PRINT YOUR NAME HERE:_____

**Mountain View Chiropractic and Wellness Center LLC**
19102 State Route 410 East #A
Bonney Lake, WA 98391
Ph 253-863-6378 Fax 253-863-6429

**WELCOME**

The doctors and staff of Mountain View Chiropractic and Wellness Center welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to therapies we offer, we will not accept you as a patient but will refer you to another health care provider as appropriate.

**INSURANCE**

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

**PATIENT IDENTIFICATION**

_____ Telephone (Home) _____
Name

(Work) _____

_____
Street (Cell) _____

_____ _____
City, State and Zip Occupation

_____ _____
Social Security # Date of Birth

Emergency Contact: _____

Telephone # _____

Name of Parent of Minor Patient (If applicable) _____

**EMAIL ADDRESS _____ (**only for health tips)

**DID SOMEONE REFER YOU? _____**

**ACCEPTANCE AS PATIENT**

I understand and agree that the doctors of **Mountain View Chiropractic Clinic** have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process if information gathering so that the doctor can determine whether to accept me as a patient.

_____ _____
Signature Date

PRINT YOUR NAME HERE:_____

MOUNTAIN VIEW CHIROPRACTIC AND WELLNESS CENTER, P.L.L.C.
19102 STATE ROUTE 410 EAST #A BONNEY LAKE WA 98391

# CONSENT FORM & ACKNOWLEDGEMENT OF PRIVACY RIGHTS

**Chiropractic** examination and therapeutic procedures (including spinal adjustment, heat, ice application, traction, laser, x-ray and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which maybe associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5-2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects and complications is available upon request.
**Acupuncture**: including needling, electro-acupuncture, cupping, moxabustion and other specialized treatments.
**Massage**: including various styles of therapeutic massage and other (body wraps, hot stone, cupping, etc).

I, _____ consent to the following examination and therapeutic treatment procedures as necessary to facilitate my diagnosis and treatment.

I, _____ consent to Mountain View Chiropractic Clinic (MVCC) use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for the purposes relating to the payment of services rendered to me, and for MVCC's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that MVCC diagnosis or treatment of me maybe conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by MVCC, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of MVCC, but that MVCC is not required to agree to these restrictions. However, if MVCC agrees to restriction that I request, the restriction is binding on MVCC.

I understand I have a right to review MVCC Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent in writing at any time, except to the extent that Physician or MVCC has acted in reliance of this consent.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself, or unless law requires it. I understand that I may look at my record and can request a copy by paying the appropriate fee. I understand my medical record will be kept no more than 10 years after the date of my last treatment.

_____ _____
Signature of Patient/Personal Representative/Guardian Date

_____
Description of Personal Representative's Authority

PRINT YOUR NAME HERE:_____

MOUNTAIN VIEW CHIROPRACTIC AND WELLNESS CENTER, P.L.L.C. 19102 STATE ROUTE 410 EAST #A BONNEY LAKE WA 98391

## Personal Health History

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment.

(Name) (Date of Birth) (Today's Date)

Please circle the conditions you currently have or have had. To be responsible for your case, we need your complete health history.

**Muscle / Joint**
- ± Arthritis
- ± Bursitis
- ± Foot trouble
- ± Hernia
- ± Low back pain
- ± Lumbago
- ± Neck pain, stiffness
- ± Pain between shoulders

**General**
- ± Allergy
- ± Chills
- ± Convulsions
- ± Dizziness
- ± Fainting
- ± Fatigue
- ± Fever
- ± Headache
- ± Loss of sleep
- ± Loss of weight
- ± Nervousness, depression
- ± Neuralgia
- ± Numbness
- ± Sweats
- ± Tremors

**Cardiovascular**
- ± Hardening of arteries
- ± High blood pressure
- ± Low blood pressure
- ± Pain over heart
- ± Poor circulation
- ± Rapid heartbeat
- ± Slow heartbeat
- ± Swelling of ankles

**Genitourinary**
- ± Bed-wetting
- ± Blood in urine
- ± Frequent urination
- ± Lack of kidney control
- ± Kidney infection
- ± Painful urination
- ± Prostate trouble
- ± Pus in urine

**Eye, Ear, Nose and Throat**
- ± Asthma
- ± Colds
- ± Crossed eyes
- ± Deafness
- ± Dental decay
- ± Earache
- ± Ear discharge
- ± Ear noise
- ± Enlarged glands
- ± Enlarged thyroid
- ± Eye pain
- ± Failing vision
- ± Far sightedness
- ± Gum trouble
- ± Hay fever
- ± Hoarseness
- ± Nasal obstruction
- ± Near sightedness
- ± Nose bleeds
- ± Sinus infection
- ± Sore throat
- ± Tonsillitis

