NW Injury & Rehab Center P.S.
CHIROPRACTIC | MASSAGE THERAPY | AUTO INJURY REHAB

NW Injury & Rehab Center P.S.
9618 NE Fourth Plain Blvd
Vancouver, WA 98662
Phone: 360-573-1933
Fax: 360-571-0143

PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Patient Name:				Married or Single Status:	*Single Married Divorced Other*
Date of Birth:		Age:		Spouse Name:	
Gender:	*M / F* *Height:*		*Weight:*	Spouse DOB:	
Referral Source:	*How did you hear about us?*				
Reason for Visit:					

CONTACT INFORMATION					
ADDRESS:					
City/State/Zip:					
Cell Phone:		Cell Carrier:		Work Phone:	
Email:				Home Phone:	
Emergency Contact:		Relationship:		Phone:	
	Check here if you authorize us to contact you via TEXT (SMS) message. We have found that text is a preferred method of contact for our patients.				

EMPLOYER INFORMATION					
Employer/School Name:					
Phone:					
Address:					
Occupational Title:					
Work Hours:	*Per: Day Week Month*	_____	% Time Sit	_____	% Time Stand

PAST HEALTH HISTORY			
DATE OF LAST:		Physical Exam:	
Chiropractic Visit:		Spinal X-Ray:	
Chest X-Ray:		MRI/CT Scan:	
Blood Test:		Urine Test:	

Injuries/Surgeries you have had:	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

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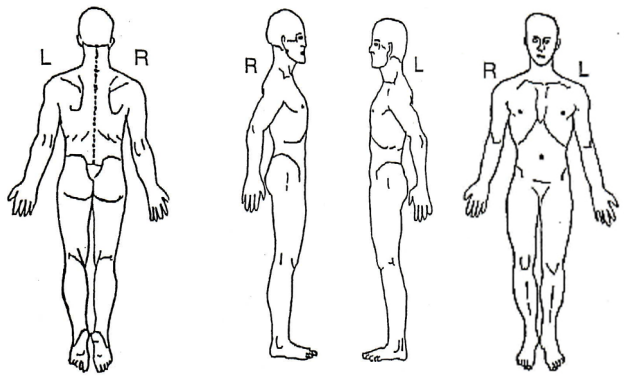
PATIENT REGISTRATION FORM

CURRENT SYMPTOM INFORMATION

Please mark with "X" location of your symptoms



Current Symptoms related to:	*AUTO* *WORK* *HOME* *OTHER*
Please describe:	
Symptoms began within:	*Days* *Weeks* *Months* *Years*
Symptoms are:	*Worsening* *Same* *Improving*
Frequency of symptoms:	*Constant* *Intermittent* *Frequent* *Occasional* *Infreque*
Symptoms worse:	*Morning* *Afternoon* *Evening*

Severity: 0-10 PAIN SCALE:	*No Pain* *0* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *Severe Pain*
QUALITY of PAIN:	*Sharp* *Shooting* *Dull* *Ache* *Stabbing* *Burning* *Stiff* *Numbness* *Tingling* *Cramps* *Other:*
Pain Radiates To:	*Head* *L / R Arm* *L / R Leg* *L /R Hand* *L / R Foot* *Groin* *Other:*
Symptoms Alleviated By:	*Rest* *Meds* *Ice* *Heat* *Massage* *Nothing Helps* *Other:*
Symptoms Aggravated By:	*Sitting* *Standing* *Walking* *Bending* *Lifting* *Other:*
Symptoms Interfere With:	*Work* *Sleep* *Daily Routine* *Recreation* *Other:*

HEALTH GOALS/EXPECTATIONS

DOCTOR NOTES

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PATIENT REGISTRATION FORM

TREATMENT HISTORY FOR CURRENT CONDITION					
	HELPED	*LITTLE HELP*	*NO HELP*	*PROCEDURE RECEIVED*	*NAME, PHONE*
Chiropractic:					
Physical Therapy:					
Primary Doctor:					
Meds:					
Surgery:					
Other:					

Place a mark on "Yes" or "No" to indicate if you have or ever had any of the following:																				
AIDS/HIV		Yes		No	***Bronchitis***		Yes		No	***Heart Disease***		Yes		No	***Pinched Nerve***		Yes		No
Alcoholism		Yes		No	***Cancer***		Yes		No	***Hepatitis***		Yes		No	***Prostate Prob.***		Yes		No
Allergy Shots		Yes		No	***Cataracts***		Yes		No	***Hernia***		Yes		No	***Rheumatoid Art***		Yes		No
Anemia		Yes		No	***Chemical Depend.***		Yes		No	***Herniated Disk***		Yes		No	***Stroke***		Yes		No
Anorexia		Yes		No	***Diabetes***		Yes		No	***High Cholesterol***		Yes		No	***Thyroid Prob.***		Yes		No
Appendicitis		Yes		No	***Epilepsy***		Yes		No	***Kidney Disease***		Yes		No	***Tonsillitis***		Yes		No
Arthritis		Yes		No	***Fractures***		Yes		No	***Liver Disease***		Yes		No	***Tumor, Growth***		Yes		No
Asthma		Yes		No	***Glaucoma***		Yes		No	***Migraine Headaches***		Yes		No	***Ulcers***		Yes		No
Bleeding Disorders		Yes		No	***Goiter***		Yes		No	***Multiple Sclerosis***		Yes		No	***Psychiatric Care***		Yes		No
Breast Lump		Yes		No	***Gout***		Yes		No	***Osteoporosis***		Yes		No	***Other:***				

FAMILY, SOCIAL, HABITS INFORMATION														
Exercise:	*None*	*Moderate*	*Daily*	*Heavy*	*Other*									
Nutritional Habits:	*Very Good*	*Good*	*Average*	*Poor*	*Very Poor*									
Supplements:														
Stress Level:	*Very High*	*High*	*Moderate*	*Low*	*None*									
Allergies:														
Medications:														
H_2O:		*Oz/Day:_____*	SMOKE:		*Packs/Day:___*	ALCOHOL:		*Drinks/Week:____*	COFFEE:		*Cups/Day:____*			

NW Injury
& Rehab Center P.S.

Informed Consent for Examination and Treatment

I (we) herby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, licensed physical therapists, chiropractic assistants, and/or licensed massage therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures, massage therapy and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risk and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care, massage therapy and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.
Date of last menstrual period: _____

_____ _____
Patient's Name (*Print*) Patient's Signature

_____ _____
Date Relationship or authority if not signed by patient

_____
Witness

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Birthdate:_____

Signature:_____ Date:_____