SLOAN FAMILY CHIROPRACTIC, P.S.

DAVID SLOAN, DC, DIBCN
HEATHER SLOAN, DC
911 5th Ave SE, Suite 202 Olympia, WA 98501
(360)956-3900/ Fax (360)956-3903

Confidential Patient Case History

1. Patient Clinical Profile
Name, Last_____ First_____ M.I._____
Mailing Address_____
City_____ State_____ Zip Code_____
Phone, Home (___)_____ Cell (___)_____ Work (___)_____
Fax (___)_____ E-mail_____
Date Of Birth_____ Age_____ Male _____ Female_____
Marital Status: S M D W Spouse Name_____
SSN_____ Number of Children_____
Occupation_____ Employer_____

2. Primary Reasons For Seeking Chiropractic Care
A. What is your primary reason for seeking chiropractic care in our office?
_____
_____
_____
B. What is your secondary reason for seeking chiropractic care in our office?
_____
_____
_____
C. Have you been seen by a Chiropractor for this or any other issue?
Yes__ No__ If Yes, where_____
D. How did you hear about our office? _____

3. Family History

A. Has/Have any member(s) of your immediate family (father, mother, sibling, grandparents, aunt/uncle, etc) been treated or diagnosed with a significant or major health condition? Yes __ No __
If Yes, Please describe which family member, what condition and how it was treated
_____
B. Mark the following conditions as they pertain to your immediate family.

Diabetes____	Heart Problems____	Kidney Problems____
Cancer ____	Headaches ____	Back Pain ____
Obesity ____		

4. Past Health History
A. How has your overall health status been during your lifetime?
Good ____ Average____ Poor____
Comments_____

B. Please check any illnesses you have had in the past:

_ Pneumonia	_ Mumps	_ Influenza
_ Rheumatic Fever	_ Small Pox	_ Pleurisy
_ Polio	_ Chicken Pox	_ Arthritis
_ Tuberculosis	_ Diabetes	_ Epilepsy
_ Whooping Cough	_ Cancer	_ Mental Disorder
_ Anemia	_ Heart Disease	_ Lumbago
_ Measles	_ Eczema	_ Thyroid
_Alcoholism	_Appendicitis	_Goiter
_Venereal infection	_Whiplash	

Other/Comments_____

Please Circle:

C. Have you had breast implant surgery Yes No

D. Have you had knee or hip replacement surgery? Yes No

E. Do you have a pacemaker? Yes No

F. Do you have any other implantable medical devices on your body? Yes No

G. Mark all of the following procedures as they pertain to you:

_ Vaccinations	_Tubes in ears	_Rectal surgery
_ Tonsillectomy	_Appendectomy	_Sinus surgery
_Gall bladder removal	_Female/Male surgery	_Hernia surgery
_Back surgery	_Thyroid Surgery	_Stomach surgery

_ Other:_____

H. Have you been involved in an auto collision, either as the driver or passenger?
Yes_____ No_____

I. Have you been injured on the job?
Yes_____ No_____

J. Have you been injured while playing sports?
Yes_____ No_____

K. Have you had any other injuries caused by falls or impacts?
Yes_____ No_____

L. Please list prescription or over-the counter medications you have taken or are currently taking and any reactions to those medications:

Medication	Reason	Medication	Reason
1.		4.	
2.		5.	
3.		6.	

Reactions:_____
_____

M. Please list any allergies you have or have experienced in the past:
_____
_____
_____

Name:_____ Date:____/____/_____

N. Please list any substance abuse and outcomes:

_____

_____

O. For Females only: Pregnancies and outcomes:

_____

Please Circle:

P. Have you ever had a lapse of memory? Yes No

Q. Were you ever knocked unconscious? Yes No

R. List any broken bones or dislocations that you have had:_____

_____

S. Have you ever had a spinal tap or spinal injection? Yes No

T. Mark the following that are **currently** a cause of significant concern for you.

General:	consistent fainting	chills	convulsions	depression
	Dizziness	loss of weight	fatigue	fever
	Headache	Loss of sleep	Weight gain	Neuralgia
	Night sweats	Wheezing	Nervousness	
Gastro-Intestinal:		Constipation	diarrhea	hemorrhoids
		jaundice	liver problems	nausea
	Stomach pain	poor appetite	poor digestion	vomiting
	Rectal bleeding	vomiting blood	Gall bladder problems	
Respiratory:	Chest Pain	Chronic cough	Difficulty breathing	
	Spitting blood	Spitting phlegm		
Muscles/Joints/Bones:		backache	foot problems	stiff neck
		painful tailbone	spinal curvature	tremors
	Twitching	weakness	Pain between shoulders	
Cardio-Vascular:	strokes	ankle swelling	high blood pressure	
	low blood pressure	heart trouble	pain over heart	
	Poor circulation	rapid heart	slow heart	
Skin or Allergies:		bruise easily	dryness	eczema
	Hives	itching		
Women:	cramps	excessive flow	irregular cycle	hot flashes

Name:_____ Date:____/____/_____

5. Social and Occupational History

A. Job description (work, school, home care, other) and describe:

_____

_____

_____

B. Please describe your job schedule

_____

_____

_____

Please Circle:

C. How many hours of television do you watch a day?

<1 1-3 3-5 >5

D. How many hours per day do you use a computer at work or home?

<1 1-3 3-5 >5

E. How many hours per day do you ride in a car or other vehicle?

<1 1-3 3-5 >5

F. How often do you exercise?

Daily 3x/week 2x/week 1x/week no exercise

How long do you exercise work outs last

<1 hr 1 hr 30 min <30 min NA

G. What are your exercise activities? (circle all that apply) [ ] I don't exercise

Walking	Swimming	Weight lifting
Stretching/flexibility	Yoga/Pilates	Resistance bands
Running/treadmill/rowing/climbing		Group exercise classes

Other:_____

H. Do you take a multi-vitamin? Yes__ No__

List any other nutritional supplements you are currently taking.

Supplement	Reason	Supplement	Reason
1.		3.	
2.		4.	

I. How often do you use tobacco?

never daily weekly yearly

J. How many servings of alcohol do you drink each week?

0 1-2 3-5 >5

K. How many servings of coffee do you drink each week?

0 1-2 3-5 >5

L. How many servings of soda do you drink each week?

0 1-2 3-5 >5

M. Have you had any mental health challenges? Yes__ No __

If Yes, Please Describe how treated:

_____

_____

_____

Name:_____ Date:____/____/_____

N. Any other health concerns:
_____
_____
_____

In case of Emergency, please provide the name and information of a friend or relative.
Name_____
Phone, Home (____)_____ Cell (____)_____

Release of Records/Imaging

I hereby authorize the release of my medical records/imaging and request that they be transferred to:

SLOAN FAMILY CHIROPRACTIC, P.S.
911 5TH AVE SE, SUITE 202
OLYMPIA, WASHINGTON 98501

Patient's Signature_____ Date____/____/____
Print Name_____

SLOAN FAMILY CHIROPRACTIC, P.S.
911 5th Ave SE, Suite 202 Olympia, WA 98501
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FINANCIAL RESPONSIBILITY STATEMENT

1. I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.

2. I understand that Sloan Family Chiropractic, P.S. will prepare any necessary reports and forms to assist me in making collection for the insurance company.

3. I understand that any amount authorized will be paid directly to Sloan Family Chiropractic and will be credited to my account upon receipt.

4. I authorize Sloan Family Chiropractic to release any information regarding my care at Sloan Family Chiropractic to my insurance company that will assist in the payment of the claim.

5. I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment

Patient's Signature_____ Date____/____/____
Print Name_____

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January 03, 2006

Patient Privacy Notice

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with notice describing how medical information about you may be used and disclosed and how you can access this information.

We are required by law to have your written consent before we use or disclose to other your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.
As our patient, you have important rights relating to inspecting and copying medical information that we maintain, amending or correcting that information, obtaining an accounting 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 information and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date, January 3, 2006, at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact: Drs. Heather & David Sloan, D.C. in our office at Sloan Family Chiropractic, P.S. Olympia, WA 98501 (360)956-3900.

Patient's Signature_____ Date____/____/____
Print Name_____

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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 towards 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 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.

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 its maximum health potential.

We do not offer to diagnose or treat any disease or condition other then 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.

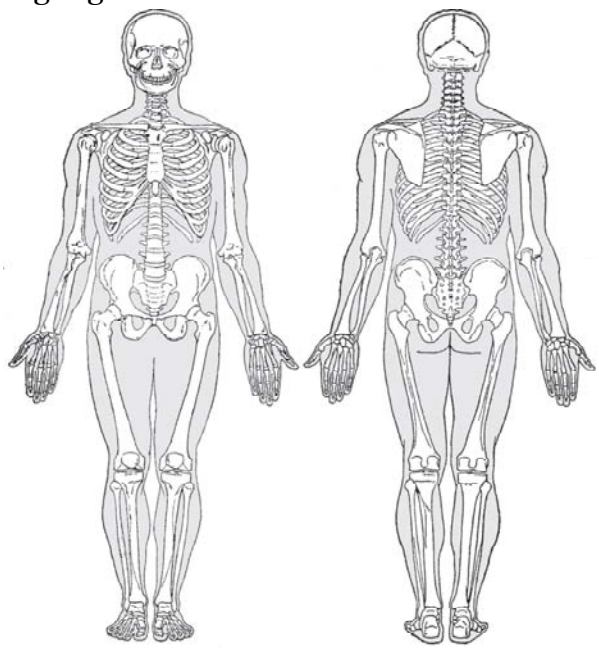
I, _____ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

Patient's Signature_____ Date____/____/____
Print Name_____

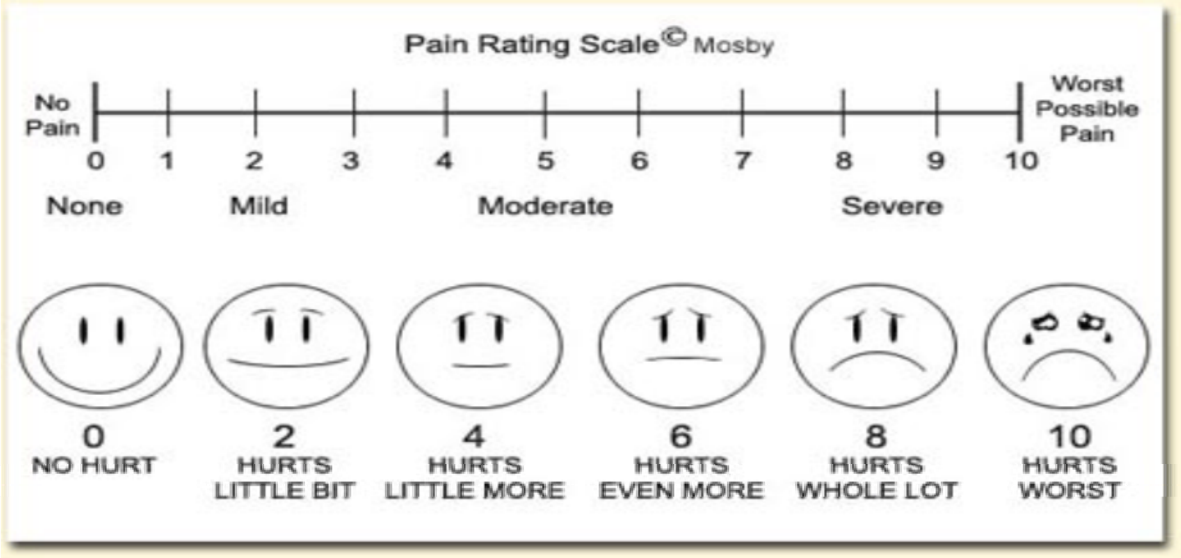
PAIN SCALE

If you are experiencing pain (sharp, dull, burning, stinging) or abnormal feelings (numbness, tingling, stiffness, abnormal sensation), please mark the area on the diagram below and label accordingly.

SP= Sharp Pain	DP= Dull Pain	B= Burning	S= Stinging
N= Numbness	T= Tingling	ST= Stiffness	A= Abnormal Sensation



Pain Scale: Please circle the number below that best describes your current pain and draw a line (or number that region) to the diagram above.



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Consent for Patient Contact

I, _____, hereby give my consent for the physicians and staff at Sloan Family Chiropractic to contact me regarding appointments and confidential health information via (please check all that apply):

☐ Message with spouse / friend / caregiver: _____

☐ Mail

☐ Answering machine / Voicemail – home / work (please circle)

☐ Fax #: (_____)_____-_____

☐ Cell phone #: (_____)_____-_____

☐ E-mail address: _____

☐ DO NOT CONTACT ANYONE OTHER THAN ME PERSONALLY

Patient's Signature_____ Date____/____/____
Print Name_____

Office Use Only

☐ Contacted patient ____/____/____ ☐ Left Message with Patient ____/____/____

Notes:_____
_____
_____
_____

Physicians Signature:_____ Date___/___/___