**Gastrointestinal**
- ± Belching or gas
- ± Colitis
- ± Colon trouble
- ± Constipation
- ± Diarrhea
- ± Difficult digestion
- ± Bloated abdomen
- ± Excessive hunger
- ± Gallbladder trouble
- ± Hemorrhoids
- ± Intestinal worms
- ± Jaundice
- ± Liver trouble
- ± Nausea
- ± Pain over stomach
- ± Poor appetite
- ± Vomiting
- ± Vomiting of blood

**Skin**
- ± Boils
- ± Bruise easily
- ± Dryness
- ± Hives or allergy
- ± Itching
- ± Skin eruptions (rash)
- ± Varicose veins

**Pain or numbness in**
- ± Shoulders
- ± Arms
- ± Elbows
- ± Hands
- ± Hips
- ± Legs
- ± Knees
- ± Feet
- ± Painful tailbone
- ± Poor posture
- ± Sciatica
- ± Spinal curvature
- ± Swollen joints

**Respiratory**
- ± Chest pain
- ± Chronic cough
- ± Difficult breathing
- ± Spitting up blood
- ± Spitting up phlegm
- ± Wheezing

**Women only**
- ± Congested breasts
- ± Cramps or backache
- ± Excess menstrual flow
- ± Hot flashes
- ± Irregular cycle
- ± Lumps in breast
- ± Menopause
- ± Painful menstruation
- ± Vaginal discharge

Are you pregnant? ± Yes ± No

If yes, how many months? _____

How many children do you have? _____

*Check any of the following conditions you currently have or have had:*
- ± Alcoholism
- ± Anemia
- ± Appendicitis
- ± Arteriosclerosis
- ± Cancer
- ± Chicken pox
- ± Cholera
- ± Cold sores
- ± Diabetes
- ± Diptheria
- ± Eczema
- ± Edema
- ± Emphysema
- ± Epilepsy
- ± Fever blisters
- ± Goiter
- ± Gout
- ± Heart disease
- ± Herpes
- ± Influenza
- ± Lumbago
- ± Malaria
- ± Measles
- ± Miscarriage
- ± Multiple sclerosis
- ± Mumps
- ± Pacemaker
- ± Pleurisy
- ± Pneumonia
- ± Polio
- ± Rheumatic fever
- ± Scarlet fever
- ± Stroke
- ± Tuberculosis
- ± Typhoid fever
- ± Ulcers
- ± Venereal disease
- ± Whooping cough

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MOUNTAIN VIEW CHIROPRACTIC AND WELLNESS CENTER, P.L.L.C.
19102 STATE ROUTE 410 EAST #A BONNEY LAKE WA 98391

Describe chiropractic problem:_____

How long have you had this condition? _____ Is it getting worse? ± Yes ± No

What seemed to be the initial cause:

Have you seen a chiropractor before? ± Yes ± No If yes, how long ago? _____

For what reason?

Height Weight Date _____

Are you under the care of a physician? ± Yes ± No If yes, for what reason? Have you been hospitalized in the last 5 years? ± Yes ± No If yes, for what reason?

Have you had any mental or emotional disorders? ± Yes ± No If yes, when?

Indicate the drugs do you now take?

| Have you ever: | Yes | No | If yes, briefly explain. |
|---|---|---|---|
| - had a broken bone? | ± | ± | |
| - been hospitalized? | ± | ± | |
| - had strains or sprains? | ± | ± | |
| - used a cane, crutch or other support? | ± | ± | |
| - been struck unconscious? | ± | ± | |
| - been hospitalized for other than surgery? | ± | ± | |

| Do you: | | | |
|---|---|---|---|
| - take minerals, herbs or vitamins? | ± | ± | |
| - think you need minerals, herbs or vitamins? | ± | ± | |
| - have any drug allergy? | ± | ± | |

| When did you last have: | Never | 0-6 mos. | 6 -18 mos. | longer |
|---|---|---|---|---|
| - spinal x-ray? | ± | ± | ± | ± |
| - spinal examination? | ± | ± | ± | ± |
| - physical examination? | ± | ± | ± | ± |

| HABITS | None | Light | Mod | Heavy |
|---|---|---|---|---|
| Alcohol | ± | ± | ± | ± |
| Coffee | ± | ± | ± | ± |
| Tobacco | ± | ± | ± | ± |
| Drugs | ± | ± | ± | ± |
| Exercise | ± | ± | ± | ± |
| Sleep | ± | ± | ± | ± |
| Appetite | ± | ± | ± | ± |
| Soft Drinks | ± | ± | ± | ± |
| Salty Foods | ± | ± | ± | ± |
| Water | ± | ± | ± | ± |
| Sugar | ± | ± | ± | ± |
| Sweeteners | ± | ± | ± | ± |

