



PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This often allows our patients to achieve superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature

Today's Date

Terms of Acceptance

When a person seeks chiropractic health care and is accepted for such care, it is essential that both are seeking and working for the same goal. As a Chiropractic Rehabilitative facility, we have one main goal - to detect and correct/reduce the Vertebral Subluxation Complex (VSC) and associated effects of the nervous system. 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.

We do not offer to diagnose or treat a disease or condition other than that which relates to vertebral subluxation. However, if during the course of a chiropractic spinal exam, we encounter complaints that warrant medical attention, we will recommend that you see the services of a provider who specializes in that area. Our primary role is to identify subluxations and our primary method of correcting them is through spinal adjustments and chiropractic rehabilitative care.

Patient or Guardian's Signature X _____ Date: _____

Consent to Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by Dr. Coogan, staff members, and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Coogan. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I have read this consent and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I acknowledge that I have not only had an opportunity to read this information but also have had/will have an opportunity to verbally discuss any questions or concerns with Dr. Coogan or any other Doctor who is providing treatment.

Patient or Guardian's Signature X _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. By signing below **I acknowledge that the Notice of Privacy Practices has either been offered to me or received by me.**

Patient or Guardian's Signature X _____ Date: _____

Female Patients Only – non-pregnancy verification for xrays

To the best of my knowledge I certify that I am **NOT** pregnant. Should I become pregnant during the course of treatment I will provide that information to the Doctor.

Patient Signature X _____ Date: _____

Consent to Treat a Minor

I authorize the Doctor and whomever he may designate as assistants to examine and administer chiropractic care as deemed necessary to treat my child.

Parent or Guardian's Signature X _____ Date: _____

Eastside Spine & Wellness – Financial Policies

Thank you for selecting us as your chiropractor. The following information describes our financial policies. Our primary goal is that you receive the optimal treatments needed to restore and maintain your health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask one of our office managers.

1. We accept the following forms of payment: Cash, Check, Visa, MasterCard, Care Credit
2. Payment is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist.
3. Chiropractic insurance is a contract between you and your insurance company. Patients should realize that professional services are rendered to a person, and not to any insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to the doctor. Ultimately the patient is responsible for all unpaid balances. On your behalf, we will help in filing your claim, handling insurance queries, processing follow-ups, and lost claims, etc. Please understand that we provide an estimate of your fees which is a **guideline** from which to work until final payment is received from your insurance company and your **exact** share of the bill is known. If you direct the insurance company to pay their share of the cost directly to this office, we will give you credit for this anticipated amount. Your insurance company will **not** be billed for services rendered until treatment has been completed. Often these payments are not received for 2 to 4 months after being submitted for payment.
4. Any pre-payments for health services are 100% refundable if those services are not rendered.
5. We do our best to provide you with an accurate estimate of your treatment costs. Ultimately, your final treatment costs will depend on how your insurance claims are processed and what services are rendered. Any “over-payments” or “under-payments” will be reconciled accordingly after all insurance claims have processed and you have concluded your active treatment program.
6. Balances older than 90 days may be subject to additional collection fees and interest charges of 1% per month. (per RCW 19.52) Returned checks may be subject to an additional \$25 non-sufficient fund fee. (per RCW 62A.3-515 & 520)
7. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account.

PATIENT RESPONSIBILITY: I authorize treatment of the patient named above and agree to pay for all fees for such treatment. I hereby authorize the clinic to receive all benefits to which my dependents or I are entitled to under my health insurance plan. I also authorize the healthcare provider or insurance company to release any information required to process the claim. In addition, I will not withhold or delay payment if my insurance company denies payment of any charges. I acknowledge my responsibility for payment of the service from Dr. Ryan Coogan in accordance with his regular fees and terms. I accept financial responsibility for all services not covered by my insurance and authorize payment to be made directly to the doctor by my insurance company.

I have reviewed and acknowledge my understanding of the office financial policies and procedures.

