Renaissance Chiropractic Center

4902 Tacoma Mall Blvd., Tacoma, WA 98409 253-473-0300

Name (F)_____(MI)_____(L)_____ Preferred Name _____ Sex M or F

Address _____ City _____ State _____ Zip _____

Phone #'s - Home ( )_____ Cell ( ) _____ Work ( ) _____

E-Mail Address _____ May we contact you at work? □ no □ yes

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail / Text

SS # _____-____-_____ Birthdate _____ Age _____ Occupation_____

Employer _____ Employer's Address _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Spouse's Name _____ Birthdate _____ Spouse's SS # _____

Children's Names & Ages_____

Emergency Contact:_____ Relationship _____ Phone #'s _____

How did you find out about our office? □ Insurance Company □ Doctor □ Our Website

□ Internet □ Friend/Family (Please tell us who referred you so we can thank them) _____

□ Other _____

Is this a new injury? YES / NO Please explain:_____

_____

Is this incident work related ? _____ **Auto Accident ?**_____ **Other Accident?** _____

When did the incident occur? _____

Have you been off work for this injury? YES / NO FOR HOW LONG? _____

If you have been off work, who took you off work? _____

What brings you here?

What are your most pressing health concerns?_____

How long have you had these concerns? _____ Is it □ getting worse □ improving □ staying the same

Where is the problem? (part of your body / for how long) _____

_____

Have you received Chiropractic before? □ no □ yes If yes, please tell us the doctor's name _____

Were you pleased with your care? □ no □ yes If no, please explain _____

Are you currently receiving care from other health professionals for these complaints ? □ no □ yes

Who is your Primary Care Physician (PCP)?_____

Do you take any medications? □ no □ yes If yes, for what conditions? _____

Do you take vitamins/herbs/homeopathics ? □ no □ yes If yes, do you take them for a specific condition?_____

Ladies: Are you pregnant**?** □ no □ yes If yes, what month are you due? _____

Date of last menstrual period_____

Health History

Please check all of the following that you currently and/or have suffered from within the past 6 months:

NOW	Past 6 Mos		NOW	Past 6 Mos		NOW	Past 6 Mos		NOW	Past 6 Mos	
□	□	Headache	□	□	Migraines	□	□	Frequent Nausea	□	□	Constipation
□	□	Neck Pain	□	□	Dental Problems	□	□	Irritable Bowel	□	□	Fatigue
□	□	Middle Back Pain	□	□	Jaw Pain	□	□	Excessive Thirst	□	□	Bloody Stools
□	□	Lower Back Pain	□	□	Vision Problems	□	□	Vomitting	□	□	Hemorrhoids
□	□	Shoulder Pain	□	□	Difficulty Breathing	□	□	Prostate Problems	□	□	Liver Problems
□	□	Arm Pain or Tingling	□	□	Stuffy Nose	□	□	Breast Pain or Lump	□	□	Stroke
□	□	Hand Pain	□	□	Allergies	□	□	Cramps	□	□	Paralysis
□	□	Leg Pain or Tingling	□	□	Fainting	□	□	Painful Urination	□	□	Tingling
□	□	Foot Pain or Tingling	□	□	Weight Loss or Gain	□	□	Bladder Problems	□	□	Numbness
□	□	Chest Pain	□	□	Poor Appetite	□	□	Excessive Urination	□	□	Cold Extremities
□	□	Infectious or Contagious disease	□	□	Auto or Work Injury	□	□	Head Injuries	□	□	Fights
□	□	Falls or Accidents	□	□	Dislocations	□	□	Spinal Tap	□	□	Surgery
□	□	Broken Bones	□	□	Use a Walker or Cane	□	□	Extensive Dental Work	□	□	Excessive Alcohol use
□	□	Sports Injuries		□	Knocked Unconscious	□	□	Diabetes	□	□	Smoking
OTHER:											

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

Do you know what spinal nerve stress/subluxation is? □ no □ yes If yes, please describe _____

_____

What would you like to gain from chiropractic care? _____

_____

Do you have friends/relatives who see chiropractors? □ no □ yes

If yes, do they use chiropractic for: □ health maintenance/optimization □ health problems □ both

Are you seeking chiropractic for: □ health maintenance/optimization □ health problems □ both

Please read through each paragraph & initial, sign and date at the bottom of the page.

____ Acknowledgement of Receipt of Notice of Privacy Practices:

RENAISSANCE CHIROPRACTIC CENTER USES PERSONAL INFORMATION ONLY AS RELATED TO PROVIDING CARE AND BILLING PURPOSES IN ACCORDANCE WITH STATE AND FEDERAL PRIVACY GUIDELINES. WE DO NOT SHARE YOUR INFORMATION BEYOND WHAT IS REQUIRED FOR THESE PURPOSES. I acknowledge that I may request a copy of the Notice of Privacy Practices or I have declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

____ Financial Responsibility:

I hereby state that the information on this form is true and correct. I authorize Renaissance Chiropractic Center to examine, take x-rays (if necessary), treat me, and do whatever they deem necessary in accordance with the state statutes, for the care and management of my condition**.** I understand and agree that health and insurance policies are an arrangement between an insurance carrier and myself. I also understand that Renaissance Chiropractic Center 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 Renaissance Chiropractic Center will be credited to my account upon receipt. However, 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 services rendered me will be immediately due and payable. **Your account will be assessed a $25.00 cancellation fee if our office is not contacted 24 hours prior to your scheduled appointment. Insurance benefits are based on a "Good faith" quote from your insurance company. However, this is not a guarantee of payment.**

___ Terms of Acceptance:

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. Chiropractic has only one goal. It is important that each patient understand 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 adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

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 it's maximum health potential.

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. I, _____, have read and fully understand the above statements.

(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature _____ Date _____

I, parent/guardian, give permission for minor's care _____