Riverwalk Family CHIROPRACTIC

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:_____

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PATIENT CONDITION

Patient Name:_____ Date:_____

When did your symptoms appear?_____

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

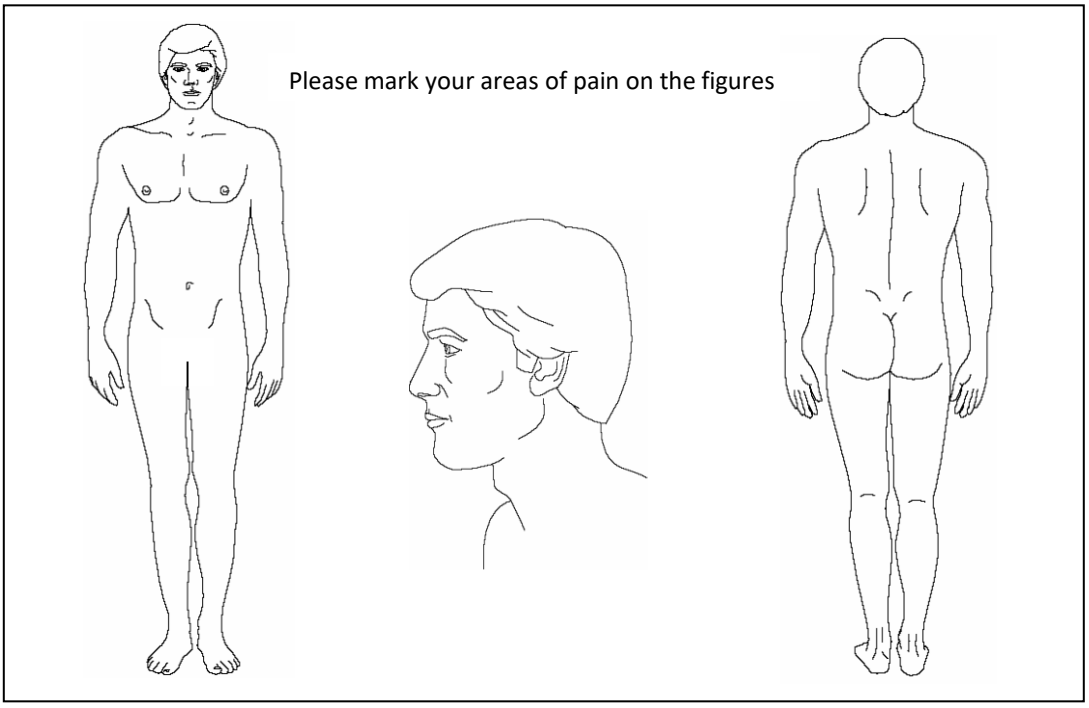
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling

☐ 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_____

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riverwalkfamilychiropractic@hotmail.com

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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 Riverwalk Family Chiropractic's 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

*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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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 Doctor of Chiropractic who now or in the future work at the clinic or officelisted 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 natureand 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

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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		N	Y	F		N	Y	F	
☐	☐	☐	AIDS/HIV	☐	☐	☐	Dizziness	☐	☐	☐	Osteoporosis
☐	☐	☐	Alcoholism	☐	☐	☐	Emphysema	☐	☐	☐	Pacemaker
☐	☐	☐	Allergies	☐	☐	☐	Epilepsy	☐	☐	☐	Painful Urination
☐	☐	☐	Anemia	☐	☐	☐	Excessive Hunger	☐	☐	☐	Painful Menstruation
☐	☐	☐	Appendicitis	☐	☐	☐	Fibromyalgia	☐	☐	☐	Pain over Stomach
☐	☐	☐	Arthritis	☐	☐	☐	Fractures	☐	☐	☐	Parkinson's Disease
☐	☐	☐	Asthma	☐	☐	☐	Frequent Urination	☐	☐	☐	Pinched Nerve
☐	☐	☐	Backache	☐	☐	☐	Gallbladder Trouble	☐	☐	☐	Pneumonia
☐	☐	☐	Bed wetting	☐	☐	☐	Glaucoma	☐	☐	☐	Poor appetite
☐	☐	☐	Belching or Gas	☐	☐	☐	Goiter	☐	☐	☐	Liver trouble
☐	☐	☐	Bleeding Disorders	☐	☐	☐	Gonorrhea	☐	☐	☐	Prostate Problem
☐	☐	☐	Bloated Abdomen	☐	☐	☐	Gout	☐	☐	☐	Prosthesis
☐	☐	☐	Blood Clots	☐	☐	☐	Heart Disease	☐	☐	☐	Psychiatric care
☐	☐	☐	Blood in Urine	☐	☐	☐	Hemorrhoids	☐	☐	☐	Rheumatoid Arthritis
☐	☐	☐	Breast Lump	☐	☐	☐	Hepatitis	☐	☐	☐	Rheumatic fever
☐	☐	☐	Bronchitis	☐	☐	☐	Hernia	☐	☐	☐	Scoliosis
☐	☐	☐	Bruise Easily	☐	☐	☐	Herniated Disk	☐	☐	☐	STI
☐	☐	☐	Bulimia	☐	☐	☐	Herpes	☐	☐	☐	Seizures
☐	☐	☐	Cancer	☐	☐	☐	High Blood Pressure	☐	☐	☐	Sinus Trouble
☐	☐	☐	Cataracts	☐	☐	☐	High Cholesterol	☐	☐	☐	Stroke
☐	☐	☐	Chemical Dependency	☐	☐	☐	Intestinal Worms	☐	☐	☐	Thyroid Problems
☐	☐	☐	Chicken Pox	☐	☐	☐	Jaundice	☐	☐	☐	TMJ
☐	☐	☐	Colitis	☐	☐	☐	Kidney Disease	☐	☐	☐	Tonsilitis
☐	☐	☐	Colon Trouble	☐	☐	☐	Kidney Infection	☐	☐	☐	Tuberculosis
☐	☐	☐	Concussion	☐	☐	☐	Lack of Bladder Control	☐	☐	☐	Tumors Growth
☐	☐	☐	Constipation/Diarrhea	☐	☐	☐	Liver Disease	☐	☐	☐	Ulcers
☐	☐	☐	Depression/Panic Disorder	☐	☐	☐	Menopause	☐	☐	☐	Vaginal Infections
☐	☐	☐	Diabetes	☐	☐	☐	Migraine Headaches	☐	☐	☐	Vomiting
☐	☐	☐	Difficult Digestion	☐	☐	☐	Miscarriage	☐	☐	☐	Whooping Cough
				☐	☐	☐	Mononucleosis	☐	☐	☐	Other_____
				☐	☐	☐	Multiple Sclerosis				
				☐	☐	☐	Nausea				
				☐	☐	☐	Nervousness				
				☐	☐	☐	Neuritis				

