Patient Health History

Today's Date _____/_____/_____ **Patient Name** _____

Suffix _____ **Nick Name**_____ **Date of Birth** _____/_____/_____ **Age** _____

Briefly list your main health problems/concerns: _____

_____

Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr . ❑ Prof . ❑ Rev.

Best Email _____ **Is this a work? ❑ or home email? ❑**

I authorize my doctor to contact me via the email address(s) provided and to send me my treatment plan as needed. Yes ____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Ph. _____ **Work Ph.** _____ **Cell Ph.** _____

Preferred Contact Method ❑ Home Phone ❑ Mobile Phone ❑ Email ❑ Text

Employment Status *(check one)*

❑ Employed ❑ Student (full time) ❑ Student (part time) ❑ Retired ❑ Self Employed ❑ Other

Place of Employment _____ **Position** _____

Job Duties (sitting, standing, twisting) _____

Do you have Health Insurance ❑ Yes ❑ No If Yes, name of Insurance Company _____

Is your deductable met? ❑ Yes ❑ No Do you have a Co-Pay ❑ Yes ❑ No Amount? $ _____

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Russian ❑ Polish ❑ German ❑ French

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? Answer _____

Do you currently use tobacco or marijuana? ❑ Yes ❑ Former smoker (years? __) ❑ Never smoked ❑ Chew

If yes, how often do you use: ❑ Chew ❑ Smoke ❑ Every day ❑ Occasional ❑ Sporadically

If yes, what is your level of interest in quitting smoking? If you smoked, how long since you quit? _____

No interest ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 *Very Interested*

Signature _____ **Date** _____/_____/_____

How did you find us? Internet Search on ❑ Google ❑ Bing ❑ Yelp ❑ Facebook ❑ Other _____

If you were referred by someone, may we thank them? Who was it? _____

Thank you, please complete page two ☺

Patient Health History

Name _____ Date ____/____/_____

Current medications, including frequency and dosage - if there are no current medications - check here: ❑

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

Supplements/Vitamins and non-prescription drugs (aspirin, ibuprofen, Tylenol) - if none, check here ❑

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

List any known allergies you have had to any medications. If no allergies are known, check here: ❑

1) _____ **2)** _____

3) _____ **4)** _____

Do you use Alcohol or any drugs? ❑ Yes ❑ No If yes, please describe _____

_____

Has any doctor diagnosed <u>you</u> with Cancer, Heart Disease, Diabetes or Osteoporosis? ❑ Yes ❑ No

Please describe: _____

Have you had an X-ray, CT scan or MRI of your <u>low back or spine</u> in the past 28 days? ❑ Yes ❑ No

I certify that to the best of knowledge; the above information is accurate and complete. I agree to notify the clinic immediately whenever I have changes in my health conditions. I understand that my chiropractor may need to contact my other physicians if my condition needs to be co managed, therefore I give authorization to my chiropractor to contact my other physicians as necessary.

Signature _____ **Date** _____**/**_____**/**_____

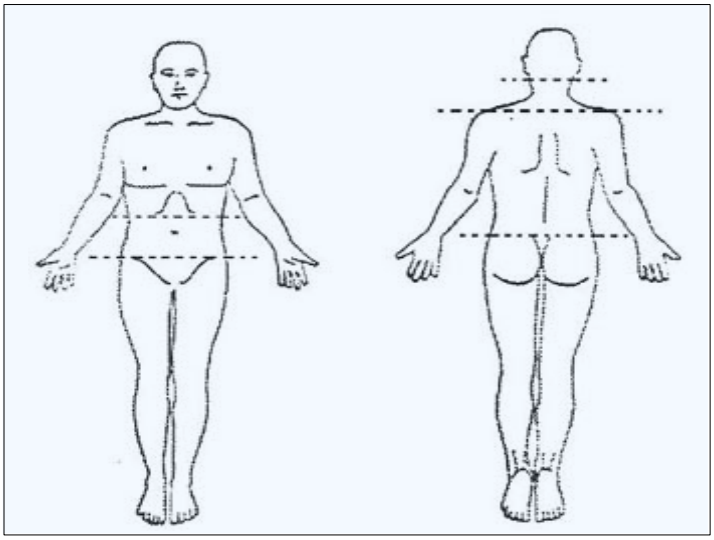
Good Health, Naturally, PLLC (360) 693-7781 FAX (360) 693-1688 www.ghn4you.com
3606 Main St. Suite 205, Vancouver WA 98663 ghn@healthonline.us

