Pearson & Weary
CHIROPRACTIC ORTHOPEDICS AND REHABILITATION

Pain Relief Clinics

Please Complete All Sections

Full Name: Nickname: Gender: ☐ M ☐ F ☐ Other:

Date of Birth: / / Age: Race: (optional)

Family Status: ☐ Single ☐ Married ☐ Widow(ed) ☐ Divorce ☐ Separated ☐ Partner No. of Children:

Full Address: City: State: Zip:

Cell Phone: ( ) Home Phone: ( ) Email:

Emergency Contact: Relationship: Phone: ( )

Employer: Occupation: Who referred you to the clinic? Full Name:

Do you have a primary care provider? ☐ Yes ☐ No Name of your Doctor / Facility:

Do you have health insurance? ☐ Yes ☐ No Insurance company:

Are you the primary subscriber? ☐ Yes ☐ No Name of primary subscriber? Date of birth / primary:

What is your relationship to the primary subscriber?

Who is financially responsible for your care? Name:

CHIEF COMPLAINT INFORMATION:

Describe the location of your chief complaint:

How did your pain begin? (note the date in the next line)

NOTE: A date of onset is <u>required</u> for Medicare and all insurance policies . Date of onset: / /

What is the severity of your complaint: 0 - no pain / 10 - severe pain:

Is your complaint getting progressively worse?

Is your complaint better at certain times of the day or with certain activities?

Is your complaint worse at certain times of the day or with certain activities?

What makes your complaint better?

What makes your complaint worse?

Circle any of the associated symptoms you experience: Numbness Tingling Weakness Headaches Feeling a catch / locking up

How frequently do you experience the symptoms you circled above?

Previous treatment including current providers you are seeing: ☐ NA

PLEASE COMPLETE THE FOLLOWING TWO PAGES!

E 16201 Indiana Ave Ste 1111 | Spokane Valley, WA 99216 | 509.927.8997 | Fax: 509.927.3919 | www.pearsonweary.com

What have they recommended and what has been the outcome? ☐ NA

Please list other concerns you have in the order of their importance: ☐ NA

Have you had chiropractic care before? ☐ Yes ☐ No Date of last treatment if applies: Name of DC:

Have you had X-rays or MRI or any other imaging performed? ☐ Yes ☐ No What body part?

Which imaging center performed the testing? ☐ NA Estimated date of most recent imaging?

PAST MEDICAL HISTORY

Have you been treated by a physician for any health condition in the past 6 months? ☐ Yes ☐ No

Please describe:

Please list your medications: ☐ NA

Please list your allergies: ☐ NA

Please list any supplements / vitamins you take on regular basis: ☐ NA

SOCIAL HISTORY

Smoking /Tobacco	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of times per week:
Alcohol	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of drinks per week:
Water	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of cups per week:
Coffee	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of cups per week:
Exercise	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of times per week:

Please describe your exercise:

PAST FAMILY HISTORY - Please list any incidence of the following in your family:

☐ Heart Disease ☐ Cancer ☐ Stroke ☐ Diabetes ☐ Arthritis ☐ Back or Disc Problems

☐ Other Describe:

YOUR GOALS AND ASPIRATIONS

Are there certain activities that you have been unable to perform that you would like to return to or begin? *(Please list)*

Patients Signature: ______________________________ Date: ____________________

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HIPAA Privacy

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI) The patient is also provided the right to request confidential communication and can be provided in the manner they choose.

☐ It is okay to leave a message with detailed information ☐ Leave call back number only

I prefer to be contacted for appointments in the following manner: ☐ Text ☐ Call ☐ Email

I give permission for all staff of Pearson & Weary Clinic (PWC) to discuss my patient care and billing account with:

Name ________________________ Name __________________________

Financial Policies

I agree to pay for services rendered as the charge is incurred. I understand that health care and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments, co-insurances, deductible and non-covered services. I also agree to pay for all copays and non-covered services after seeing the doctor. I authorize the doctor and his/her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjustor, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of the professional services rendered and hereby release him/her of any consequences thereof. I hereby authorize and direct payment of any and all medical /chiropractic expense benefits allowable to the doctor as payment toward the total charges for the professional services rendered.