Signature: _____

Date: _____

About You

Full Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: (____) _____ Work Ph: (____) _____ Cell Ph: (____) _____

Email: _____ Gender: M F Birthdate: ____/____/____ Age: _____

Social Security #: _____ - _____ - _____ Marital Status: M S D W Spouse Name: _____

Family Doctor: _____ City: _____ Phone #: _____

I give permission for Eastside Spine & Wellness to send a brief progress report to my physician: Please Initial

Occupation: _____ Employer: _____

Emergency Contact: _____ Emergency Ph:(____) _____

How did you find us? Internet/Website Location Other health care provider (name) _____

Community Event (screening, seminar, health fair, massage event) Family/Friend (name) _____

Experience with Chiropractic

Have you seen a chiropractor before? Yes No Who? _____ Last Visit: _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take xrays to evaluate your spine? Yes No

Were "after" xrays taken at the end of treatment to assess your progress? Yes No

Did you receive "adjustments" only? Yes No Exercises? Yes No Rehab Traction? Yes No

Did you know that your posture and spinal alignment are related to your health? Yes No

Are you aware of any of your poor posture habits? Yes No

Explain: _____

Trauma History

Most spinal health problems (subluxations) are the result of the cumulative effects of past and current traumas. The following questions will help us develop a comprehensive history of your spinal health traumas.

Have you been involved in any motor vehicle accidents (car, motorcycle, boat, etc...)? Yes No

Explain: _____

Have you been involved with any of the following sports? Gymnastics Soccer Football Martial Arts

Wrestling Basketball Cheerleading/Dance Baseball/Softball Volleyball Rugby Boxing

Skiing/Snowboarding - Other high impact or contact sports: _____

Do your job or daily activities require any sustained/repetitive postures, positions, or activities: Yes No

Explain: _____

History of sitting at a desk/computer for extended periods of time (school, work, leisure)? Yes No

Explain: _____

How many hours per day do you currently spend? ____ sitting (driving, desk/computer, leisure) ____ standing

List all previous injuries/accidents: _____

Have you had any spinal surgeries? Yes No Explain: _____

List all other surgeries: _____

General Health History

Please check any of the conditions below that currently affect you or that you have experienced in the past:

MUSCULOSKELETAL

- ___ fibromyalgia
- ___ gout
- ___ osteoarthritis
- ___ rheumatoid arthritis
- ___ osteoporosis
- ___ cysts
- ___ bursitis
- ___ bone/joint disease
- ___ scoliosis
- ___ fractures
- ___ stiff/painful joints
- ___ low back/hip/leg pain
- ___ neck/shoulder/arm pain
- ___ headache
- ___ muscle pain
- ___ disc herniations

RESPIRATORY

- ___ pneumonia
- ___ asthma
- ___ difficulty breathing
- ___ sinus problems
- ___ emphysema

CIRCULATORY

- ___ anemia
- ___ hemophilia
- ___ low blood pressure
- ___ high blood pressure
- ___ raynaud's
- ___ varicose veins
- ___ blood clots
- ___ diabetes
- ___ heart condition
- ___ heart attack
- ___ stroke
- ___ thrombosis/embolism

DIGESTIVE

- ___ ulcers
- ___ irritable bowel syndrome
- ___ colitis
- ___ gallstones
- ___ hepatitis
- ___ crohn's disease
- ___ gas/bloating
- ___ indigestion
- ___ constipation/diarrhea

SKIN

- ___ rashes/warts/moles
- ___ eczema/dermatitis
- ___ psoriasis
- ___ fungal infections
- ___ herpes/cold sores

NERVOUS SYSTEM

- ___ multiple sclerosis
- ___ parkinson's disease
- ___ bell's palsy
- ___ spinal cord injury
- ___ paralysis
- ___ trigeminal neuralgia
- ___ seizures

OTHER

- ___ cancer
- ___ urinary/kidney disease
- _____
- ___ liver disease
- ___ anxiety/panic attacks
- ___ chronic fatigue syndrome
- ___ eyes/ears/nose/throat
- _____
- ___ immune system
- ___ thyroid problems