Intake Sheet & Progress Form

Today's Date ___/___/____ Date of Injury ___/___/_____ o - New Injury? Auto or Work Injury o -Yes, o - No

Name _____ Email _____ Cell Ph. ( ) _____

On the figures below, please mark the areas where you feel pain or discomfort. Include all affected areas.
If your pain radiates, draw an arrow from where it starts to where it stops.



Symbols to use

Ache: >>>
Cramping: +++
Numb: ===
Tingling: 000
Burning: XXX
Stabbing: /////
Throbbing: ~~~

Age _____
Height _____
Weight _____

What makes symptoms worse?

Sitting Standing
Lifting Bending
Walking Driving
Reaching Twisting
Other? _____
_____

What makes symptoms better?

Chiropractic Massage
Ice Heat
Sitting Standing
Lying down Rest
Movement Stretching
Other?_____

How long has the pain or problem been present?
_____

Please Explain _____
_____
_____

Is there anything that is prolonging your recovery?
_____
_____

Joint replacement surgery?
Yes - o No - o
Left___ Right ___
Knee Hip Shoulder Other
_____

Please place an X (or a range of X's) on the line below representing the pain or symptoms you are experiencing today.

Pain Free |——————————————| Worst Pain Possible

Please place an X on this line to represent the highest level of pain or other symptoms over the last week or two?

Pain Free |——————————————| Worst Pain Possible

Please place an X on this line to rate your ability to function at your job.

Complete Function |——————————————| No Function

How much has pain or other symptoms limited your daily activities?

No Interference |——————————————| Unable to do any activities

Which daily activities are limited? _____

In the past week, have your symptoms been present: o 0-25% o 26-50% o 51-75% o 76-100% of the time?
Is there anything you would like to add about your condition that would be helpful for us to know?
Please explain _____
_____

Please complete the other side too ;-) Thank You!

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Initial Health Status

Date ___/___/_____

Name _____ Date of Birth __/__/_____ New Injury? Yes - No

The following information will help us treat you in the most thorough and complete way.
Please fill out this form completely and bring anything that concerns you to our attention.

Please check all of the following that apply to you:

- ☐ Recent fever
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Head injuries or concussion(s)
- ☐ Stroke
- ☐ Corticosteroid use
- ☐ Weight ☐ - Gain ☐ - Loss, how much? _____
- ☐ Birth control pills
- ☐ Dizziness/fainting/loss of balance
- ☐ Numbness in groin/buttocks
- ☐ Cancer or tumors
- ☐ Osteoporosis
- ☐ Prostate problems
- ☐ Menstrual problems
- ☐ Urinary problems
- ☐ Other health problems (explain) _____

_____

- ☐ Currently pregnant (due date ___/___/_____)
- ☐ Marked morning pain/stiffness
- ☐ Pain unrelieved by position or rest
- ☐ Pain at night
- ☐ Visual disturbances
- ☐ Epilepsy/seizures
- ☐ Weakness in legs or arms
- ☐ Sleeping troubles
- ☐ Fatigue, low energy, or depression
- ☐ Shortness of breath
- ☐ Frequent colds or illnesses
- ☐ Tension/irritability
- ☐ Allergies
- ☐ Medications – Ask for Supplement Form
- ☐ Surgeries _____

_____

_____

Problems with: ☐ eyes ☐ ears ☐ nose ☐ throat ☐ asthma ☐ chronic cough ☐ other? _____

