Zindt Chiropractic Center • 3819 South M Street • Tacoma, WA 98418

Patient Information

Name: _____ DOB: _____/_____/_____

Gender: ☐ Male ☐ Female Preferred Name: _____

How did you hear about us? _____

SSN: _____-_____-_____ Email: _____

Address: _____

Cell Phone #: _____ Home Phone #: _____

Do you want text reminders? ☐ Yes ☐ No If so, who is your cell provider? _____

Are you... ☐ Employed ☐ Unemployed ☐ Student ☐ Retired

Employer/School: _____

Occupation/Study: _____ City, State: _____

Emergency Contact Information

Name: _____ Relation to patient: _____

Cell Phone #: _____ Home Phone #: _____

Insurance Information

Insurance Company: _____ Subscriber ID: _____

Primary Policy Holder: _____ Group #: _____

Payment Method for all services not paid by a third party: ☐ Credit/Debit ☐ Check

My Authorization

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

Patient/Guardian Signature: _____ Date: _____/_____/_____

My Financial Responsibility

I certify that the above information is correct. I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

Patient/Guardian Signature: _____ Date: _____/_____/_____

Patient Name: _____

My Certification

I certify that the above information is correct to the best of my knowledge, and I willingly request services from Zindt Chiropractic Center. I consent to the treatment of spinal manipulation and any other treatments I may receive at Zindt Chiropractic Center. I agree to keep any future appointments I may make. For any **missed appointment or appointment cancelled with less than 24 hours' notice,** I understand there will be a **$25 charge** to my account and a $50 charge for a missed Re-Exam.

Patient/Guardian Signature: _____ Date: _____/_____/_____

My Privacy

I understand that I have certain rights to privacy regarding my protected heath information. I understand that this information can and will be used to conduct, plan, and direct my treatment, follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment, obtain payment from third party payers, and conduct normal healthcare operations such as assessments and accreditation. It is my understanding that my information will not be given out or sold to any third party entity. If it is my wish to release any information that the provider may need or that I may want released to another provider, I will need to sign a records release form.

Patient/Guardian Signature: _____ Date: _____/_____/_____

Informed Consent

Please read this entire statement before signing. It is important the you understand the information that is being presented to you. The primary treatment of chiropractic care is spinal manipulative therapy. The provider will use these techniques to treat you today and any future appointments you may have. The provider may use hands or mechanical instruments upon your body in such a way as to move your joints. This action may cause an audible "pop" or "click" sound similar to the sound you hear upon "cracking" your knuckles. You may also feel a sense of movement within your joints.

As part of the analysis, examination, and treatment you are consenting to the following procedures: spinal manipulation, palpation, vital signs, range of motion testing, postural analysis, hot/cold therapy, and basic neurological testing. As with any healthcare procedure there are certain complications which may arise during the chiropractic treatment. These complications include but are not limited to: fracture, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, and separations. Some patients will feel some stiffness and soreness following the first few days of treatment. The provider will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to the provider's attention, it is your responsibility to inform the provider to receive the appropriate care suited for you.

I have read and discussed it with the doctor at Zindt Chiropractic Center and have had my questions answered to my satisfaction. I will not hold my doctor or any staff member at Zindt Chiropractic Center responsible for any errors or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended to me by the doctor. Having been informed of the risks, I hereby give my consent to that treatment.

Patient/Guardian Signature: _____ Date: _____/_____/_____

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Financial Agreement: Health Insurance

Patient Name: _____

Provider Name: Sarah L. Zindt, D.C.

Welcome to Zindt Chiropractic Center! Our team aims to provide you with the very best care available for your condition and to clearly communicate our billing practices. Please carefully read the following policies to familiarize yourself with how your medical billing will be handled.

Explanation of Insurance Coverage

Most insurance policies cover chiropractic care, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles as well as any unpaid balances. We will do our best to verify your insurance coverage and bill your insurance company in a timely manner. Your insurance company will send their payments directly to this office.

Payment Arrangements

We are contractually obligated to take deductible payments and insurance co-payments at the time of service. If you are unable to pay, please speak with our office manager about alternative payment arrangements.

Release of Information

If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

Voluntary Termination of Care

It is our policy that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be due immediately.

Once again, we welcome you to our office! If at any time you have questions about your payment arrangements or about your care in this office, please do not hesitate to ask. Your signature below indicates that you have read and agree to the above statements.

Patient Signature: _____ Date: _____/_____/_____

Insurance Allowable Rates

Insurance	99202	98940	98941
	Exam	1-2 Regions	3-4 Regions
Aetna	$98.89	$26.91	$38.61
Cigna	$86.69	$36.63	$53.03
First Choice	$99.75	$26.88	$48.72
Kaiser	$108.27	$38.56	$55.87
Premera	$92.34	$22.23	$31.84
Regence	$106.00	$26.73	$38.28
United Healthcare	$81.50	$29.50	$38.00
Medicare	$71.59	$28.08	$40.40

The amount above is what the patient will pay into their deductible until it is met.
If they do not have a deductible to contribute to, they will pay either the co-pay or co-insurance
(a percentage of the fixed allowed rate shown above.)