If required by my health insurance policy, it is my responsibility to obtain a referral for my primary care physician prior to treatment at PWC. I also understand that if I do not have prior authorization and it is denied, I am responsible for any charges not covered by my insurance company. I understand benefits are sometimes misquoted by the insurance company.

Time of Service (TOS) Discount

Certain services provided may not be covered by your health plan. Those services are deemed important to your recovery. Because you are responsible for paying for those services on the date the service is rendered, we offer a time of service discount of $25.00 off the total of all non-billed charges for that day. (This will not include supplements or supplies.) Examples of non- covered services may include (but are not limited to) the examples noted below:

Service	Fee
Active release / Advanced Muscle Integration:	$48 fee: With the TOS discount, the fee is $23
Extremity and Active release:	$78 fee: With the TOS discount, the fee is $53
Initial examination (Medicare)	$136 - $241 fee: With the TOS discount, the fee is $111 - $216
Re-examination (Medicare)	$90 - $142 fee: With the TOS discount, the fee is $65 - $117
Laser	$54 fee: With the TOS discount, the fee is $29

Cancellation Policy

We realize that emergencies come up, but if you need to cancel an appointment for any reason we do require 24 hours notice. We do have a waiting list of other patients who are in pain and would like to be seen as soon as possible.
Clinic Policy: If you do not contact our office 24 hours prior to your scheduled appointment on more than (2) two occasions, you will be billed for the 3rd missed appointment for a fee of $25.00, whether it be for chiropractic or movement. If you do not contact the office 24 hours prior to your scheduled massage appointment, you will be billed $35.00.

____________________________ ____________________________ ______________
Patient’s or Guardian Printed Name Patient’s or Guardian Signature Date

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Patient name: Date:

DESCRIBE YOUR CHIEF COMPLAINT TODAY:

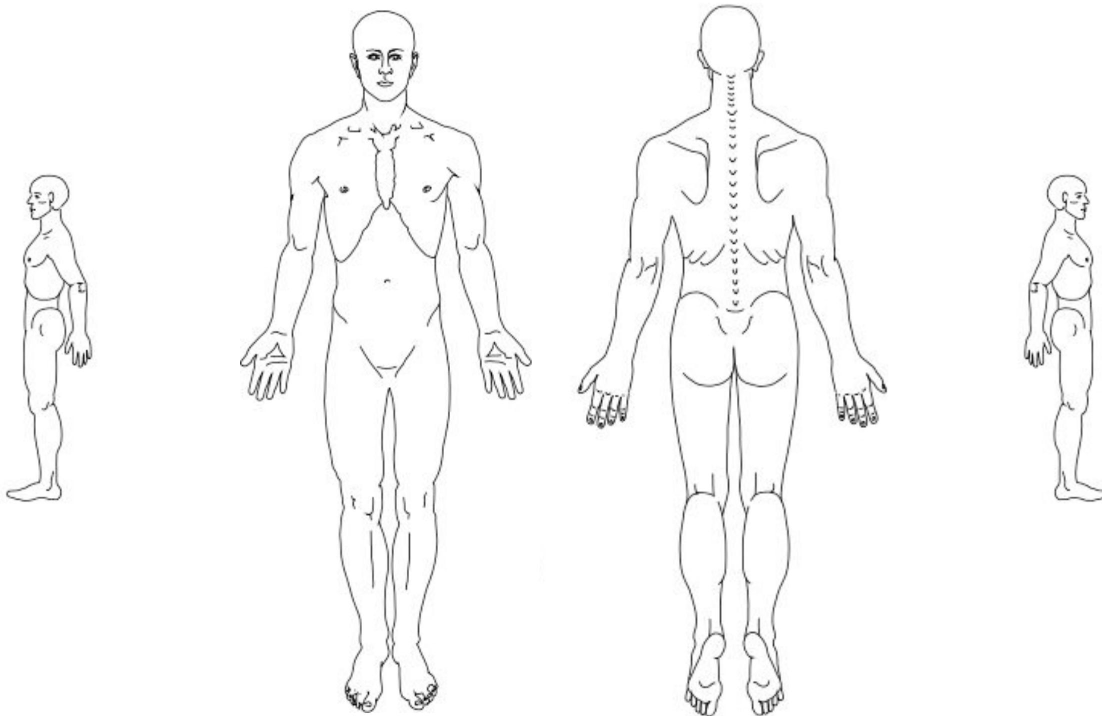
____

____

____

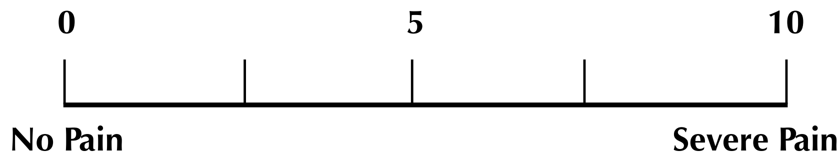
Mark or circle the area of your symptoms on the drawing and indicate if possible:

