Thomas G. Koch D.C. •Andria L. Goff D.C.

NEW PATIENT REGISTRATION - CHIROPRACTIC

Today's Date ____________

Name ____
Last First MI

Address ____
(Complete Mailing) Street Apt# City State Zip

Social Security # _________ - _______ - _________ Date of Birth_____________ Age_________

Sex: ☐ M ☐ F e-mail____

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Partnered ☐ Minor

Primary Phone (______) _______ - _________ ☐ home ☐ cell ☐ work

Secondary Phone (______) _______ - _________ ☐ home ☐ cell ☐ work

Employer_______________________ Occupation______________ Phone (______) _______ - _________

Spouse_________________________ Occupation______________ Phone (______) _______ - _________

Emergency Contact_________________ Relationship _____________ Phone (______) _______ - _________

Reason for this visit: ☐ routine ☐ illness type____________ ☐other ________________

☐accident date ____________ type: ☐ auto ☐ home ☐ work ☐ other__________________

Describe:____

How did you hear about us?____

PAYMENT IS EXPECTED AT TIME OF VISIT

Insurance: Primary____________________________ Secondary ______________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Riverwalk Family Chiropractic will help to prepare any forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Riverwalk Family Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature:____Date:______________
Guardian or Spouse's
Signature Authorizing Care:_______________________________________Date:______________

151 S. Worthen St. Suite 1, Wenatchee, WA, 98801 • Phone: 509-888-1099, Fax: 509-888-2068
riverwalkfamilychiropractic@hotmail.com

Riverwalk Family CHIROPRACTIC

Thomas G. Koch D.C. •Andria L. Goff D.C.

PATIENT CONDITION

Patient Name:________________________________ Date:____________________________

When did your symptoms appear?____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

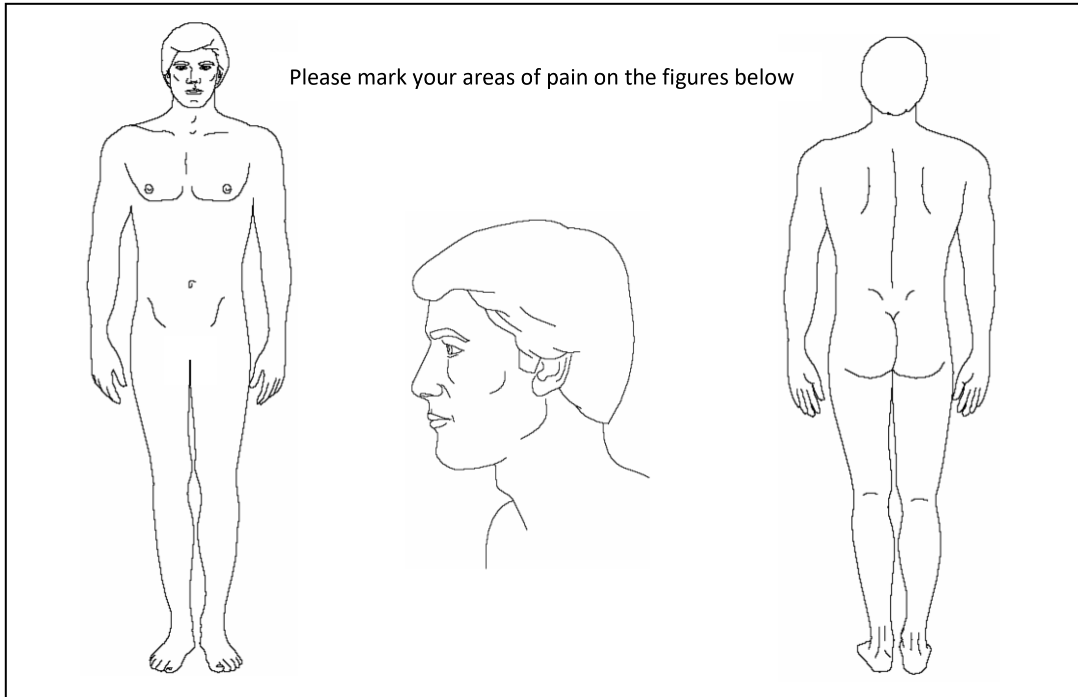
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling

☐ Cramps ☐ Stiffness ☐ Swelling ☐Other____

How often do you have this pain?________________________ Is it constant or does it come and go?___________________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying Down



0 No Pain	Rate the pain you are experiencing on the bar below	10 Worst Pain

Does anything help your pain?____

Does anything make it worse?____

What treatment have you already received for this condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐None ☐Other____

Name and address of other doctor(s) who have treated you for your condition______________________________________

AGREE TO PAY

Patient Name: ____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself and not between my insurance company and this clinic. I request Riverwalk Family Chiropractic to complete any usual and customary reports and forms assisting in collecting from my insurance company. I agree to pay any required co-payment and/or a percentage of services as they are rendered. I also agree to pay any and all charges that are charged to my account when no insurance is provided. I understand that I am ultimately responsible for payment in full to this clinic.

RECEIPT AND ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and/or have been given an opportunity to read a copy of HIPPA Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights I can contact Andria L. Goff D.C. at
(509) 888-1099 or andiragoffdc@gmail.com.

____

Signature of Patient Date

____

Signature of Parent, Guardian or Personal Representative* Date

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*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ Patient Refuses to Acknowledge Receipt:

____

Signature of Staff Member Date

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Thomas G. Koch D.C. •Andria L. Goff D.C.

Consent Form

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, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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 I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, 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.

