

**SpineMed Spinal Decompression  
Redmond Wellness & Chiropractic**

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**PLEASE PRINT CLEARLY.**

**Full Name:** \_\_\_\_\_ **Gender:** M F **Age:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Social Security#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **E-mail** \_\_\_\_\_ **Home Phone:** (\_\_\_\_) \_\_\_\_\_  
**Marital Status:** S M D W **# of Children:** \_\_\_\_\_ **Work Status:** Full time Part-time Retired **Cell:** (\_\_\_\_) \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_

**Name of Spouse, Parent or Guardian:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
**Spouse's Employer:** \_\_\_\_\_ **Spouse's Occupation:** \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_  
**In case of an Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_

**Who may we thank for referring you?** \_\_\_\_\_

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Redmond Wellness & Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Redmond Wellness & Chiropractic to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

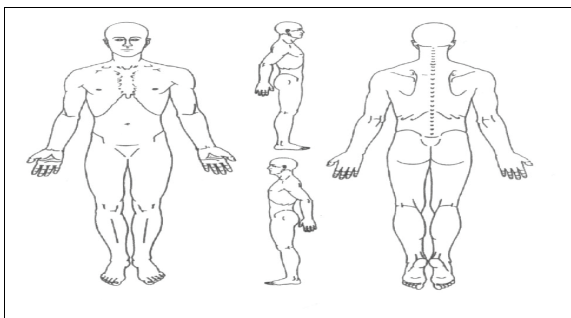
**I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.**

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Spouse's or Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**TREATMENT: What type of treatment are you looking for?**

- I am looking for the most minimal amount of care to “patch up the symptoms” of my problem.
- I am looking to resolve my symptoms and then go on to “fix the cause” of my problem.



Please mark on the diagram the following symbols as they relate to the patients' symptoms:

- SS = spasms
- ST = stiffness
- DP = dull pain
- SP = sharp pain
- SH = shooting pain
- TI = tingling
- NU = numbness
- O = Other

**COMPLAINT/PROBLEM: In relation to your primary complaint:**

When did you first seek treatment for this problem? \_\_\_\_\_ Has another doctor(s) treated you for this condition: Y N

Whom? MD DO DC DDS Other: \_\_\_\_\_ Name of primary doctor? \_\_\_\_\_

Treatment(s) Tried: Medication Surgery Lifestyle change Chiropractic other \_\_\_\_\_

Have you had any intolerance or reactions to treatments? Y N Describe: \_\_\_\_\_

When did the problem start?: \_\_\_\_\_ How did it originally occur? \_\_\_\_\_

Has it become worse recently? Y N Same Better Gradually worse How frequent is the condition? Constant Daily Intermittent

How long does it last? All day Few hours Minutes Is this condition interfering with your? Work Sleep Daily routine Recreation

Does anything relieve the symptom(s)? Y N Medication (prescription or OTC) Rest Exercise/Stretch Other: \_\_\_\_\_

If no, what have you tried to do that has not helped? Medication (prescription or OTC) Rest Exercise/Stretch Surgery Chiropractic

Other: \_\_\_\_\_ On a scale of 1-10 (10 being worst), rate the pain/symptom (s) today \_\_\_\_\_ At it's worst \_\_\_\_\_

How long has it been since you really felt good? Days Weeks Months Years  >10 years

Describe the pain/problem: Sharp Dull Numbness Tingling Aching Burning Stabbing Other: \_\_\_\_\_

What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other: \_\_\_\_\_

What do you believe is the cause of the problem? \_\_\_\_\_

Are there any other conditions or symptoms that may be related to your major symptom? Y N If yes, what? \_\_\_\_\_