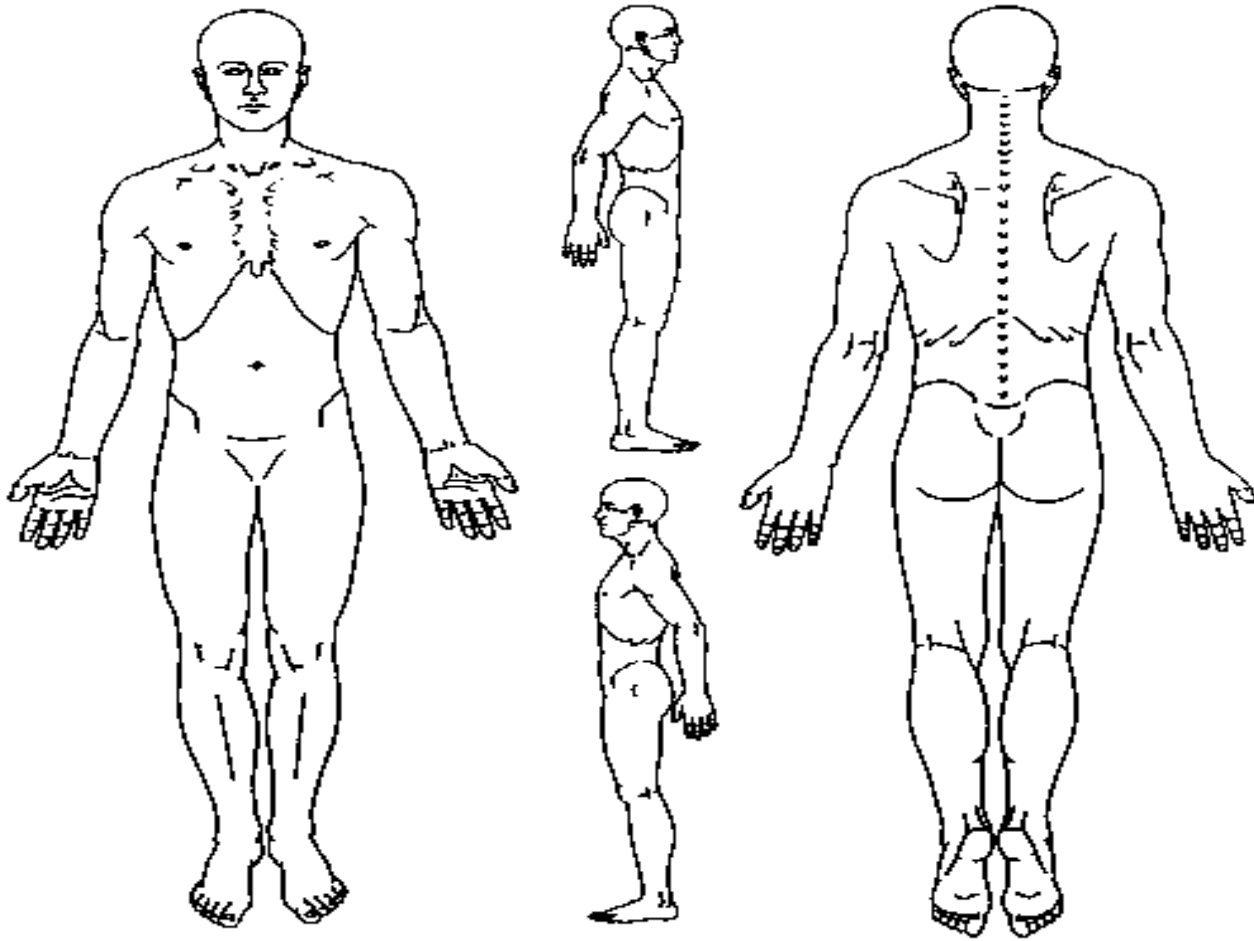
Please list any ALLERGIES: _____

Please list any other medical/health conditions not otherwise reported: _____

Recent history of ANY of the following?: cancer unexplained weight loss immunosuppression (weak immune system) IV drug use urinary infection recent infection pain not relieved by rest high fever bladder infection loss of sensation around your buttock region major weakness in your legs diagnosed with osteoporosis

Name: _____ Date: _____

Please mark all of the areas on the diagram below where you have complaints



A = Ache X = Burning 000 = Numbness/tingling
S = Stiffness /// = Stabbing

Current Complaints

Please answer the following questions regarding your present complaint(s): please check all that apply

