Houk
Chiropractic
Clinic

3809 North Monroe
Spokane, WA 99205
HoukChiropractic.com
9720 North Nevada
Spokane, WA 99218

Confidential Patient Information

Date ______________

First Name: ______________ Last Name: ______________ Initial: ______

Major Complaint Information

What is your major complaint(s)? ________________________________

____

When did this symptom(s) begin? ________________________________

Using the symbols provided in the Pain Index, mark the areas on the illustrations below where you are experiencing pain, followed by a number from 1 to 10 indicating the extent of the pain. (1 being minor, 10 being severe)

RIGHT LEFT RIGHT

Pain Index

B Burning
S Sharp/Stabbing

For example: if you are experiencing moderately severe burning pain in back of your neck, you should note a "B8" on the neck of the illustration.

If this is an injury, describe what happened:

____

____

____

____

On a scale of 1 – 10 how do you feel now? (1 being best, 10 being the worst)

1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? ☐Yes ☐No When? ______________

These symptoms developed from? ☐Auto Accident ☐Work-Related ☐Other: ______________

Have you reported this to your: Insurance company ☐Yes ☐No Employer ☐Yes ☐No

What aggravates this condition? ________________________________

What decreases the symptoms/pain? ________________________________

Have you seen other doctor(s) for this condition? ☐Yes ☐No Doctor's Name(s): ______________

____

Date consulted: ______________ Diagnosis: ________________________________

Does this condition interfere with your sleep? ☐Yes ☐No If so, how many times do you wake up in pain per night? ________________________________

In what position do you sleep? ☐Back ☐Side ☐Stomach

Do you sleep with a pillow? ☐Yes ☐No How many? ______________

Does heat affect the pain? ☐Yes ☐No If so how? ______________

Does cold affect the pain? ☐Yes ☐No If so how? ______________

Do you wear a heel lift? ☐Yes ☐No If so, which side? ☐Right ☐Left

Does it cause pain to cough, grunt or sneeze? ☐Yes ☐No If so, where? ______________

Check those activities below during which you experience difficulty or pain:

- ☐ Lying on back
- ☐ Lying on side with knees bent
- ☐ Turning over in bed
- ☐ Lying flat on stomach
- ☐ Getting in/out of car
- ☐ Gripping
- ☐ Climbing
- ☐ Dressing self
- ☐ Sexual activity
- ☐ Sleeping
- ☐ Pushing
- ☐ Pulling
- ☐ Reaching
- ☐ Kneeling
- ☐ Stooping
- ☐ Sitting
- ☐ Bending forward
- ☐ Bending backward
- ☐ Walking
- ☐ Standing for periods over one hour
- ☐ Sneezing
- ☐ Coughing
- ☐ Other: ____________

Fill out the next three sections as they apply to you

Headaches

Do you have a family history of headaches? ☐Yes ☐No Do you get headaches? ☐Yes ☐No Frequency: ________________

Do you experience the following along with your headaches: Pain or cracking in your jaw? ☐Yes ☐No Neck? ☐Yes ☐No

Abnormal blood pressure? ☐Yes ☐No ☐High ☐Low Nausea, Vomiting or Visual disturbance? ☐Yes ☐No

When was your last eye exam by a doctor? ☐1-6 months ☐6-12 months ☐1-2 years ☐over 2 years Results: ____________

Lower Back Pain

Do you experience sharp pain or spasms in your back? ☐Yes ☐No If so, where? ______________________________________

Does pain radiate to your leg or hip? ☐Yes ☐No

Do you have impairment of bowel or urinary function? ☐Yes ☐No Explain: ______________________________________

Neck Pain

If you have a neck injury, does it effect: (Check all that apply) ☐hearing ☐vision ☐balance ☐cause ringing in your ears

Do you hear grating sounds? ☐Yes ☐No Do you feel pressure or pain behind your eyes: ☐Yes ☐No

Do you feel ripping or tearing? ☐Yes ☐No Where? ______________________________________

Do you have difficulty lifting or turning your head? ☐Yes ☐No If so, in which direction? ☐Right ☐Left ☐Up ☐Down

If female, are you pregnant? ☐Yes ☐No ☐Not Sure If yes, what is your due date? ____________________

List all medications you are taking now, including over the counter medication: ______________________________________

____

Are you allergic to any medications? ☐Yes ☐No ☐Not Sure Please List: ______________________________________

____

Have you ever had any surgeries or hospitalizations? ☐Yes ☐No Please List:

Type of Hospitalization/Surgery:	Date:	Type of Hospitalization/Surgery:	Date:

Have you had spinal x-rays in the last 12 months? ☐Yes ☐No When: ______________________________________

Have you had any other imaging studies in the last 12 months? ☐Yes ☐No When: ______________________________________

Have you ever been seen by a chiropractor before? ☐Yes ☐No Please List:

Name of chiropractor:	Date:	Name of chiropractor:	Date:

Do you have a family physician? ☐Yes ☐No Name of physician: ____________________ Phone: __________

Address: ______________________________________

City: ____________________ State: ____________________ Zip Code: __________

Additional Complaints

Do you have, or have you ever had, any diseases or medical problems not listed? ☐Yes ☐No If so, please list: ____________________

____
____
____
____
____
____
____
____

Any additional information you would like the doctor to know about before beginning care at Houk Chiropractic Clinic? __________

____
____
____
____
____
____
____
____

Emergency Contact

Name: ______________________________ Relation: ______________

Home Phone: ______________________ Work Phone: ______________________

Address: ____

City: ____________________ State: ______________ Zip Code: __________

Insurance Information

Insurance Company: ______________________________ Phone #: ______________

Address: ____

City: ____________________ State: ______________ Zip Code: __________

Insured's Name: ____________________ Insured's SS #: ______________ Group #: __________

Insured's Birth Date: ____________________ Insured's Employer: ______________________

Personal Information

Address: ____

City: ____________________ State: ______________ Zip Code: __________

Home Phone: ______________________ Work Phone: ______________________

Mobile Phone: ______________ Pager : ______________ Email: ______________________

Social Security #: ______________ Birth Date: ______________ Age: _____ Sex: ☐M ☐F

Drivers License #: ____

Marital Status: ☐S ☐M ☐D ☐W Spouses Name: ______________________ # of Children: _____

Occupation: ______________________ Employers' Name: ______________________

Work Address: ____

City: ____________________ State: ______________ Zip Code: __________

How were you referred to Houk Chiropractic Clinic? ______________________________

Do you have an Attorney (for an Injury Claim)? ☐Yes ☐No Name: ______________________

Phone #: ______________________ Address: ______________________

Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill. If my account is turned over for collection, there will be a $20.00 charge added to my account.

I hereby authorize physicians and staff at Houk Chiropractic Clinic to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Houk Chiropractic Clinic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks elated to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with chiropractic Care.

Soreness – Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns – Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor, or a staff member at Houk Chiropractic Clinic.

Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAS, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Other Problems – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature ______________________ Date ______________

Patient /Legal Guardian Signature ______________________ Date ______________

Seasonal Address Information

If you reside at a second address during part of the year, please provide the information below:
Second Address: ______________________

City: ______________ State: ______________ Zip Code: ______________

Phone #: ______________

Check months at this address:

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec