

Welcome!

River City Chiropractic extends a warm and personal welcome to you on behalf of the staff and doctor. Our goal is to provide you with the finest health care as well as offer you many informative and entertaining educational opportunities.

Please read the following...

What to expect:

FIRST VISIT

- Consultation with doctor
- Chiropractic examination
- Specific X-ray series.

SECOND VISIT

- Report of findings video
- Report of your health findings by doctor
- **First specific chiropractic adjustment given**
- Treatment plan for initial intensive care given
- Sign up for health care class

Health History

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ WORK PHONE (____) _____ CELL(____) _____

DATE OF BIRTH _____ AGE _____ EMAIL _____

EMPLOYER _____ ADDRESS _____

SOCIAL SECURITY NUMBER _____ MARITAL STATUS S M D W

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____

WORK PHONE (____) _____ EMERGENCY CONTACT _____ PHONE(____) _____

WHO REFERRED YOU TO OUR OFFICE? _____

MAJOR COMPLAINT _____

PAIN OR PROBLEM STARTED ON _____ IS THIS DUE TO AN ACCIDENT? _____

DATE AND TYPE OF ACCIDENT _____

PAINS ARE: SHARP DULL CONSTANT INTERMITTENT

IS THIS CONDITION INTERFERING WITH: WORK? SLEEP? ROUTINE?

OTHER DOCTORS SEEN FOR THIS CONDITION _____

CONTINUED ON BACK

Other Symptoms:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Twitches | <input type="checkbox"/> Ear Ring | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fever | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Heart Burn |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Asthmatic Symptoms | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pains | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Skin disorder | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue/Lack of energy | <input type="checkbox"/> Acne | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Decrease in Hearing |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Sinus Difficulties |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Reproductive Difficulties | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Heavy Feeling of Head | | | |

Injuries/ Surgeries you have had	Description	Date
Fall _____	_____	_____
Head Injuries _____	_____	_____
Broken Bones _____	_____	_____
Dislocations _____	_____	_____
Surgeries _____	_____	_____
Diseases/Pathologies _____	_____	_____

Exercise	Work Activity	Habits	Packs/Day	Vitamins	Medications
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	_____	_____	_____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/Week _____	_____	_____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine	Cups/Day _____	_____	_____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level	Reason _____	_____	_____
Are you Pregnant? <input type="checkbox"/> Yes	<input type="checkbox"/> NO	Due Date _____			

INSURANCE INFORMATION

Do you have insurance? Yes No
 If so, please complete the following questions and **Give your card to the front desk for copying.**
 Insurance Company's Name _____ Address _____
 _____ Phone _____
 Policy or Certificate No. _____ Medicare No. _____
 Group # _____ Secondary Insurance Coverage _____
 Name and Address _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign Directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I give authorization to **River City Chiropractic** for my treatment.

 Responsible Party Signature

 Relationship _____ Date _____

Chiropractic provides three types of care. The first is Initial Intensive Care which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins Reconstructive Care which corrects the years of damage that occurred when there were few symptoms. And finally Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then You'll be able to begin a course of care that fits your health goals.

Neck Pain Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- I have no pain at the moment (0)
- The pain is very mild at the moment (1)
- The pain is very moderate at the moment (2)
- The pain is fairly severe at the moment (3)
- The pain is very severe at the moment (4)
- The pain is the worst imaginable at the moment (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain (0)
- I can look after myself normally but it causes extra pain (1)
- It is painful to look after myself and I am slow and careful (2)
- I need some help but manage most of my personal care. (3)
- I need help every day in most aspects of self-care. (4)
- I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift very light weights. (4)
- I cannot lift or carry anything at all. (5)

Section 4 – Reading

- I can read as much as I want to with no pain in my neck. (0)
- I can read as much as I want to with slight pain in my neck. (1)
- I can read as much as I want to with moderate pain in my neck. (2)
- I cannot read as much as I want because of moderate pain in my neck. (3)
- I can hardly read at all because of severe pain in my neck. (4)
- I cannot read at all. (5)

Section 5 – Headaches

- I have no headaches at all. (0)
- I have slight headaches that come infrequently. (1)
- I have moderate headaches which come infrequently. (2)
- I have moderate headaches which come frequently. (3)
- I have severe headaches which come frequently. (4)
- I have headaches almost all the time. (5)

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty. (0)
- I can concentrate fully when I want to with slight difficulty (1)
- I have a fair degree of difficulty concentrating when I want to. (2)
- I have a lot of difficulty concentrating when I want to. (3)
- I have a great deal of difficulty concentrating when I want to. (4)
- I cannot concentrate at all. (5)

Section 7 – Work

- I can do as much work as I want to. (0)
- I can do my usual work, but no more. (1)
- I can do most of my usual work, but no more. (2)
- I cannot do my usual work. (3)
- I can hardly do any work at all. (4)
- I cannot do any work at all. (5)