____

Patient Name (please print name)

____

Patient Signature (or guardian) Date

____

Witness Signature Date

Thomas G. Koch D.C. •Andria L. Goff D.C.

PATIENT HISTORY

Patient Name:____________________________ Date:____

Date of Last: Physical Exam_______________ Spinal X-Ray_________________ MRI, CT-Scan, Bone Scan________________________

Please list any of the following: Allergies?____

Medications?____

Vitamins/Herbs/Minerals?____

Place a mark on “N”=No, “Y”=Yes to indicate if **you** have had any of the following and “F”=Family if anyone in your **family** has

N	Y	F	
☐	☐	☐	AIDS/HIV
☐	☐	☐	Alcoholism
☐	☐	☐	Allergies
☐	☐	☐	Anemia
☐	☐	☐	Appendicitis
☐	☐	☐	Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Backache
☐	☐	☐	Bed wetting
☐	☐	☐	Belching or Gas
☐	☐	☐	Bleeding Disorders
☐	☐	☐	Bloated Abdomen
☐	☐	☐	Blood in Urine
☐	☐	☐	Breast Lump
☐	☐	☐	Bronchitis
☐	☐	☐	Blood Clots
☐	☐	☐	Bruise Easily
☐	☐	☐	Bulimia
☐	☐	☐	Cancer
☐	☐	☐	Cataracts
☐	☐	☐	Chemical Dependency
☐	☐	☐	Chicken Pox
☐	☐	☐	Colitis
☐	☐	☐	Colon Trouble
☐	☐	☐	Concussion
☐	☐	☐	Constipation/Diarrhea
☐	☐	☐	Diabetes
☐	☐	☐	Depression/Panic Disorder
☐	☐	☐	Difficult Digestion
☐	☐	☐	Dizziness
☐	☐	☐	Emphysema

N	Y	F	
☐	☐	☐	Epilepsy
☐	☐	☐	Excessive Hunger
☐	☐	☐	Epilepsy
☐	☐	☐	Fractures
☐	☐	☐	Frequent Urination
☐	☐	☐	Fibromyalgia
☐	☐	☐	Gallbladder Trouble
☐	☐	☐	Glaucoma
☐	☐	☐	Goiter
☐	☐	☐	Gonorrhea
☐	☐	☐	Gout
☐	☐	☐	Heart Disease
☐	☐	☐	Hemorrhoids
☐	☐	☐	Hepatitis
☐	☐	☐	Hernia
☐	☐	☐	Herniated Disk
☐	☐	☐	Herpes
☐	☐	☐	High Blood Pressure
☐	☐	☐	High Cholesterol
☐	☐	☐	Intestinal Worms
☐	☐	☐	Jaundice
☐	☐	☐	Kidney Disease
☐	☐	☐	Kidney Infection
☐	☐	☐	Lack of Bladder Control
☐	☐	☐	Liver Disease
☐	☐	☐	Menopause
☐	☐	☐	Migraine Headaches
☐	☐	☐	Miscarriage
☐	☐	☐	Mononucleosis
☐	☐	☐	Multiple Sclerosis
☐	☐	☐	Nausea
☐	☐	☐	Nervousness
☐	☐	☐	Neuritis
☐	☐	☐	Osteoporosis

N	Y	F	
☐	☐	☐	Pacemaker
☐	☐	☐	Painful Urination
☐	☐	☐	Painful Menstruation
☐	☐	☐	Pain over Stomach
☐	☐	☐	Parkinson’s Disease
☐	☐	☐	Pinched Nerve
☐	☐	☐	Pneumonia
☐	☐	☐	Poor appetite
☐	☐	☐	Liver trouble
☐	☐	☐	Prostate Problem
☐	☐	☐	Prosthesis
☐	☐	☐	Psychiatric care
☐	☐	☐	Rheumatoid Arthritis
☐	☐	☐	Rheumatic fever
☐	☐	☐	Scoliosis
☐	☐	☐	STI
☐	☐	☐	Sinus Trouble
☐	☐	☐	Stroke
☐	☐	☐	Siezures
☐	☐	☐	Thyroid Problems
☐	☐	☐	Tonsillitis
☐	☐	☐	Tuberculosis
☐	☐	☐	Tumors or Growths
☐	☐	☐	TMJ
☐	☐	☐	Ulcers
☐	☐	☐	Vaginal Infections
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting Blood
☐	☐	☐	Whooping Cough
☐	☐	☐	Other__________

Are you pregnant? ☐Yes ☐ No
Due Date_________________

Exercise	**Work Activity**	**Habits**	
☐ None	☐ Sitting	☐ Tobacco Use	Amount/Day________________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week________________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Cups/Day___________________
☐ Heavy	☐ Heavy Labor	☐ High Stress Levels	Reason______________________

Injuries/Surgeries you have had	**Description**	**Date**
Falls	______________________________	______________
Head Injuries	______________________________	______________
Broken Bones	______________________________	______________
Dislocations	______________________________	______________
Surgeries	______________________________	______________

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Records Transfer Request

Date: ____________

To (Doctor/Hospital): ____

Address: ____

City: ______________________ State: __________ Zip: ______________

Phone: ______________________ Fax: ______________________

I hereby authorize the release of my health records, including insurance/billing information, or copies of such, and any X-rays on file and request that they be transferred to:

Riverwalk Family Chiropractic
Thomas G. Koch D.C.
Andria L. Goff D.C.

151 S. Worthen St. Suite 1, Wenatchee, WA 98801
Phone: (509)888-1099; Fax: (509)888-2068

______________________________ ______________________________

Print name of patient Signature (patient, parent or guardian)

____

DOB