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 ACCDENT____

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:

___Headaches	___Twitches	___Ear Ring	___Stomach Upset
___Migraines	___Pins & Needles in Legs	___Fever	___Indigestion
___Neck Pain	___Pins and Needles in Arms	___Bed Wetting	___Heart Burn
___Sleeping Problems	___Numbness in Fingers	___Asthmatic Symptoms	___Constipation
___Back Pains	___Shortness of Breath	___Skin disorder	___Cold Sweats
___Nervousness	___Fatigue/Lack of energy	___Acne	___Loss of balance
___Tension	___Depression	___Fainting	___Allergies
___Irritability	___Lights Bother Eyes	___Loss of Smell	___Decrease in Hearing
___Chest Pain	___Blurred Vision	___Loss of Taste	___Sinus Difficulties
___Dizziness	___Double Vision	___Diarrhea	___Ear Infections
___Face Flushed	___Loss of Memory	___Feet Cold	___Hands Cold
___Neck Stiff	___Numbness in Toes	___Reproductive Difficulties	___Carpal Tunnel
___Heavy Feeling of Head			

Injuries/ Surgeries you have had	**Description**	**Date**
Fall	________________________________	______________
Head Injuries	________________________________	______________
Broken Bones	________________________________	______________
Dislocations	________________________________	______________
Surgeries	________________________________	______________
Diseases/Pathologies	________________________________	______________

Exercise	**Work Activity**	**Habits**		**Vitamins**	**Medications**
___None	___Sitting	___Smoking	Packs/Day______	___________	________
___Moderate	___Standing	___Alcohol	Drinks/Week_____	___________	________
___Daily	___Light Labor	___Coffee/Caffeine	Cups/Day______	___________	________
___Heavy	___Heavy Labor	___High Stress Level	Reason_________	___________	________

Are you Pregnant? ___Yes ___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 you 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 make 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. (o)
☐ I can read as much as I want to with slight pain in my neck. (1)
☐ I can read as much as I want 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 you 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 make 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. (o)
☐ 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. (o)
☐ 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.)

____
____
____
____

Accident / Injury History

Personal Information:

Last Name	First Name	Circle one: **Male** **Female**
Address:	City, State, Zip:	
Home Phone:	Work Phone:	Social Security No:
Date of Birth:	Date of Injury/Onset:	
Dominant Hand: Circle one **Left** **Right** **Both**		

Insurance Information:

Responsible Party's Name:	
# 1 Insurance Company:	Adjuster:
Address:	
Phone Number:	Claim Number:
#2 Insurance Company	Adjuster:
Address:	
Phone Number:	Claim Number:
Have you retained an attorney?	Name:

1. Enter a full description of the accident, injury, or onset in the space below.

2. Enter the details of your condition during and immediately after your injury/onset.

Patient Signature ______________________________

Date ______________

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type	2. Your position in vehicle	3. What was your vehicle doing at the time of the accident?
❑ Car ❑ Station Wagon	❑ Driver ❑ Front Passenger	❑ Stopped at intersection ❑ Stopped in Traffic ❑ Stopped at light
❑ Van ❑ Pickup Truck	❑ Left Rear Passenger	❑ Making a right turn ❑ Making a left turn ❑ Parking
❑ Large Truck ❑ Bus	❑ Right Rear Passenger	❑ Proceeding along ❑ Slowing down ❑ Accelerating
❑ Other ____________	❑ Other ________________	❑ Other ______________________________

4. Time/Speed/Damage	5. Details of Accident	6. Road conditions
Time of accident ________	Visibility at time of accident	❑ Icy ❑ Wet ❑ Sandy ❑ Dark ❑ Clean and dry
Your vehicle's speed: ___________mph	❑ Poor ❑ Fair ❑ Good	
Their vehicle's speed: ___________mph	Who hit who/what	Point of impact
Damage to your vehicle	❑ You hit other vehicle	❑ Head-On ❑ Left Front ❑ Right Front
❑ Mid ❑ Moderate	❑ Other vehicle hit you	❑ Rear-End ❑ Left Rear ❑ Right Rear
❑ Totaled	You hit...(object) ________________	

7. Body Position, etc.

Did you see the accident coming: Yes ❑ ❑ No	Does your vehicle have headrests? Yes ❑ ❑ No
Were you braced for the impact? Yes ❑ ❑ No	What was the position of your headrest at the time of impact?
Did you have a seat belt on? Yes ❑ ❑ No	❑ Even with top of head ❑ Even with bottom of head ❑ Middle of neck
Did you have a shoulder harness on? Yes ❑ ❑ No	What was the direction of your head at the time of impact?
	❑ Facing straight forward ❑ Turned to the right ❑ Turned to the left

Did driver side airbags deploy? Yes ❑ ❑ No Did passenger side airbags deploy? Yes ❑ ❑ No Did side airbags deploy? Yes ❑ ❑ No

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident	10. After the accident
Did your body strike the inside of the vehicle? Yes ❑ ❑ No	Check off your symptoms right after and a few days following:
If yes, describe: ____________________	❑ Headache ❑ Dizziness ❑ Mid back pain ❑ Cold hands
Did you lose consciousness during the injury? Yes ❑ ❑ No	❑ Neck pain ❑ Nausea ❑ Low back pain ❑ Cold feet
If yes, for how long?____________________	❑ Neck Stiffness ❑ Confusion ❑ Nervousness ❑ Diarrhea
Your vehicle's estimated damage? ____________	❑ Fainting ❑ Fatigue ❑ Loss of taste ❑ Depression
Damage to their vehicle: ❑ Mild ❑ Moderate ❑ Totaled	❑ Ringing in ears ❑ Tension ❑ Toe numbness ❑ Anxious
Did police show up at the scene? Yes ❑ ❑ No	❑ Loss of smell ❑ Irritability ❑ Constipation ❑ Chest pain
Was an accident report filled out? Yes ❑ ❑ No	❑ Pain behind eyes ❑ Shortness of breath ❑ Sleeping Problems
	Others: ______________________________

11. Emergency Room?	12. Treatment History:
Where did you go after the accident?	Fill in any other doctor(s) seen prior to your first visit to this office.
❑ Home ❑ Work ❑ Hospital ER ❑ Private Doctor	1. Dr. ________________ First visit date: ___/___/___
How did you get there?	Specialty:________________ X-rays done? Yes ❑ ❑ No
❑ Drove self ❑ Somebody else ❑ Ambulance ❑ Police	Types of treatments received? ________________
Where X-rays done? Yes ❑ ❑ No Was lab work done? Yes ❑ ❑ No	Did treatments benefit you? Yes ❑ ❑ No
Body parts X-rayed? ________________	Last visit date: ___/___/___
What lab work? ________________	2. Dr. ________________ First visit date: ___/___/___
The X-Rays revealed? ________________	Specialty:________________ X-rays done? Yes ❑ ❑ No
Treatments? ❑ Cervical Collar ❑ Ice Other: __________	Types of treatments received? ________________
Medications: ________________	Did treatments benefit you? Yes ❑ ❑ No
Follow-up instructions: ________________	Last visit date: ___/___/___

(c) 2002 Report Master, Inc. All rights reserved

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 Manger 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