ROYBAL CHIROPRACTIC
CONFIDENTIAL PATIENT INFORMATION

Last Name_____ First Name_____ M.I._____ Date_____

Address_____ City_____ Zip Code_____

Home Phone_____ Cell Phone_____

Email_____ DOB_____ Sex: Male/Female

Social Security_____ Martial Status: S/ M/ D/ W Spouse Name:_____

Do You Have Children? Y/ N If Yes, List Names & Ages_____

_____

Occupation_____ Employer_____

Employer Addresss/Phone_____

Hours Worked Per Week_____ Supervisor_____

Emergency Contact #1_____ Phone Number_____

Emergency Contact #2_____ Phone Number_____

Primary Care Physician_____ Phone Number_____

Sleep Position_____ Type of Pillow_____

Daily Water Intake_____ Vitamins Taken_____

Who may we thank for referring you to our office_____

Insurance Information

Work Injury Y/ N Motor Vehicle Collision Y/ N

Primary Insurance (to be billed)_____

Secondary Insurance (if applicable)_____

Payment Policy

The payment policy of Roybal Chiropractic, P.S., is that all co-pays and payments are due and payable at the time of service. I acknowledge and understand that this is the payment policy of Roybal Chiropractic, P.S. I understand that if my insurance (including Personal Injury and Labor & Industry Claims) does not respond within 60 days or fails to pay for services rendered, I am responsible for any and all remaining balances on my account.

Patient Signature_____ Date_____

Legal Gaurdian (if under 18)_____ Date_____

Witness _____ Date_____

Roybal Chiropractic
Mario Roybal, D.C.

1203 W. Francis Avenue
Spokane, WA 99205
509.328.7575
Fax 509.328.5031
www.roybalchiro.com

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____

Roybal Chiropractic, P.S.
Patient Name:_____
Date of Injury:_____

Health Information Form
Date:_____
Insurance ID#_____

Have you had any recent injuries or illnesses?

_____
_____
_____

Have you had any surgeries?

_____
_____
_____

* Do you have or suffer from any of the following?

Allergies	( )	Lupus	( )
Arthritis	( )	Numbness	( )
Asthma	( )	Osteoarthritis	( )
Blood Clots	( )	Osteoporosis	( )
Broken Bones	( )	Scoliosis	( )
Depression	( )	Spasms	( )
Diabetes	( )	Tingling	( )
Disk Problems	( )	Varicose Veins	( )
Headaches	( )	GI Problems	( )
High/Low BP	( )	Pancreatitis	( )
Jaw pain	( )	Epilepsy/Seizures	( )

Current Health Information

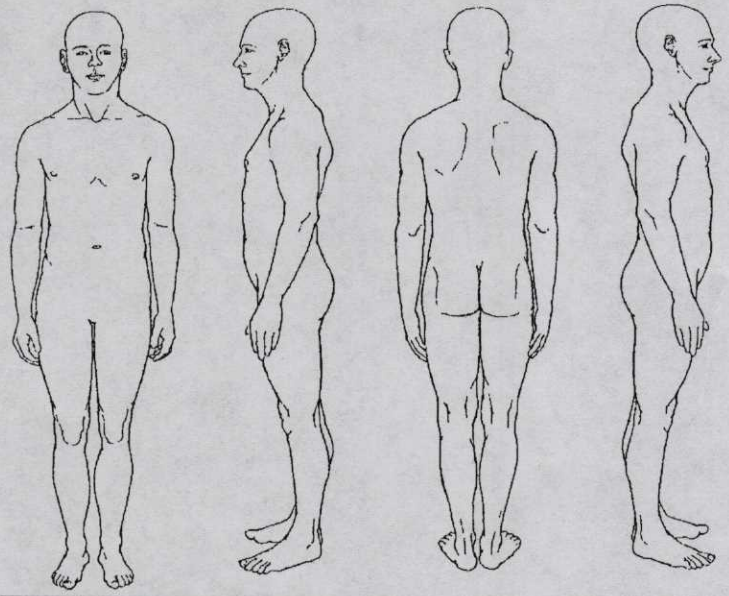
Are you pregnant?_____
Date of last menstrual period?_____
Do you wear contacts?_____
Do you smoke?_____
Do you drink coffee or soda?_____
If so, how much?_____
Have you ever had a massage before?_____
Have you had any type of cancer?_____
Are you allergic to any medication?_____
Are you taking any medication_____
Other symptoms than those above?_____

* Does anyone in your family suffer from any conditions listed above? If so, please explain. _____
_____
_____

Draw today's symptoms on the figures.