With your present condition – does it affect your activities of daily life? Ex: doing dishes, laundry, walking, sitting, travel, sleeping? List all below

PRINT YOUR NAME HERE:_____

MOUNTAIN VIEW CHIROPRACTIC AND WELLNESS CENTER, P.L.L.C.
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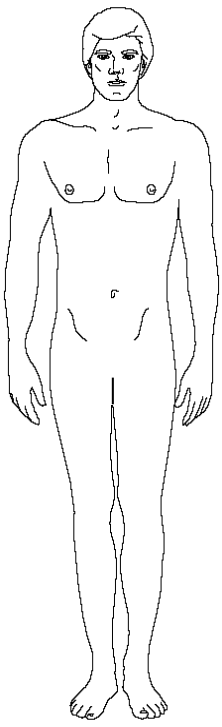
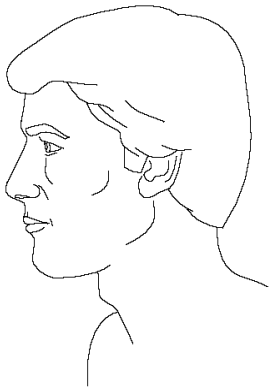
FAMILY HEALTH HISTORY

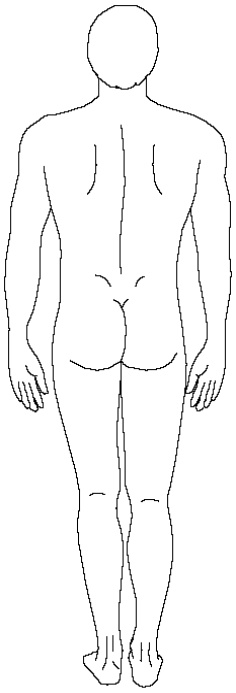
Some health conditions are the result of hereditary spinal weaknesses. Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

| RELATIONSHIP | PRESENT AND PAST HEALTH PROBLEMS |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Please mark your areas of pain on the figures below**







PRINT YOUR NAME HERE:_____

Mountain View Chiropractic and Wellness Center
Chiropractic ● Acupuncture ● Massage
19102 State Route 410 EAST #A ▪ Bonney Lake, WA 98391
Ph 253-863-6378 ▪ Fax 253-863-6429

# CLINIC FINANCIAL POLICY

1. All payments are due at the time of service, unless special arrangements have been agreed upon prior to the visit.
2. All co-pay will be due at the time of service, once your insurance coverage has been verified and we have established what your responsibility is.
3. As a courtesy to our patients, we will bill your insurance company for you. Please keep in mind that if there is a discrepancy, we will let you know as soon as possible, however we will not get involved with any dispute between you and your insurance carrier.
4. If you have a credit balance, we will reimburse you after payment has been received.
5. All supplements/vitamins, lab tests, supports and other supplies must be paid for at the time they are received.
6. All workers' compensation cases will be billed directly to the insurance company, providing the appropriate paperwork has been filled out and a claim is filed. Please keep in mind that if your claim is denied you are responsible for prompt payment of your account.
7. Personal injury and auto accident cases will be billed to your auto insurance company, providing that a claim has been filed and the appropriate paper work has been completed.
8. Keep in mind we do not do third party billing to other insurance companies.
9. If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service.
10. Generally, supplements/vitamins, lab tests, supports and other supplies may not be covered by insurance companies and must be paid for at the time they are received. Should your insurance company pay, we will reimburse you for the amount paid.

# CLINIC LATE CANCELLATION FEE POLICY

Your appointment times have been reserved for you. In order to offer timely and optimal care for all our patients, we request 24 hours notice for cancellation of visits. Kindly provide us notice by calling the front desk. Please always leave a message if your call goes directly to our voice mail.

*Please note that in the case of massage appointments you will be charged a $35 fee for any visit cancellations without 24 hours notice.*

I _____ have read and understand the above clinic financial and fee policies.

