in our spine, causing a **subluxations (sub-lux-a-shun).** It has been extensively documented that subluxations, causing stress to your nerves will weaken & distort the overall structure of your spine, which may cause serious and adverse affects on your overall health.

*Please **CHECK** any health conditions you may be experiencing.*

Cervical Spine

□ Neck Pain	□ Thyroid Condition	□ Jaw Pain / TMJ	□ Numbness in Arms
□ Headaches / Migraines	□ Visual Disturbances	□ Sinusitis	□ Recurrent Cold
□ Allergies / Hay Fever	□ Dizziness/ Vertigo	□ Weak Grip	□ Shoulder Pain
□ Insomnia	□ Ear Aches/ Tinnitus	□ Memory Trouble	□ Low Energy

Thoracic Spine

□ Heart Attacks	□ Asthma / Wheezing	□ Recurrent Lung Infections	□ Heartburn
□ Heart Palpitations	□ Shortness of breath	□ Pain on Inhalation	□ Hypo/hyperglycemia
□ Heart Murmurs	□ Tachycardia	□ Pain in Chest/ Ribs	□ Indigestion
□ Kidney Problems	□ Immune Deficiencies	□ High/Low Blood Pressure	□ Stomach Troubles

Lumbar Spine

□ Low Back Pain	□ Constipation	□Recurrent Bladder Infections	□ Menstrual Cramps
□ Pain in hips/legs/feet	□ Diarrhea	□ Frequent Urinating	□ Reproductive Problems
□ Burning Feet	□ Ulcers/ gastritis	□ Difficulty Urinating	□ Prostate Problems
□ Swollen Ankles	□ Coldness in legs/feet	□ Tingling in legs /feet	□ Sexual Dysfunction

Please list any health conditions not mentioned: _____

By signing below, I attest that the information I provided is true and accurate.

Patient Signature: _____ Date: _____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working toward the same objective. Chiropractic 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: An 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.
VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve 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.
HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of disease.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. 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 a health care provider who specializes in that area. 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 a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Patient Signature: _____ Date: _____

HIPPA Patient Privacy Practice Summary

We are committed to preserving the privacy of your personal health information. We are required by law to protect the privacy of your medical information and to provide you with notice describing the following:

We are required by law to have your written consent before we use or disclose to others your healthcare information for purpose of providing or arranging for your healthcare, the payment for, or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. However, we may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or permission.

As our patient, you have important rights relating to inspecting and copying your medical information, amending or correcting that information, obtaining an account of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health insurance and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explain your rights and our obligations under the law. We may revise this Notice from time to time.

You have the right to receive the most current copy of this Notice. If you have not yet read or received this, please ask at the front desk for a copy, and it will be provided to you. If you have any questions, concerns or complaints about the Notice or your medical information, please contact Dr. Scott Mindel or Dr. Julie Sutton at our office number, (206) 441-7984.

If you would like to authorize a spouse, partner, or family member to make inquires about or changes to your appointments only, please provide their name below. We will not release any treatment related information to that party without your permission.

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Consent to Evaluate & Adjust a Minor Child

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

Guardian 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-rays can be hazardous to an unborn child.

Patient Signature: _____ Date: _____

Financial Policy

We share your concerns about rising health care costs. Our fees represent usual and customary charges based on community standards. Patients are expected to pay for professional services at the time of the visit.

Your insurance policy is an agreement between you and the insurance company. It is important that you understand your health and accident benefits listed in your policy. You or your guardian is personally responsible for any charges for services which are rendered to your account. There are many variations in the HMO's and PPO's of today. We request that you call your insurance company to verify benefits within the first week of care. As a courtesy to you, our office will also call your insurance company to verify insurance coverage; however, this is not a guarantee of what the insurance company will pay. We will try, to the best of our ability, to estimate what your co-insurance/co-pay will be at each visit. Insurance companies have 90 days to respond to claims sent out; therefore, please take note that we may not know for this amount of time what is being paid and/or considered for payment by your insurance company. The claims will be sent to your insurance company, they will determine if they apply to your deductible and send an Explanation of Benefits (EOB) to you and our office. You will then receive a bill in the amount of what your insurance company applied to your deductible. Insurance deductibles that you may have with your plan are your responsibility. If notified by the insurance company that services rendered are not payable under the "medical necessity" clause in your contract, you agree to accept full responsibility for those denied services. Any balance not paid by the insurance company ultimately becomes your responsibility. TIME OF SERVICE FEES: Chiropractic Adjustment $59-107; Spinal Rehabilitation $35-85; Massage $80-160; Rehabilitation Equipment for Home Use $45-85

Patient Signature: _____ Date: _____

About my Insurance *Please reference and sign Financial Policy for additional information regarding your health insurance.*

Insurance Company: _____ Provider or Eligibility Phone Number: _____
Address: _____
Policy/Member Number: _____ Group Number (if applicable): _____

About the insured person, if other than self:

Name: _____ Date of Birth: _____ Relationship to patient: _____