1. Identify CURRENT symptomatic areas in your body by making letters on the figures below. (Use the letters provided in the key to identify the symptoms you are feeling today.)
2. Circle the area around each letter, representing the size and shape of each symptom location.

Key
P= pain or tenderness
S= joint or muscle stiffness
N= Numbness or tingling



"Revised" Oswestry Disability Index

Section 1 – Pain Intensity

- ❑ The pain comes and goes and is very mild
- ❑ The pain is mild and does not vary much
- ❑ The pain is comes and goes and is moderate
- ❑ The pain is moderate and does not vary much
- ❑ The pain comes and goes and is severe
- ❑ The pain is severe and does not vary much

Section 2 – Personal Care (washing, dressing, etc.)

- ❑ I would not have to change my way of washing or dressing in order to avoid pain
- ❑ I do not normally change my way of washing or dressing even though it causes some pain
- ❑ Washing and dressing increases the pain, but I manage not to change my way of dressing
- ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it
- ❑ Because of the pain, I am unable to do some washing and dressing without help
- ❑ Because of the pain, I am unable to do any washing or dressing without help

Section 3 - Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it causes extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than1/2 of a mile.
- ❑ Pain prevents me walking more than 1/4 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like without pain
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

Section 6 – Standing

- ❑ I can stand as long as I want without extra pain.
- ❑ I have some pain while standing, but it does not increase with time
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ an hour.
- ❑ I cannot stand for longer than ten minutes without increasing pain.
- ❑ I avoid standing because it increases the pain straight away

Section 7 – Sleeping

- ❑ I get no pain in bed.
- ❑ I get pain in bed, but it does not prevent me from sleeping well
- ❑ Because of pain, my normal night's sleep is reduced by less than one-quarter
- ❑ Because of pain, my normal night's sleep is reduced by less than one-half
- ❑ Because of pain, my normal night's sleep is reduced by less than three-quarters
- ❑ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limitingmy more energetic interests, i.e. sports, dancing.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have hardly any social life because of pain.

Section 9 – Traveling

- ❑ I get no pain while traveling.
- ❑ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done by lying down.

Section 10 – Changing Degree of pain

- ❑ My pain is rapidly getting better
- ❑ My pain fluctuates, but overall is definitely getting better.
- ❑ My pain seems to be getting better, but improvement is slow at present.
- ❑ My pain is neither getting better nor worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

Roybal Chiropractic, P.S.

Informed Consent

I, _____, patient, hereby request and consent to the performance of chiropractic spinal adjustments and other chiropractic procedures by Mario D. Roybal, B.S., D.C.

The following points have been explained to me, to my satisfaction, and I have had the opportunity to discuss them with the doctors of chiropractic.

1. Chiropractic care is the science, philosophy and art of locating and correcting spinal sublaxation (misalignments) and as such, is oriented toward improvement of spinal function, relative range-of-motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptoms, disease of condition, as a result of treatment in this clinic.
2. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click".
3. It is my intention to rely on the doctor to exercise professional judgment during thr course of any procedures, which he/she feels at the time to be in my best interest.
4. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related to the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.
5. It is not reasonable to expect the doctor to be able to anticipate, or explain, all possible risks and complications of a given procedure on any particular visit.
6. And undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment.
7. As with any health care professionals, there are certain complications which may arise during a chiropractic adjustment. Those complications include strain/sprains, dislocations, fractures, disc injuries, CVS's (cerebral-vascular accidents), or strokes. These complications are rare occurrences.
8. We acknowledge the new HIPPAA laws and must have your permission to release any medical information.

