Anik J. St. Martin, DC, D.A.C.C.P.
Darin J. Shook, DC
Craig Werner, DC
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Advantage
CHIROPRACTIC & MASSAGE

1312 Vandercook Way • Longview, WA 98632 • 360.425.6620 • Fax 360.425.1277
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Matt Grimm, LMP

PREGNANCY INTAKE FORM

Name: _____ Birth Date: _____ Age: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Email: _____

Social Security # _____ Referral/How did you hear about us? _____

IF THE PATIENT IS A MINOR COMPLETE THIS SECTION

Lives with: ☐ Both Parents ☐ Mother ☐ Father Names and Ages of Siblings: _____

Mother's Name: _____ Email Address: _____

Address: _____ City: _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Type of Work: _____

Business Phone: _____ Business Address: _____

Father's Name: _____ Email Address: _____

Address: _____ City: _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Type of Work: _____

Business Phone: _____ Business Address: _____

IF THE PATIENT IS 18 YEARS OF AGE OR OVER COMPLETE THIS SECTION

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Names and Ages of Children: _____

Have you ever had a different name, maiden name? Please list: _____

Business Employer: _____ Type of Work: _____

Business Phone: _____ Business Address: _____

Name of Spouse: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Spouse's Employer: _____ Type of Work: _____

Business Phone: _____ Business Address: _____

THIS SECTION IS REQUIRED BY ALL

Person to Call if Unable to Reach You: _____

Phone # _____ Relationship: _____

Address: _____ City: _____ State _____ Zip _____

Authorized Person to Discuss any Account/Health Information: _____

Phone # _____ Relationship: _____

Address: _____ City: _____ State _____ Zip _____

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PERSONAL HEALTH INSURANCE

☐ I **do not** have personal health insurance. In the absence of insurance, any non-covered charges become patient responsibility.

Health Insurance Company _____

Billing Address _____

Phone _____ ID # _____ Group # _____

Policy Holder's Name: _____ DOB: _____

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____

Have you previously received Chiropractic care? ☐ Yes ☐ No Provider : _____

Other Doctors Seen For This Condition: ☐ Yes ☐ No Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? ☐ Yes ☐ No

PAST HEALTH CONDITION

Previous illnesses you've had in your life: _____

_____

Have you ever broken any bones? Which? _____

Previous Injury or Trauma: _____

_____

Medications and reasons for taking them?: _____

_____

Surgeries: Date and type of surgery?_____

_____

Allergies: _____

Family Health History: Associated health problems of relatives:

_____

_____

Deaths in immediate family: Cause of parents or siblings death and age of death Age at death

_____

_____

Females/ Pregnancies and outcomes: Pregnancies/Date of Delivery/Outcome/Miscarriages

_____

_____

Patient's Name: _____ DOB: _____ Date: _____

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Social and Occupational History:

Job description: _____

_____

_____

Work schedule: _____

_____

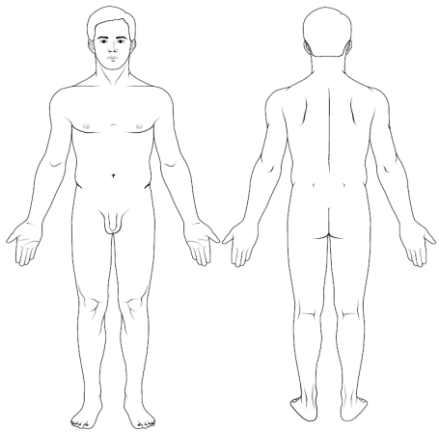
Recreational activities: _____

_____

_____

Alcohol use: ☐ **Yes** ☐ **No** **Frequency**_____

Tobacco use: ☐ **Yes** ☐ **No** **Frequency**_____



Please outline on the diagram the area of problem

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Fatigue
- ☐ Allergies
- ☐ Headache
- ☐ Loss of sleep
- ☐ Fever

MUSCLE / JOINT / BONE
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Arm pain/numbness/weak
- ☐ Leg pain/numbness/weak
- ☐ Joint pain / Stiffness
- ☐ Walking problems
- ☐ Jaw pain

GENITO-URINARY
- ☐ Blood/discolor in urine
- ☐ Lack of bladder control
- ☐ Painful urination

NERVOUS SYSTEM
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

CARDIO-VASC-RESP
- ☐ Chest pain
- ☐ Blood pressure problems
- ☐ Irregular heart beat
- ☐ Shortness of breath
- ☐ Stroke
- ☐ Blood clots
- ☐ Swelling of ankles

GASTROINTESTINAL
- ☐ Appetite poor / excessive
- ☐ Gas/Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Weight trouble
- ☐ Excessive thirst
- ☐ Indigestion / Heartburn
- ☐ Nausea
- ☐ Stomach pain
- ☐ Vomiting

