Family Chiropractic
204 Pinehurst Dr. SW #103
Tumwater, WA 98501

Welcome!

Women's Health Chiropractic Intake
Dr. Amanda Kugel

Date _____

Welcome to our office! **The following information is confidential. It will be used to complete your history and understand your condition, so please be as neat and accurate as possible while completing this form. If you have questions about any portion of this form, please ask at the front desk.**

First Name: _____ MI: ____ Last Name: _____
Name of Parent/Guarian: _____
DOB: ____/____/_____ Age: _____ Sex: _____ Marital Status: ❑ Single ❑ Married ❑ Other
Employment Status: ❑ Employed ❑ FT Student ❑ PT Student ❑Retired ❑ Self Employed ❑ Other
Address 1: _____ Address 2 : _____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Alternate Phone: _____
Personal Email: _____
May we email you with office news and updates: ❑Yes ❑ No Thanks
Preferred Communication: ❑Phone ❑Mail/Letter ❑Email ❑Patient Portal ❑Fax ❑Decline

Emergency Contact: _____ Relationship to Patient: _____
Phone: _____ Alternate Phone: _____

Describe the reason(s) for this visit today:
_____
_____

Who referred you to us? _____

Who is your Primary Care Provider? _____ Date of last visit _____
Reason for last visit _____
May we update them on this current issue? ❑Yes ❑ No _____

Have you been to another provider for this issue? ❑Yes ❑ No
If yes, who? _____ How long ago? _____
May we update them on this current issue? ❑Yes ❑ No

Prior treatments and outcomes: _____
_____
_____

Past Medical History
Major medical illnesses: _____
Major surgical illnesses-list operations and dates: _____
_____
_____
Trauma: fractures, lacerations ❑Yes ❑ No _____
Previous hospital admissions with dates and diagnoses _____
_____
_____
Current medications, vitamins/supplements, including dosage: _____
_____

Family History: circle all that apply
Arthritis, Allergy, Asthma, Autism, Autoimmune disorders, Blood disorders, Cancer, Cardiac Disease, Diabetes, Epilepsy, Genetic disorders, Scoliosis, Stroke, Hypertension

Social History
Smoking: (check one) ❑ Never
✈Current Smoker: What is the frequency that you smoke? _____
✈Former Smoker: Smoking End Date: _____
Exercise: (check one) ❑ None ❑ Occasional ❑ Daily Favorite workout _____
Alcohol: Drinks/week _____ ❑Coffee/Caffeine: Cups/day _____ ❑ High Stress Level
Are you pregnant? ❑ No ❑Yes, How many weeks: _____
Are you currently trying to become pregnant? ❑ No ❑Yes Last Pelvic Exam: _____

Review of Systems: Indicate any current or past issues that have caused concern to seek evaluation.

❑ recent weight changes
❑ glasses/contacts
❑ double vision
❑ blurred vision
❑ sensitivity to light
❑ dry eyes
❑ change in vision
❑ weakness
❑Loss of Consciousness
❑ Memory Problems
❑ Seizures/Convulsions
❑ Cold or Heat Intolerance
❑ fatigue
❑ fainting
❑ nausea
❑ conjunctivitis
❑vomiting
❑ balance problems
❑ear infections
❑ draining ears
❑ jaw pain
❑ loss of hearing
❑ ringing/buzzing in ears
❑neck stiffness
❑ dizziness/vertigo
❑ shoulder pain
❑ arm pain
❑ wrist/hand pain
❑colds
❑ sore throat
❑tonsillitis
❑ mouth breathing
❑ mouth, lip or gum sores
❑ tooth pain
❑cavities

❑oral thrush
❑snoring
❑ apnea
❑nosebleeds
❑eczema
❑ Upper back pain
❑ headaches
❑ numbness arms or hands
❑ Night Sweats
❑palpitations
❑difficulty breathing
❑heart murmurs
❑chest pain
❑ ECG/EKG
❑Excessive Sweating
❑Mammogram
❑ Breast Tenderness
❑ chest x-ray
❑pneumonia or TB
❑bronchitis
❑wheezing
❑chronic cough
❑ emphysema
❑constipation
❑diarrhea
❑change in stool color or character
❑vomiting
❑jaundice
❑abdominal pain
❑ Hemorrhoids
❑ Colonoscopy
❑ Excessive Thirst or Hunger
❑Hot Flashes
❑ pain with bowel movement
❑change in appetite

❑excessive gas
❑ upset stomach
❑change in urinary frequency
❑blood or discharge in urine
❑pain with urination
❑previous urinary tract infections
❑ Vaginal Discharge or Chronic Yeast
❑ Low Back pain
❑Liver Problems
❑drug reactions
❑ tension
❑ anxiety
❑irritability
❑ depression
❑fevers
❑scoliosis
❑joint pain or swelling
❑difficulty swallowing
❑injuries
❑gait changes
❑ Hip pain
❑ Leg pain
❑asthma
❑ sinus problems
❑hay fever
❑allergic rhinitis
❑knee pain
❑ ankle/foot pain
❑Numbness Legs or Feet
❑High Blood Pressure
❑ Low Blood Pressure
❑ Pelvic Inflammatory Disease
❑Breast Cancer &/or Benign Tumors
❑ Fibroids

Office Policies

We are in network with Regence BS. All other insurances are considered out-of-network. We will bill Regence BS on your behalf, and for all other plans we will provide you with the description of services you received, and you may submit this directly to your insurance company for possible reimbursement if your plan includes out of network benefits. Please know your insurance coverage prior to your visit. All payment is expected at the time of service in the form of debit cards, master card, visa, cash and check. A $30.00 fee will be charged for all returned checks. _____*(Initials)*

In the event that you are not able to keep your scheduled appointment, please give 24 hours' notice prior to canceling. Canceling with less than 24 hours' notice or missing an appointment will result in being charged the cost of the appointment. _____*(Initials)*

NOTICE OF PRIVACY PRACTICE We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records to get information about it by contacting our office at 360-352-8112. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information.
_____*(Initials)*

Informed Consent

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. If your history and examination indicate the need you will receive further diagnostic tests or a referral to a specialist. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific joint. Adjustments are usually performed by hand but may also be performed by hand-guided instruments or equipment. In addition to adjustments, other treatments used by chiropractors include soft-tissue manipulation, nutritional recommendations and exercise. Please list any preferences here_____

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Reasonable alternatives to these procedures will be explained to you following the physical exam to determine your condition and appropriate care plan.

Most people have no negative reactions to chiropractic care. In those who do, the most common side-effects/complications associated with chiropractic care are local soreness/discomfort, headaches, tiredness, radiating discomfort and dizziness. The vast majority of which resolve within 48 hours and are not associated with any pathology or lasting problems.

I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained the risks (if any) and suggested alternatives when those risks exist. I understand the purpose of care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

By signing I have read and understand the Office Policies and Informed Consent:

Print Patient Name: _____

Signature: _____ **Date:** _____