Heart: ☐ stent ☐ bypass ☐ angioplasty ☐ history of angina ☐ arrhythmia ☐ heart surgery ☐ other

Digestive: ☐ reflux ☐ IBS ☐ GERD ☐ colectomy ☐ other gastric surgery ☐ gluten/celiac _____

Family history of: ☐ cancer ☐ diabetes ☐ heart problems ☐ cholesterol ☐ other _____

Children: ages ___ ___ ___ ☐ boys ☐ girls ☐ both ☐ Do your kids receive regular chiropractic care? ____

Are you under stress at work or at home? Y N Do you participate in any stress reduction activities such as:
Meditation - ☐ massage ☐ yoga ☐ creative visualization or other? _____

How long has it been since you felt REALLY healthy? _____ On a scale of 0 to 100, where 0 is nearly dead and 100 is optimum health, what number is your health today? ____ Where would you like to be? ____

We are sorry to subject you to all of these forms, but thank you for filling them out! By having this information, we will be able to help you more quickly and efficiently. Again, Thank You for choosing Good Health Naturally.

I certify to the best of knowledge, the above information is complete and accurate. I agree to notify the clinic and my chiropractor immediately whenever I have changes in my health condition(s). I understand that my chiropractor may need to contact my other physician(s) if my condition needs to be co-managed, therefore I give authorization to my chiropractor to contact my other physician(s), as necessary.

Patient Signature _____ Date ____/____/_____

Good Health Naturally PLLC
Wellness Center

Relief Today,
Better Health Tomorrow

Dr. Mark J. Blessley, NTS, BS, DC
Sarah Strohmeyer, LMT

204 E. 25th Street
Vancouver, WA 98663
(360) 693-7781
www.ghn4you.com
ghn@healthonline.us

A clear definition of our policies will allow us both to concentrate on the big issue of regaining and maintaining your health.

CONSENT TO TREAT

Any medical or chiropractic care has potential risks. The chiropractic care, massage therapies and modalities used at Good Health Naturally, PLLC have been carefully evaluated for safety and effectiveness. The risks of injury are extremely low however if you have special needs or any concerns about treatment at this clinic, *please ask Dr. Blessley or any staff member* for clarification and/or more information on our treatments or policies.

I have read and understand the above statement and hereby give my consent to treatment. Initials _____

INSURANCE
Co-payments will be collected at the time of service. We will bill your insurance company for you, but ultimately you are responsible for any fees not covered by your insurance company. If you have an unmet deductible, a partial or full payment will be required at the time of service.

TOS (Time of Service Discount)
A 20% discount on fees is available for Chiropractic Care if the full amount is paid at the time of service (or in advance). This program is available for all patients and insurance companies who pay at the time of service. Ask.

WORKERS COMPENSATION and PERSONAL INJURY
We will fill out necessary forms and submit them through proper channels after we receive information from you.

SPECIAL NEEDS/HARDSHIP CASES
Special needs and/or hardship cases may receive treatment at a discount or at no charge. Retail items are not included. A statement of hardship will be required to be signed and kept in patients file and another may be required from a counselor, priest/minister or other person having knowledge of the hardship situation.

Our office will provide insurance billing services for you as a courtesy. Please know that your health insurance benefits are based on a contract between you and your health insurance carrier and any benefits quoted are not a guarantee of payment. Final determination of payment will only be made after claims have been received and processed. Remember that you as a patient are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and/or any other balances that are not covered by your contract or paid by your insurance carrier.

I am aware of the HIPPA privacy policy of the clinic and have been offered a personal copy. _____

I understand that I am ultimately responsible for all charges and fees that are incurred by me at this office for services and/or products, and I agree to pay any outstanding bills incurred in this office as well as paying for co-pay, co-insurance and/or deductible amounts as well as interest and attorney fees in the event of non-payment. I understand the requirements of the plans outlined above.

Signature_____ Date _____