**Please check all of the symptoms/conditions that apply. (P=Past / C= Current)**

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> P / C Headache      | <input type="checkbox"/> P / C High Blood Pressure | <input type="checkbox"/> P / C Fatigue             | <input type="checkbox"/> P / C Elbow / Hand Pain | <input type="checkbox"/> P / C Shoulder Pain        |
| <input type="checkbox"/> Walking Problems    | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Abdominal Pains           | <input type="checkbox"/> Nausea/Vomiting         | <input type="checkbox"/> Weak Muscles               |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Paralysis                 | <input type="checkbox"/> Neck Pain                 | <input type="checkbox"/> Hip Pain                | <input type="checkbox"/> Migraines                  |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Ankle / Foot Pain         | <input type="checkbox"/> Insomnia                  | <input type="checkbox"/> Low Back Pain           | <input type="checkbox"/> Knee Pain                  |
| <input type="checkbox"/> Constipation        | <input type="checkbox"/> Joint Stiffness           | <input type="checkbox"/> Osteoporosis              | <input type="checkbox"/> Herniated Disc          | <input type="checkbox"/> Bowell/Bladder Dysfunction |
| <input type="checkbox"/> Tingling Hands/Feet | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Degenerative Disc Disease |  |   |

**ALLERGIES/Sensitivities: Please list all allergies** \_\_\_\_\_

**MEDICATIONS: Please list all medications that you are currently taking with the date you began taking them.** \_\_\_\_\_

**SUPPLEMENTS: Please list all vitamins and supplements that you are currently taking with the date you began taking them.** \_\_\_\_\_

**SCARS / SURGICAL PROCEDURES: Have you had any surgical procedures?** YES NO Any Scars? YES NO

SPINE: Cervical Thoracic Lumbar EXTREMITIES: Shoulder/Elbow/Hand/Wrist R L Hip/Knee/Ankle/Foot R L

ABDOMINAL/CHEST: Appendix Colon Gall Bladder Heart Lungs Breast Other: \_\_\_\_\_

BROKEN BONES \_\_\_\_\_

CAR ACCIDENTS/INJURIES \_\_\_\_\_

**HABITS:**

	Heavy	Moderate	Light	None	5-7x/wk	3-5x/wk	1-3x/wk	None	Type
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Exercise</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Aerobic <input type="checkbox"/> Weights
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs
Soda / Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Sleep</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5+	4	3	2	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Meals / day</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	64+ oz	32-64 oz	16-32 oz	<8 oz	
					Water / day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**WORK ACTIVITY:**  Heavy Labor  Light Labor  Mostly Sitting  Mostly Standing  Walking / Moving  Driving

**How have you taken care of your health in the past?**

Medications  Emergency Room  Surgery  Routine Medical  Nutrition/Diet  Vitamins/Supplements  Holistic Care  Chiropractic  Ignore it  Other \_\_\_\_\_

**How did the previous method(s) work for you?**

Bad results  Some results  Great results  Nothing changed  Did not get worse  
 Results were temporary  Still trying  Confused  Other \_\_\_\_\_

**How have others been affected by your health condition?**

No one else is affected  Haven't noticed any problems  They tell me to do something about it  
 People are tired of hearing about it  People avoid me  Other \_\_\_\_\_

What are you afraid this might be, or beginning to, affect?

Job  Kids  Future abilities  Marriage  Self-esteem  Sleep  Time  
 Finances  Mobility  Recreational Activities  Other \_\_\_\_\_

**How has your health condition affected your job, relationships, finances, family, or other activities?  
Please give examples.** \_\_\_\_\_  
\_\_\_\_\_

**What has that cost you (time, money, happiness, freedom, sleep, promotion, etc.)? Give three examples.** \_\_\_\_\_  
\_\_\_\_\_

**What are you most concerned about regarding your problem?** \_\_\_\_\_  
\_\_\_\_\_

**Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.** \_\_\_\_\_  
\_\_\_\_\_

**What would be different/better without this problem? Again, please be specific.** \_\_\_\_\_  
\_\_\_\_\_

**What do you desire most to get from working with us?** \_\_\_\_\_  
\_\_\_\_\_

**What is that worth to you?** \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_