Pain (P) **Numbness (N)** **Tingling (T)** **Achey (A)** **Sharp (S)**



VISUAL ANALOGUE SCALE

Please rate your pain regarding your chief complaint.



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Functional Rating Index

For use with Neck and or Back Problems

In order to assess your condition we must understand how much your body pain / problems have affected your ability to manage everyday activities. For each item below, please **CIRCLE the number** which most closely describes your condition right now.

PAIN INTENSITY

0	1	2	3	4
no pain	mild pain	mod pain	severe pain	worst pain

SLEEP DISTURBANCE

0	1	2	3	4
perfect	mildly	moderate	greatly	totally

PERSONAL CARE RESTRICTIONS

0	1	2	3	4
none	mild	moderate	severe	needs help

PAIN WITH TRAVEL (DRIVING)

0	1	2	3	4
no pain	mild long trip	moderate long trip	moderate short trip	severe short trip

ABILITY TO DO WORK

0	1	2	3	4
can do extra work	can do only usual work	can do 50% of usual work	can do 25% of usual work	unable to work at all

ABILITY TO DO RECREATION

0	1	2	3	4
can do all activity	most activity	some activity	a few activities	cannot do any

FREQUENCY OF PAIN

0	1	2	3	4
no pain	25% of day	50% of day	75% of day	constant pain

PAIN WITH LIFTING WEIGHT

0	1	2	3	4
no pain heavy wt	some w/ heavy wt	worse w/ mod wt	worse w/ light wt	worse w/ any wt

WALKING

0	1	2	3	4
no pain any distance	pain after 1 mile	pain after 1/2 mile	pain after 1/4 mile	pain with all walking

ABILITY TO STAND

0	1	2	3	4
no pain several hours	increased pain after 2 hours	increased pain after 1 hour	increased pain after 1/2 hour	increased pain with any stand

Please circle the average level of pain in the last week. (No pain 0 - Worst pain 10)

0 1 2 3 4 5 6 7 8 9 10

Name: ____________________________ Date: ____________ Score: (by staff) ________

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Full Name ____ Date: ________

Review of Systems: In order to provide the best care possible, please check those health concerns that apply to you. Please write **C** for **Current** and **P** for **Past** history in the box to the left of the condition.

P	C		P	C		P	C	
		CONSTITUTIONAL			**IMMUNOLOGIC**			**EAR / NOSE /**
		Weight change			Allergies to food			Dizziness
		Fever			Hepatitis			Tinnitus
		Weakness			Rheumatoid			Hearing Loss
		Undue fatigue			Lupus			Nose Bleeds
		CARDIOVASCULARR			Psoriasis			Hoarseness
		High BP			**RHEUMATOLOGIC**			Swallowing difficulty
		Faintness			Chest pain			**GASTROINTESTINAL**
		Vertigo			Cough			Appetite change
		Chest pains			Asthma			Nausea
		Heart palpitations			Bronchitis			Diarrhea
		GENITOURINARY			**PSYCHIATRIC**			Constipation
		Hernia			Anxiety			**HEMATOLOGIC**
		Frequent urination			Depression			Anemia
		Painful urination			Insomnia			Bruise easily
		Rashes			Energy Loss			**HEMATOLOGIC**
		Skin lesions			**CANCER (yr)**			Hot /cold intolerance
		JOINT REPLACED (yr)						Excessive sweating
								Thyroid problems
		HERNIATED DISC (yr)			**FRACTURE (yr)**			**OTHER**
								Loss of bowel control
		SURGERY (yr)			**TRAUMA (accidents)**			Osteporosis
								Stroke / TIA (yr)
								Heart attack (yr)

If none of these conditions apply: Please check ☐ NA