In certain instances, additional information or precautions may be necessary for Chiropractic or Massage care. Please inform the doctor if you have any of the following conditions:

Active Cancer	Cardiac Problems	Use of Contacts
Severe Injuries	Chronic Illness	Recent Surgery
Arthritis	Phlebitis	Bursitis
High-Risk Pregnancies		

****Massage Clients****

A massage provides pain and tension relief by stretching and working the muscles. Please remove whatever clothing you feel comfortable removing or wear loose fitting clothing and lay face down under the cover. You are covered at all times with a sheet except for the area being worked on. There is relaxing music that you can choose from to listen to during your massage.

****A $25 FEE WILL BE REQUIRED FOR MISSED MASSAGE THERAPY APPOINTMENTS IF WE ARE NOT NOTIFIED 24 HOURS IN ADVANCE OF THE CANCELLATION.**

After an adjustment or massage you may feel achy, experience a sore throat or other flu like symptoms. It is important to drink plenty of water before and after to help eliminate the above symptoms.

I have read the above consent, or had it read to me, have had the opportunity to ask questions and receive answers and I am comfortable with the information provided. I hereby request and consent to the performance of massage, chiropractic adjustments and other chiropractic procedures, including various modes of therapy and diagnostic x-rays, on me (or on _____, patient for whom I am legally responsible) by Dr Mario Roybal, B.S., D.C.; Dr Burk Thomas, D.C.; Brandy Schlegel LLC, LMP; Rachelle Jameson LMP; Wendy Marshall LMP.

_____	_____
Print Patient Name	Print Parent/Legal Guardian Name
_____	_____
Signature of Patient or Parent/Guardian	Date signed
_____	_____
Witness	Date signed

HIPPA Privacy Practice Notice

The undersigned acknowledges that they have had an opportunity to view and/or receive a copy of the Provider's Notice of Privacy Practice pursuant to HIPPA and consents to the use of their health information that is consistent with HIPPA and State and Federal Law.

Patient Signature: _____ Date: _____

NOTICE OF RELEASE OF INFORMATION

I, _____ AUTHORIZE Roybal Chiropractic to discuss and/or release my health care information to the following people. (Please include names of spouses, parents, power of attorney's, etc.)

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

Patient Signature: _____ Date: _____

Roybal Chiropractic, PS

Mario D. Roybal, DC
1203 W Francis Avenue, Spokane, WA 99205

Notice of Non-Covered Services:

As your physician, I want to provide you with the best care possible. There are services that I feel are necessary for the treatment of your condition and maintenance of good health that may not be covered by your insurance health benefits contract. You are expected to pay for those services in full. Let me reassure you that I will order only the tests and treatments that I feel are necessary for your treatment and care. If you have any questions about whether or not a particular service is covered by your health benefits contract, you can call your insurance plan or someone in our office will be happy to assist you if it is something they can answer. Thank you for your understanding.

Notice of Professional Fees:

Professional services at Roybal Chiropractic are consistent with the usual and customary healthcare practices, and actual services applied are specific to each case and health care needs. The services are described using standard universally accepted insurance language, and with fees set according to usual and customary rates. Because of the possibility that insurance may deny coverage for care rendered, or benefits may not fully cover services required in your care, we recommend that you look at our fees:

New Patient Exam/Evaluation & Management Services.....	$84.50 - 240.00
Established Patient Exam/Evaluation Management Services....	$20.00 – 165.00
Chiropractic adjustment/manipulations.....	$25.00 – 53.00
Extraspinal/joint manipulations.....	$20.00 – 30.00
Radiology professional interpretation....	$15.00
MRI Professional review.....	$50.00
Manual Therapy procedures...	$20.00 – 45.00 per base time unit
Therapeutic exercise procedures.....	$20.00 – 50.00 per base time unit
Neuromuscular reeducation procedures.....	$40.00 – 55.00 per base time unit
Mechanical traction.....	$35.00 per base time unit
Massage Therapy.....	$50.00 – 66.00 per hour
Wellness.....	$37.00 – 50.00 per unit

Notice of Payment and Billing Policies:

Our office policy is that we DO NOT routinely send out billing statements or carry balances on your account. Payment is due at the time of service.

I understand the disclosures and agree to the policies as set forth above.

Signature Printed name Date