EYE, EAR, NOSE, THROAT
- ☐ Vision problems
- ☐ Dental problems
- ☐ Hearing difficulty
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sore throat

SKIN
- ☐ Bruise easily
- ☐ Rash

MEN only
- ☐ Lump in testicles
- ☐ Other:

WOMEN only
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Menstrual irregularity
- ☐ Other:

Date of last Menstrual period_____

CONDITIONS Check (✓) conditions you currently have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Gall bladder problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Chemical Dependency
- ☐ Prostate Problem
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Other_____

Patient's Name: _____ DOB: _____ Date: _____

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Pregnant Mother's Intake Form

Prenatal History:

1) Is this your first pregnancy? _____
2) How many births have you had? _____
3) How many weeks pregnant are you now? _____
4) Have you experienced any traumas (accidents, falls during this pregnancy)? _____
   Please describe: _____
5) Are you taking any medications during this pregnancy? _____
6) Do you smoke or drink alcohol? ☐ Yes _____ ☐ No
7) Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? _____
8) Please list dates, frequency and reason for these procedures:
   _____
9) How has your diet been during this pregnancy? ☐ Good ☐ Fair ☐ Poor
   Please Describe: _____
10) Have there been any stressful events in your life during this pregnancy? ☐ Yes ☐ No
    _____
11) What are your most significant fears associated with this birth?
    _____
12) Who is your birth care provider/midwife/doula/OB? _____
13) Will you have someone with you at birth for support (other than birth care provider)? _____
14) Please specify who: _____
15) Where do you plan on delivering? _____
16) Have you put together a birth plan? ☐ Yes ☐ No

Patient's Name: _____ DOB: _____ Date: _____

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Previous Birth History

1) **Place of birth**: Hospital, Birthing Center, Home
2) **Delivering Practitioner**:
   ☐ OB/GYN ☐ Certified Nurse Midwife ☐ Certified Practicing Midwife ☐ Lay Midwife
3) **Position of Delivery**: ☐ Lithotomy position (on back with feet up) ☐ On your side ☐ Kneeling ☐ Squatting ☐ Other? _____
4) **Was labor induced?** (Contractions were stimulated prior to the natural onset of labor?) ☐ Yes ☐ No
   If yes, specify type: ☐ Pitocin ☐ Prostagland Gel (applied to your cervix)
5) **Were your membranes ruptured by your care provider?** ☐ Yes ☐ No ☐ Unknown
6) **Were contractions stimulated intravenously with pitocin once labor started?** ☐ Yes ☐ No ☐ Unknown
7) **Did you receive any pain Medications or anesthesia?** ☐ Yes ☐ No ☐ Unknown
   If yes, please specify: _____
   If you had an epidural, how many centimeters were you dilated when it was administered? _____
8) **Did you experience back pain during labor?** ☐ Yes ☐ No
9) **Did you deliver vaginally?** ☐ Yes ☐ No
10) **Baby presentation at time of delivery**: ☐ Normal ☐ Posterior ☐ Brow ☐ Fascial ☐ Breech
    If breech, specify type: ☐ Footling ☐ Frank ☐ Complete ☐ Kneeling
    Was there any visible injury to your baby? ☐ Yes ☐ No ☐ Unknown
    If so, where on your baby was the injury sustained? _____
11) **Did your care provider assist delivery with his/her hands?** ☐ Yes ☐ No ☐ Unknown
    Was there any turning of the neck, or traction (pulling) applied to the neck? ☐ Yes ☐ No ☐ Unknown
12) **Were operative devices used to facilitate the birth?** ☐ Yes ☐ No ☐ Unknown
    If yes, please specify: ☐ Forceps ☐ Vacuum Extraction
    If yes, were there any visible signs of injury to your baby? ☐ Yes ☐ No ☐ Unknown
    If yes, where was the injury sustained? _____
13) **Was there a birthing coach present?** ☐ Husband ☐ Doula ☐ Friend ☐ Other
    If other, please specify? _____
14) **At what week of pregnancy was your baby born?** _____

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THINK, MOVE, NUTRITION

The way you move, how you think, and how you eat, affect the overall function of your nervous system. According to research, the potential side effects of chiropractic care are: increased perception of life options and hope, positive changes in emotional states, increased levels of well-being, and improvement of conditions unrelated to pain.

Your answers to the following questions are very relevant to your overall health and will help you reach your goals.

