14575 Bel-Red Rd, Ste 100, Bellevue, WA 98007
Office: 425.641.8052 Fax: 425.641.8053 Web: BCAspine.com

BCA BELLEVUE CHIROPRACTIC ASSOCIATES

PATIENT HEALTH QUESTIONNAIRE

Name _____ Age _____ Sex _____ Date _____

CHECK ALL BOXES THAT APPLY

Have you or any immediate family member ever been told you have:

	You	Family
Cancer	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Angina/chest Pain	☐	☐
Stroke	☐	☐
Arthritis	☐	☐

Do you have a history of:

- ☐ Shortness of Breath
- ☐ Allergies
- ☐ Asthma
- ☐ Breast Implants
- ☐ Bronchitis
- ☐ Kidney Disease/Stones
- ☐ Polio
- ☐ Emphysema
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Ulcers

Women: are you pregnant? ☐ No ☐ Yes

CHECK ALL BOXES THAT APPLY

What current problem(s) do you experience:

- ☐ Nausea/Vomiting
- ☐ Fever/Chills/Sweats
- ☐ Numbness or Tingling
- ☐ Muscular Weakness
- ☐ Unexplained Weight Change
- ☐ Dizziness
- ☐ Night Pain
- ☐ Headaches
- ☐ Surgery
- ☐ Bowel or Bladder Changes

For this problem have you received treatment from:

- ☐ Orthopedist
- ☐ Physiatrist
- ☐ Neurosurgeon
- ☐ Physical Therapist
- ☐ Massage Therapist
- ☐ Osteopath
- ☐ Acupuncturist
- ☐ Psychologist
- ☐ Other Chiropractor
- ☐ Other _____

Have you had any recent illness, including upper respiratory infections (flu) or urinary tract infections?

☐ No ☐ Yes

Describe: _____

How often do you feel stress is a significant factor in your life?

☐ Never ☐ Seldom ☐ Regularly ☐ Always

Do you Smoke?

☐ No ☐ Yes How many packs? _____

For how long? _____

Do you drink alcohol?

☐ No ☐ Yes # of drinks per week? _____

Do you drink caffeine?

☐ No ☐ Yes # of cups per day? _____

List all medications and supplements:

_____

_____

_____

List regular exercise/activity:

_____

_____

_____

Other comments:

_____

_____

_____

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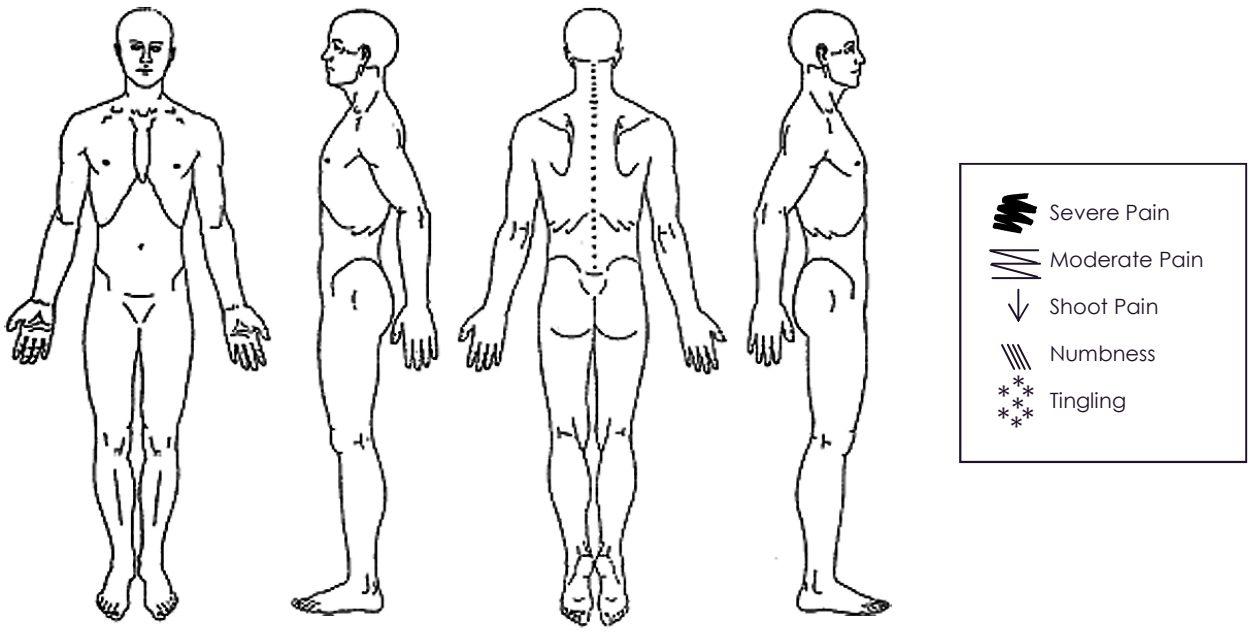
CURRENT ASSESSMENT

Name _____ Weight _____ Height _____ Age _____ Date _____

When did your symptoms begin? _____

Is your condition caused by a specific accident/injury? ☐ No ☐ Yes ☐ Auto ☐ Work
If yes, please explain: _____

Pain Diagram: Mark the site of symptoms on the figures using the key below.



Circle your primary concern, the Intensity, and frequency experienced over the past 2 weeks. If applicable, complete the same for your second concern.