Section 8 – Driving

- I can drive my car without any neck pain. (0)
- I can drive my car as long as I want with slight neck pain (1)
- I can drive my car as long as I want with moderate pain in my neck. (2)
- I cannot drive as long as I want because of moderate pain in my neck. (3)
- I can hardly drive at all because of severe pain in my neck. (4)
- I cannot drive at all. (5)

Section 9 – Sleeping

- I have no trouble sleeping. (0)
- My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- My sleep is mildly disturbed (1-2 hours sleepless). (2)
- My sleep is moderately disturbed (2-3 hours sleepless). (3)
- My sleep is greatly disturbed (3-5 hours sleepless). (4)
- My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all. (0)
- I am able to engage in all my recreation activities with some pain in my neck. (1)
- I am able to engage in most, but not all, of my usual activities because of pain in my neck. (2)
- I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- I can hardly do any recreation activities because of pain in my neck. (4)
- I cannot do any recreation activities at all. (5)

Back Pain Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- I have no pain at the moment (0)
- The pain is very mild at the moment (1)
- The pain is very moderate at the moment (2)
- The pain is fairly severe at the moment (3)
- The pain is very severe at the moment (4)
- The pain is the worst imaginable at the moment (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain (0)
- I can look after myself normally but it causes extra pain (1)
- It is painful to look after myself and I am slow and careful (2)
- I need some help but manage most of my personal care. (3)
- I need help every day in most aspects of self-care. (4)
- I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift very light weights. (4)
- I cannot lift or carry anything at all. (5)

Section 4 – Walking

- Pain does not prevent me from walking any distances. (0)
- Pain prevents me from walking more than 1 mile (1)
- Pain prevents me from walking more than ¼ of a mile. (2)
- Pain prevents me from walking more than 100 yards (3)
- I can only walk using stick or crutches (4)
- I am in bed most of the time and have to crawl to the toilet. (5)

Section 5 – Sitting

- I can sit in any chair as long as I like. (0)
- I can sit in my favorite chair as long as I like. (1)
- Pain prevents me from sitting for more than 1 hour. (2)
- Pain prevents me from sitting for more than ½ an hour (3)
- Pain prevents me from sitting for more than 10 minutes. (4)
- Pain prevents me from sitting at all. (5)

Section 6 – Standing

- I can stand as long as I want without extra pain (0)
- I can stand as long as I want but it gives me extra pain (1)
- Pain prevents me from standing more than 1 hour. (2)
- Pain prevents me from standing more than ½ an hour. (3)
- Pain prevents me from standing for more than 10 minutes. (4)
- Pain prevents me from standing at all. (5)

Section 7 – Sleeping

- My sleep is never disturbed by pain. (0)
- My sleep is occasionally disturbed by pain. (1)
- Because of pain, I have less than 6 hours of sleep. (2)
- Because of pain, I have less than 4 hours of sleep. (3)
- Because of pain, I have less than 2 hours of sleep. (4)
- Pain prevents me from sleeping at all. (5)

Section 8 – Social Life

- My social life is normal and causes me no extra pain. (0)
- My social life is normal but increases the degree of pain. (1)
- Pain has no significant effect on my social life apart from limiting my more energetic interests. (2)
- Pain has restricted my social life and I do not go out as often. (3)
- Pain has restricted my social life to my home. (4)
- I have no social life because of pain. (5)

Section 9 – Traveling

- I can travel anywhere without pain. (0)
- I can travel anywhere but it gives extra pain (1)
- Pain is bad but I manage journeys of over two hours (2)
- Pain restricts me to short necessary journeys under 30 minutes (3)
- Pain prevents me from traveling except to receive treatment. (4)
- I cannot travel at all. (5)

Section 10 – Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box

- No Yes (If yes, please state the type of treatment you have received.)

**River City Chiropractic
1109 E. Polston Ave.
Post Falls, ID 83854**

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. 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. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name

Signature

Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature

Date



Patient Financial Policy

River City Chiropractic

1109 E Polston Ave

Post Falls, Idaho 83854

208-777-4000

In the interest of good communication and our continued commitment to provide high quality Chiropractic care, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choice for your care.

We are committed to support you in understanding your spinal health and will always present you with the best recommendations to treat your personal situation. To make these services affordable we are pleased to offer you the following payment options.

1. Check or Cash
2. Visa, Mastercard, Discover, American Express
3. Payment Plan

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office—this includes any treatment that is not a benefit of any chiropractic insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within ninety (90) days of date of service, regardless of whether or not my insurance benefits have been received.

Please make your questions and concerns known to our Billing Manager who is happy to discuss this policy and ensure that you have an outstanding experience.

Signature (responsible party)_____

Date_____

Patient Health information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to 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.

1. The patients understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or 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 a consent at any time during care. This would not affect 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 this office 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.

Name of Patient

Date