On a percentage scale, how would you rate your overall health? _____ %
On a percentage scale, what is your goal for overall health? _____ %

How do you think?
On percentage scale, how happy are you? _____ %
On a percentage scale, how would you rate the quality of your relationships? _____ %
How would you rate your stress levels in relation to work (Circle One)? Mild Moderate Severe
How would you rate your stress levels in relation to home life (Circle One)? Mild Moderate Severe
Do you have other sources of stress? _____
Do you take anti-depressant or anti-anxiety medications? Yes No Medication _____
How many hours of sleep to you get on average per night? _____
Do you take medications to help you sleep? Yes No Medication _____

How well do you move?
How many days per week do you exercise? _____
What type of exercise and how long for one session? _____
What do you do for fun? _____
When was the last time you enjoyed your favorite activity? _____
What would you like to do for fun that you are not presently doing? _____
How many hours per day do you sit? _____
How many hours per day do you spend in front of a screen (Computer, TV or Games)? _____
Do you have a personal fitness goal? _____

How well do you eat?
Fruits (amount per day)_____
Vegetables (amount per day)_____
How many days per week do you eat breakfast? _____
What is a sample breakfast for you? _____
How many days per week do you eat lunch? _____
What is your average lunch? _____
How many days per week do you eat dinner? _____
What is your average dinner? _____
How many times per week do you eat with family/friends? _____

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OFFICE POLICIES

Please be on time for your appointment. Being late or last minute cancellations cause severe scheduling disruptions, which can interfere with the quality of care you and other patients receive.

Please DO NOT wear strong perfumes or colognes. We see many patients with allergies and respiratory problems, strong scents can impair their progress.

Continued cancellations or missed appointments may result in being released from care.

Please silence cell phones or leave them in your car.

Children are welcome here as patients and guests. If you bring children with you for your appointment, you are responsible for their actions at all times.

For your children's safety they may not play with the exercise equipment, adjusting tables or window blinds.

Food is not allowed in the office due to food allergies of other patients, especially children.

Please notify the Doctor of **any changes in your health status**, regardless of the significance.

Signature of Responsible Party: _____ Date: _____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is very important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

I have read and was supplied a copy of the **HIPPA guidelines. I have read and fully understand the above Informed Consent and hereby grant permission to receive chiropractic care.**

Signature of Responsible Party: _____ Date: _____

Consent to Evaluate and Adjust a Minor Child

I, _____ being a parent or legal guardian of _____ have read and
(Parent or Legal Guardian) (child)
fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Signature of Responsible Party: _____ Date: _____

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FINANCIAL POLICIES

Payment is expected at the time of service.

We accept the following forms of payment; Cash, Personal Checks, Debit Cards, Visa and MasterCard.

No balance policy: Any patient responsibility is expected at the time of service. Balances after insurance payments and any non-covered charges by insurance are due upon receipt of your statement.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Late Fee: A late fee of $10.00 will be imposed on each account that is over thirty (30) days past-due. All balances will accrue a $10.00 late charge every billing cycle.

Returned checks: There is a $25.00 fee for any checks returned by the bank.

Massage no show/late cancellation fee: If you do not show up for an appointment, or cancel with less than 24 hours' notice, a $10.00 fee will be charged. This late no show /cancellation fee goes directly to our massage therapists for compensation of time loss.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. All delinquent accounts bear interest at the legal rate. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Cowlitz County, Washington.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Insurance Billing: If we are contracted with your insurance company, we must follow our contract and their requirements.

Copays are due at the time of service. It is the insurance company that makes the final determination of your eligibility.
We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.
If you have any visit limit or dollar maximum it is your responsibility to keep track of this and be aware of your benefits.
Insurance coverage is never a guarantee of payment. If there are any problems between the insurance company and the patient, the patient would need to file a grievance directly with the insurance company. Your signature below indicates assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.

Your insurance company determines benefits when they receive our claims. Any statement made by our staff regarding your coverage is in no way a guarantee of payment for your services. I acknowledge that I am responsible for payment of all non-covered services.

Non-Contracted Insurance Billing: If you see a non-contracted (out of network) provider your insurance company may send you a check. You will need to sign the check and return it to our office for services rendered. I acknowledge that I am responsible for payment of all non-covered services.

Medicare: Medicare does not cover the following services at a Chiropractic office: Massage, Exams, Re-exams, X-Rays, Therapeutic exercises, Durable medical equipment or Supplements. We expect payment for any non-covered Medicare service at the time of your visit. If you have a copay with your supplemental insurance, it is to be paid at the time of your visit.

Workers Compensation: We require approval/authorization by your employer and/or worker's compensation carrier. If your claim is denied, you will be responsible for payment in full.
In addition to this verification, we require that you allow us to bill your health insurance if your claim is denied. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney and/or insurance company. In addition to this verification, we require that you allow us to bill your health insurance if your claim is denied or you exceed your benefits. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

By signing below, I acknowledge that I understand the policies contained herein.

Print Patient's Name: ________

Print Responsible Party's Name (if not the patient): _____

Signature of Responsible Party: _____ Date _____