Primary Concern

Head | Neck | Mid Back | Low Back

Extremity (arm/leg) _____

Frequency of Symptoms: Constant | Intermittent

RANGE OF PAIN INTENSITY

0 1 2 3 4 5 6 7 8 9 10

No Pain Extreme Pain

Secondary Concern

Head | Neck | Mid Back | Low Back

Extremity (arm/leg)_____

Frequency of Symptoms: Constant | Intermittent

RANGE OF PAIN INTENSITY

0 1 2 3 4 5 6 7 8 9 10

No Pain Extreme Pain

Patient Initials:

For Office Use
Score: ____ / ____

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FINANCIAL POLICY

APPOINTMENTS: We realize unexpected situations occur. If your schedule does change and you have to cancel your appointment, please call with at least 24 hours notice so that we may offer that time to another person. If you will be late, please call immediately as we may need to reschedule your appointment. We do charge a $38 fee for missed or cancelled appointments without 24 hours notice. This fee cannot be billed to your insurance company. If you miss 3 appointments without proper notice, all future appointments may be cancelled.

Initials: ____

FINANCIAL INFORMATION: You are financially responsible for all charges including but not limited to co-payments, deductibles and non-covered services. As a courtesy to patients we will verify your benefits and review them with you. However, it is always your responsibility to know your insurance benefits prior to treatment to prevent unexpected costs.

Initials: ____

HEALTH INSURANCE: Most health insurance companies require a portion of each visit to be patient responsibility, in the form of a deductible, co-pay and/or co-insurance amount and we ask for this payment at time of service.

Initials: ____

MEDICARE PATIENTS: We will bill Medicare. Medicare will only pay for services that it determines to be "reasonable and necessary". If Medicare denies any services, your secondary insurance will most likely not cover the services. Current Medicare regulations will not reimburse for the following services: exams, physical therapy, massage, x-rays, supports. Although they will usually pay for treatments, they may not pay for every treatment overall, or within a certain time period. Non-covered services will be charged directly to you and you will be responsible for payment. Please see Medicare Waiver.

Initials: ____

CASH PATIENTS: Payment for services is expected at the time of your visit unless other arrangements have been made. If we are not billing insurance, we can offer you a 20% discount when full payment is made at the time of each visit. We accept cash, checks, debit, Visa, and Mastercard.

Initials: ____

WORKERS COMPENSATION PATIENTS: We will bill your workers compensation carrier. An accepted claim pays 100% of treatment charges. If not accepted by workers comp, your health insurance will be billed.

Initials: ____

AUTO ACCIDENT PATIENTS: We will send PIP claims to your auto insurance company. These carriers usually pay 100% of billed charges. If your carrier does not, we will notify you. You will be responsible for unpaid charges. If you were a pedestrian, passenger, or bicyclist injured in an auto accident, we will send claims to the driver's auto insurance first. If you do not have PIP, your health insurance may pay the claims.

Initials: ____

By signing below you hereby authorize your insurance benefits to be paid directly to BCA. You agree to not withhold or delay payment if your insurance company denies payment on any of your charges. In the event it should become necessary to forward your unpaid balance to a collection agency, you agree to pay interest and collection fees. If legal action is taken against this account, you agree to pay all reasonable attorney fees, filing fees and any other costs associated with this action. Checks returned without sufficient funds will be charged a $35.00 fee.

Balances unpaid after 60 days will accrue a 1.5% (18% annually) finance charge each billing cycle. Balances unpaid after 60 days must have payment arrangements with our billing office. Balances unpaid after 90 days will be turned over to collections.

Patient Name	Date
X Signature	Person Responsible for bill (if patient is under 18 years)

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Before beginning treatment it is our office policy to inform you of what to expect, possible complications of chiropractic, as well as complications of other approaches. Remember that all forms of treatment, including non-treatment, have associated risks. If you have any questions please be sure to ask the doctor.

WHAT TO EXPECT:

The treatment at our office will consist of adjustments/manipulation of the joints and soft tissues using hands and/or a mechanical instrument. You may feel joint movements and you may hear joint clicks or other noises. Physical therapy methods along with therapeutic exercise may also be used.

CHIROPRACTIC RISKS:

Chiropractic treatment is one of the safest methods of treating back pain. Nevertheless, unexpected problems can occur. Minor problems such as soreness and stiffness may occur in the beginning of the treatment plan. Slightly more serious problems are local burns from heat generated physical therapy equipment. More significant problems such as fracture of weakened bone, sprains and disc injuries are rare. A stroke temporally linked to neck adjustments is an extremely rare complication. Studies vary, but most show that such an occurrence is less than 1/2,000,000 treatments. Stroke has also been linked to ordinary activities such as hair shampooing or gazing at the stars.

OTHER TREATMENTS AND RISKS:

Medications: Many commonly used medications such as NSAIDs (ex: Advil, Aleve) or Tylenol carry risks of tissue damage including stomach ulcers or kidney/liver damage. This damage can occur quickly and may be irreversible. There is a significant higher risk of developing a serious complication with NSAIDs Pain medications are habit forming and may mask pain allowing further tissue damage.

Surgery: Surgery is the treatment of choice in less than 1% of back pain patients. Your doctor has screened for surgical "red flags" and will refer you for a surgical opinion if indicated. Clinical results of surgery for mechanical back pain have been disappointing and expose you to unnecessary hospital and medication risks.

Rest/Non-treatment: Long periods of rest has been shown to increase the likelihood of recurrence of back episodes and make chronic pain more likely. Likewise, non-treatment may cause permanent mechanical problems to develop, causing future back problems.

Patient Name	Date
Patient or Legal Guardian Signature	Minor Release

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ACKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review this office's NOTICE OF PRIVACY PRACTICES as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations.
- Provide & coordinate treatment among health care providers who may be involved in my care.

(Optional) I authorize the following person(s) to obtain my medical information:

_____

_____

_____

Patient Name	Date
Patient or Legal Guardian Signature	Relationship to Patient

FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Rights due to the following reason:

- ☐ Communication barriers
- ☐ Emergency situation
- ☐ The patient refused to sign
- ☐ Other