- Poor posture
- Neck Pain
- Headaches
- Upper back pain
- Arm Pain
- Mid-back Pain
- Low-back Pain
- Leg Pain
- Hip Pain
- Pain and tension across the shoulders
- Numbness/tingling in arms/hands
- Numbness/tingling in legs/feet
- Dizziness
- Jaw pain/dysfunction
- Shoulder joint pain
- Elbow pain
- Wrist/Hand pain
- Knee pain
- Ankle/Foot pain
- Stiffness in joints Where? _____
- Other: _____

For each of the complaints listed above, please describe in more detail using the questions on the next page

MAIN COMPLAINT _____ When did this begin? _____

How did it start? slip/fall lifting nothing specific accident/injury poor posture habits sleeping

Other: _____ Has it? improved worsened remained the same

What makes it worse? head/neck movement back movement general movement/activity lifting bending
turning/twisting driving sitting walking standing running cough/sneeze poor posture sleeping

Other: _____

Is it worse? in the morning during the day at the end of the day after certain activities it varies

What makes it better? general movement/activity inactivity exercise sitting standing rest/laying down changing positions heat ice massage medications _____

Other: _____

Quality: dull/ache sharp stabbing burning throbbing numbness/tingling stiff

Do your symptoms radiate to other areas? yes no Where? _____

Frequency: daily several days/week several days/month Other: _____

Timing: intermittent (25% of time) occasional (25-50% of time) frequent (50-75% of time) constant (>75% of time)

Average pain level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST

Worst pain level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST

COMPLAINT #2 _____ When did this begin? _____

How did it start? slip/fall lifting nothing specific accident/injury poor posture habits sleeping

Other: _____ Has it? improved worsened remained the same

What makes it worse? head/neck movement back movement general movement/activity lifting bending
turning/twisting driving sitting walking standing running cough/sneeze poor posture sleeping

Other: _____

Is it worse? in the morning during the day at the end of the day after certain activities it varies

What makes it better? general movement/activity inactivity exercise sitting standing rest/laying down changing positions heat ice massage medications _____

Other: _____

Quality: dull/ache sharp stabbing burning throbbing numbness/tingling stiff

Do your symptoms radiate to other areas? yes no Where? _____

Frequency: daily several days/week several days/month Other: _____

Timing: intermittent (25% of time) occasional (25-50% of time) frequent (50-75% of time) constant (>75% of time)

Average pain level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST

Worst pain level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST

COMPLAINT #3 _____ When did this begin? _____

How did it start? slip/fall lifting nothing specific accident/injury poor posture habits sleeping

Other: _____ Has it? improved worsened remained the same

What makes it worse? head/neck movement back movement general movement/activity lifting bending
turning/twisting driving sitting walking standing running cough/sneeze poor posture sleeping

Other: _____

Is it worse? in the morning during the day at the end of the day after certain activities it varies

What makes it better? general movement/activity inactivity exercise sitting standing rest/laying down changing positions heat ice massage medications _____

Other: _____

Quality: dull/ache sharp stabbing burning throbbing numbness/tingling stiff

Do your symptoms radiate to other areas? yes no Where? _____

Frequency: daily several days/week several days/month Other: _____

Timing: intermittent (25% of time) occasional (25-50% of time) frequent (50-75% of time) constant (>75% of time)

Average pain level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST

Worst pain level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST

Healthy/Wellness Lifestyle

Do you exercise? Yes No HOW OFTEN? 1x 2x 3x 4x 5x per week OTHER: _____

What activities? Jogging Swimming Biking Weights Cycling Yoga Pilates Hiking Walking

Other: _____

Do you currently take any of the following supplements?

Omega 3 Fish Oil Probiotics Multi-Vitamin Vitamin D

Other: _____

Health Goals

What are you looking to get out of your care (goals/expectations)? _____

What are your health goals in 5 years (how do you want to feel and what would you like to be able to do?)

We thank you for giving us an opportunity to evaluate your spinal health!

The following are our commitments to you...

We are committed to evaluate you to the best of our ability.

We are committed to clearly explain our findings to you.

We are committed to educate you in your health care options.

We are committed to help you follow through with the care that you choose.

We are committed to help guide you to obtain the level of health that you desire.

Yours in Health,

Dr. Coogan and staff at Eastside Spine & Wellness