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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RFC CANCELLATION POLICY

We will apply a charge to your account of **$50 for chiropractic** appointments and/or **$85 for 1-hour massage** appointments if an appointment is not kept and **24-hour notification** is **NOT** given prior to the appointment.

Twenty four hour notice means to call, or email our office 24 hours prior to your scheduled appointment time. For Monday appointments, notice must be given before close of business at noon the Saturday before the scheduled time.

If you cannot make the appointment and wish to give your scheduled time to a family member or friend that is an existing patient, please call the office to make those arrangements. Under this circumstance, you will not be charged for a missed visit.

If you arrive late to your massage appointment, your appointment will be shortened. Massage therapy sessions start and end to accommodate each client's experience. We have reserved this time for you and need to honor the schedule we have set for all of our clients that day.

If you are more than 15 minutes late without contacting our front desk staff, you will be considered a NO SHOW and your massage will be canceled. The missed appointment fee will be charged in this case.

PATIENT PRINTED NAME:_____

PATIENT SIGNATURE:_____

DATE:_____

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Records Transfer Request

Date: _____

To (Doctor/Hospital): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I hereby authorize the release of my chiropractic 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

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Patient Exam

Date:_____

Patient's Name:_____
Height_____Blood Pressure_____
Weight_____Pulse Rate_____
PATIENT SEATED:
Dynamometer: Rt._____Lt._____

Reflexes: Biceps Rt._____Triceps Rt._____Brachioradialis Rt._____
L_____ Lt._____ Lt._____

Patellar Rt._____ Achilles Rt._____ Pupillary Direct_____
Lt._____ Lt._____ Consensual_____

Cervical Range of Motion:
Flexion_____Restricted_____Normal_____Pain_____
Extension_____ Restricted_____Normal_____Pain_____
Rt. Rotation_____Restricted_____Normal_____Pain_____
Lt. Rotation_____Restricted_____Normal_____Pain_____
Rt. Lat. Flexion__Restricted_____Normal_____Pain_____
Lt. Lat. Flexion__Restricted_____Normal_____Pain_____
Foramina Compression Test: Positive__Negative__RLB and Comp__LLB and Comp____Pain_____
George's Test: Functional Maneuver-Positive_____Negative_____
Bechterew's Test: Positive_____ Negative_____ Pain_____
PATIENT STANDING: Posture Analysis
Posterior Aspect: Head Tilt-Rt._____Lt._____Normal_____
Shoulder Balance- Low Rt._____Low Lt._____ Normal_____
Hip Level- Low Rt._____Low Lt._Normal_____
Lateral Aspect: Kyphosis- Cervical_____Thoracic_____Lumbar_____
Lordosis- Cervical_____Thoracic_____Lumbar_____
Adam's Test (scoliosis check)- Structural_____ Functional_____Negative_____
Gait- Even_____ Irregular_____
Kemp Sign – Left_____ Right_____
Heel Walking (L5)_____ Toe Walking (SI)_____
Lumbar Range of Motion: Flexion - Restricted Normal_____Pain_____
Extension - Restricted Normal_____Pain_____
Lateral Flexion-Rt Restricted Normal_____Pain_____
Lt. Restricted_____ Normal_____Pain_____
Station Test – Positive_____ Negative_____
Romberg Test – Positive_____ Negative_____
PATIENT PRONE: Deerfield Leg Check – Lt. Positive_____Rt. Positive_____
Lt. Negative_____Rt. Negative_____
Cervical Syndrome_____ SAR _____ SAL_____
Ely's Test – Positive_____ Negative_____
Nachlas Test – Positive_____ Negative_____
Muscle Tension & Tenderness – LS_____L_____T_____C_____
PATIENT SUPINE: Soto-Hall Test – Positive_____Negative_____Pain_____
Leg Lowering Test - Positive_____Negative_____
Laseque's Test - Positive_____Negative_____Pain_____
Braggard's Test - Positive Rt._____Negative Rt._____
Positive Lt._____Negative Lt._____
Well Leg Raising Test - Positive_____Negative_____Pain_____
Fajersztajn Test - Positive_____Negative_____
Other Pertinent Test and Findings:_____

Provider Signature:_____

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