Other Fees

Missed Appointment Fee	$25.00
Missed Re-Exam Fee	$50.00
Lumbar Belt	XS-L: $38.00 / XL: $39.00
Ice Pack	Small: $7.50 / Large: $15.00
Records Request	$35.78

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Health Questionnaire

Name: _____ DOB: _____/_____/_____

Main reason for visit: _____

If your condition is due to an accident, was it: ☐ Auto ☐ Work ☐ Home ☐ N/A Date: _____

If not, what caused the condition? _____

When did symptoms appear? _____ Is the condition worsening? ☐ Yes ☐ No

Does pain interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other: _____

Rate your pain **at best** from 0-10 (0=no pain, 10=extreme pain): _____ Rate your pain **at worst**: _____

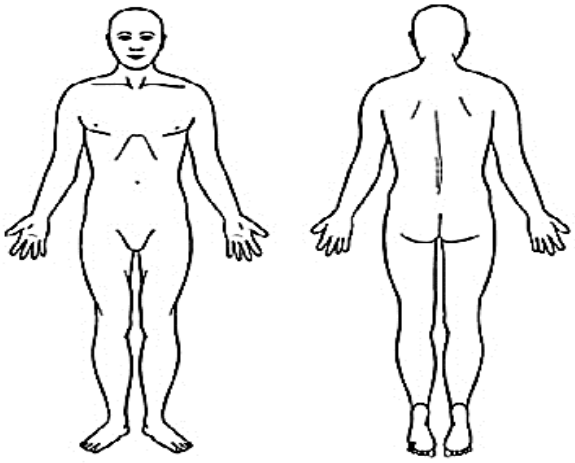
Circle any symptoms that describe your pain: Cramping - Aching - Dull - Sharp - Deep - Shooting

Widespread - Lightning-like - Throbbing - Nagging - Burning - Stinging - Pressure - Tingling

Does the pain travel to other areas? ☐ Yes ☐ No If yes, where? _____

Please indicate areas of pain/discomfort on the diagram using the following symbols:

Ache: ^ ^ ^ ^
Numbness: = = = =
Pins & Needles: o o o o
Burning: x x x x
Stabbing: / / / /



What activities, if any, make your condition worse? _____

What activities, if any, make it better? _____

Have you received other treatment for the condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care

Any other pain/symptoms? _____

What physical activities do you do at work? _____

Are you on a special diet? ☐ Yes ☐ No If yes, what diet and why? _____

Have you gained or lost over 10 pounds in the past month unintentionally? ☐ Yes ☐ No

How many caffeine drinks do you have per day? _____ How many alcoholic drinks do you have per week? _____

Do you or have you ever smoked or chewed tobacco? ☐ Yes ☐ No If yes, for how long? _____

Are you pregnant or plan to be pregnant? ☐ Yes ☐ No If yes, what is your due date? _____

Is this your first pregnancy? ☐ Yes ☐ No If no, how many pregnancies have you had? _____

Check any health conditions that apply:

- ☐ Headaches
- ☐ Sinus Issues
- ☐ Dizziness
- ☐ Ear/Nose/Throat Issues
- ☐ Neck Pain
- ☐ TMJ/Jaw Pain
- ☐ Shoulder/Arm Pain
- ☐ Wrist/Elbow/Hand Pain
- ☐ Chest Pain
- ☐ Mid-Back/Rib Pain
- ☐ Low Back Pain
- ☐ Hip/Leg Pain
- ☐ Knee Pain
- ☐ Ankle/Foot Pain
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Arthritis (Type: _____)
- ☐ Difficulty Walking
- ☐ Thyroid Issues
- ☐ Asthma/Difficulty Breathing
- ☐ Irritable Bowel Syndrome
- ☐ Liver Trouble/Hepatitis
- ☐ Kidney Issues
- ☐ Prostate Issues
- ☐ Menstrual Issues
- ☐ Stomach Issues
- ☐ Colon Issues
- ☐ Heart Problems
- ☐ Diverticulitis
- ☐ Difficulty Urinating
- ☐ Poor Circulation
- ☐ Skin Issues
- ☐ Easy Bruising
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Diabetes (Type I / Type II)
- ☐ Hypertension
- ☐ High Blood Pressure
- ☐ Chronic Cough/Cold
- ☐ Cancer (Type: _____)
- ☐ Unexplained Fatigue
- ☐ Frequent Infections
- ☐ Anxiety
- ☐ Depression
- ☐ Glasses/Contacts

Other conditions not listed: _____

History of Injuries (check all that apply and elaborate in the space provided):

- ☐ Car Accident(s)
- ☐ Falls
- ☐ Head Injuries
- ☐ Broken Bones
- ☐ Dislocations
- ☐ Infections
- ☐ Loss of Consciousness
- ☐ Mental/Emotional Disorders
- ☐ Treated for Spine/Nerve Disorder

Details and dates of any incidents above: _____

_____

Surgeries/Hospitalizations (list and date): _____

Family History:

Relation	Living	Deceased	Age (now/at passing)	Serious Illness/Cause of Death
Mother				
Father				
Sister				
Brother				
Daughter(s)				
Son(s)				

Are you currently seeing another healthcare provider? ☐ Yes ☐ No Provider's Name: _____

If yes, for what condition(s)? _____

Have you had any of the following done in the last two years? ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Cortisone Epidural

If yes, when and where? _____

Current medications: _____

_____

Do you have any concerns regarding domestic or sexual violence? ☐ Yes ☐ No

All the answers I have given are correct to the best of my knowledge, and I agree to continue with my chiropractic evaluation at Zindt Chiropractic Center at this time.

Patient/Guardian Signature: _____ Date: _____/_____/_____

Clinician Signature: _____ Date: _____/_____/_____

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example 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 very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ 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
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

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 the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example 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 very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

Section 6 – Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15