_____ _____

Patient / Guardian Signature Date

PRINT YOUR NAME HERE:_____

# Oswestry Low Back Pain Scale

**Please rate the severity of your pain by circling a number below:**

***No pain*** | 0 1 2 3 4 5 6 7 8 9 10 | ***Unbearable pain***

**Name**_____ **Date**

**Instructions:** Please circle the **ONE NUMBER** in each section which most closely describes your problem.

**Section 1 – Pain Intensity**
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

**Section 2 – Personal Care (Washing, Dressing, etc.)**
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

**Section 3 – Lifting**
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

**Section 4 – Walking**
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

**Section 5 – Sitting**
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

**Section 6 – Standing**
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

**Section 7 – Sleeping**
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

**Section 8 – Social Life**
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

**Section 9 – Traveling**
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

**Section 10 – Changing Degree of Pain**
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

**Total**_____

PRINT YOUR NAME HERE:_____

# Modified Oswestry — Neck Disability 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 check the ONE box that applies to you. We realize you may consider that two statements in any one **section relate to you,** but please just mark the box that most closely describes your problems.

Section 1 — Pain intensity
- ❍ I can tolerate the pain I have without having to use pain killers.
- ❍ The pain is very mild at the moment.
- ❍ The pain is moderate at the moment.
- ❍ The pain is fairly severe at the moment.
- ❍ The pain is very severe at the moment.
- ❍ The pain is the worst imaginable at the moment.

Section 2— Personal care (washing, dressing, etc.)
- ❍ I can look after myself normally without causing extra pain.
- ❍ I can look after myself normally, but it is very painful.
- ❍ It is painful to look after myself and I am slow and careful.
- ❍ I need some help but manage most of my personal care.
- ❍ I need help every day in most aspects of self care.
- ❍ I do not get dressed, wash with difficulty and stay in bed.

Section 3— Lifting
- ❍ I can lift heavy weights without extra pain.
- ❍ I can lift heavy weights but it gives extra pain.
- ❍ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- ❍ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ❍ I can lift only very light weights.
- ❍ I cannot lift or carry anything at all.

Section 4— Reading
- ❍ I can read as much as I want to with no pain in my neck.
- ❍ I can read as much as I want to with slight pain in my neck.
- ❍ I can read as much as I want with moderate pain in my neck.
- ❍ I can't read as much as I want because of moderate pain in my neck.
- ❍ I can hardly read at all because of moderate pain in my neck.
- ❍ I cannot read at all.

Section 5 — Headaches
- ❍ I have no headaches at all.
- ○ I have slight headaches which come infrequently.
- ○ I have moderate headaches which come infrequently.
- ❍ I have moderate headaches which come frequently.
- ❍ I have severe headaches which come frequently.
- ❍ I have headaches almost all the time.

Section 6 — Concentration
- ❍ I can concentrate fully when I want to with no difficulty.
- ❍ I can concentrate fully when I want to with slight difficulty.
- ❍ I have a fair degree of difficulty in concentrating when I want to.
- ❍ I have a lot of difficulty in concentrating when I want to.
- ❍ I have a great deal of difficulty in concentrating when I want to.
- ❍ I cannot concentrate at all.

Section 7 — Work
- ❍ I can do as much work as I want to.
- ❍ I can only do my usual work, but no more.
- ❍ I can do most of my usual work, but no more.
- ❍ I can't do my usual work.
- ○ I can hardly do any work at all.
- ❍ I can't do any work at all.

Section 8— Driving
- ❍ I can drive my car without any neck pain.
- ❍ I can drive my car as long as I want with slight pain in my neck.
- ❍ I can drive my car as long as I want with moderate pain in my neck.
- ❍ I can't drive my car as long as I want because of moderate pain in my neck.
- ❍ I can hardly drive at all because of severe pain in my neck.
- ❍ I can't drive my car at all.

Section 9— Sleeping
- ❍ I have no trouble sleeping.
- ❍ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ❍ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ❍ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ❍ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ❍ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10— Recreation
- ❍ I am able to engage in all of my recreation activities with no pain in my **neck.**
- ❍ **I am able to engage in all** of my recreation activities with some pain in my neck.
- ○ I am able to engage in most, but not all of my recreation activities because of pain in my neck.
- ❍ I am able to engage in only a few of my recreation activities because of pain in my neck
- ❍ I can hardly do any recreation activities because of pain in my neck
- ❍ I can't do any recreation activities at all.

Patient Name _____ Date _____