Millennium Chiropractic

**Alex Zylstra DC**
**7517 Custer Rd. W.**
**Lakewood, WA 98499**
**(253) 473-7777**

# CONFIDENTIAL PATIENT APPLICATION

Date _____

Name _____ Home Phone ( ) _____

Cell Phone ( )_____ E-Mail _____

Address _____ City _____ St _____ Zip _____

Age _____ Birth date _____ Sex M F Marital Status S M W D

How many children? _____ Social Security Number _____

Occupation _____ Employer _____

Employer Address _____ Work Phone ( ) _____

Name of Spouse (or responsible party, if minor) _____

Occupation _____ Employer _____

Employer Address _____ Work Phone ( ) _____

**Referred by:**_____

Do you have medical insurance? Y N *If yes, please give us your card so that we can make a copy of it.*

# ACCIDENTS/FALLS/OTHER INJURIES

Auto Accidents Y or N How recent _____ Treatment Y or N

Past Work Injuries Y or N How recent _____ Treatment Y or N

Other Injuries Y or N How recent _____ Treatment Y or N

Have you received chiropractic care before? Y or N

If yes, with Dr. _____ Where _____ Last Visit_____

Did you have good results? Y or N

# PRESENT COMPLAINTS

Please explain the symptoms you have by **circling** or **writing** in the space provided. If you are unsure, please leave it blank.

## HEADACHES

How long have you been having headaches? _____

How often do you have headaches? **Constant/Daily/5-6 times a week/3-4 times a week/1-2 times a week/1 time every 2 weeks/1 time a month** _____

Which side do you normally get your headaches? **Right/Left/Both Sides** _____

Where are your headaches? **Back of the head /Side of the head/Temples/Top of the head/In the Eyes/In the sinuses**

_____

Can you describe the headache? **Sore/Achy/Dull/Throbbing /Sharp/Stabbing/Migraine**

**Pressure** _____

**On a scale of 0-10, zero being no pain at all and ten being the worst imaginable pain,**

How would you rate your pain? **0 1 2 3 4 5 6 7 8 9 10**

Do you do anything to make your headache better or go away? _____

Does anything make your headache worse? _____

Do you get dizziness with your headaches? **Yes/No** _____

Do you get ringing in the ears with your headaches? **Yes/No** _____

Do you get blurry vision with your headaches? **Yes/No** _____

Do you get sinus problems or seasonal allergies? **Yes/No** _____

Do you have any of the following jaw problems? **Pain/Clicking/Popping/Clenched teeth/Grinding teeth**

_____

## NECK

How long have you been having neck symptoms? _____

How often do you have neck symptoms? **Constant/Daily/5-6 times a week/3-4 times a week/1-2 times a week/1 time every 2 weeks/1 time a month** _____

Which side do you normally get your neck symptoms on? **Right/Left/Both Sides**

Can you describe your neck symptoms? **Sore/Achy/Dull/Throbbing/Sharp/Stabbing/Stiff/Burning/Shooting**

**On a scale of 0-10, zero being no pain at all and ten being the worst imaginable pain,**

How would you rate your pain or Stiffness? **0 1 2 3 4 5 6 7 8 9 10**

Do you do anything to make your neck symptoms better or go away? _____

Does anything make your neck symptoms worse? _____

Do you get any pain, numbness, tingling or weakness into the arms or hands? **Yes/No** Please Describe.

_____

# MIDDLE BACK

## (From the base of the neck to the bottom of the ribs)

How long have you been having middle back symptoms? _____

How often do you have middle back symptoms? **Constant/Daily/5-6 times a week/3-4 times a week/1-2 times a week/1 time every 2 weeks/1 time a month** _____

Which side do you normally get your middle back symptoms on? **Right/Left/Both Sides**

Can you describe your middle back symptoms? **Sore/Achy/Dull/Throbbing/Sharp/Stabbing/Stiff/Burning/Shooting**

**On a scale of 0-10, zero being no pain at all and ten being the worst imaginable pain,**

How would you rate your pain or stiffness? **0 1 2 3 4 5 6 7 8 9 10**

Do you do anything to make your middle back symptoms better or go away? _____

_____

Does anything make your middle back symptoms worse? _____

Do you ever have pain when taking a full breath in or out? **Yes/No** _____

# LOWBACK AND HIPS

How long have you been having low back or hip symptoms? _____

How often do you have low back or hip symptoms? **Constant/Daily/5-6 times a week/3-4 times a week/1-2 times a week/1 time every 2 weeks/1 time a month** _____

Which side do you normally get your low back or hip symptoms on? **Right/Left/Both Sides**

Can you describe your low back or hip symptoms? **Sore/Achy/Dull/Throbbing/Sharp/Stabbing/Stiff/Burning/Shooting**

**On a scale of 0-10, zero being no pain at all and ten being the worst imaginable pain,**

How would you rate your pain or stiffness? **0 1 2 3 4 5 6 7 8 9 10**

Do you do anything to make your low back or hip symptoms better or go away? _____

_____

Does anything make your low back or hip symptoms worse? _____

_____

Do you get pain, numbness, tingling or weakness into your legs or feet? **Yes/No** _____

_____

# OTHER

**If you have any other conditions or problems that you are concerned about, please describe below.**

_____

_____

_____

_____

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# Quality of Life Questionnaire

*Please rate your ability to perform the following activities*

## Work Activity Performance

| | | | | |
|---|---|---|---|---|
| Squatting | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Bending | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Sitting | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Standing | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Grasping | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Working Above Shoulder | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Lifting | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Hand/Wrist Motion | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Foot/Ankle Motion | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| _____ | ☐Able | ☐Limited | ☐Painful | ☐Unable |

## Daily Activity Performance

| | | | | |
|---|---|---|---|---|
| Washing/Bathing | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Dressing | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Sweeping/Vacuuming | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Dishes | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Laundry | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Yard Work | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Sexual Activity | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Lifting | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Climbing Steps | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Walking | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Sleeping | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Driving | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Concentrating/Reading | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| _____ | ☐Able | ☐Limited | ☐Painful | ☐Unable |

## Recreational Performance

| | | | | |
|---|---|---|---|---|
| Running/Jogging | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Lifting Weights | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Yoga | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| Other Exercises | ☐Able | ☐Limited | ☐Painful | ☐Unable |
| _____ | ☐Able | ☐Limited | ☐Painful | ☐Unable |

**MEDICATIONS: What medications are you currently taking, and for what conditions?**

_____
_____
_____
_____

**SURGERIES: Please list any surgeries you have undergone, and/or any surgeries you plan to have.**

_____
_____
_____
_____

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- **Open adjusting rooms:** We keep an open environment in the office to create a sense of warmth, family, healing and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request an appointment in one of our closed private exam rooms. A doctor or trained staff member will speak with you about your condition or other matters in the closed private exam room.

- **To Family and Close Friends Involved in Your Care:** Our office has an open, family-centered approach to wellness and we believe it is in all our patient's best interests to have the support and cooperation of their families. Therefore, our office *strongly encourages* that the spouse or significant other be present when the doctor goes over the patient's report and recommendations for treatment and wellness.

- **Financial Policies:** We will bill your primary insurance company (if applicable) as a courtesy to you. The patient is always responsible for the payment of their care. An insurance contract is between the patient and the insurance company. Insurance coverage is never guaranteed. If there are any problems between the insurance company and the patient, the latter may file a grievance directly with your insurance company. Your signature below assigns 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. Accounts with balances 30 days past due may be charged a service fee of 12% per year compounded monthly. Any account where no payment has been received for sixty days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient. NSF checks or rejected credit card payments will be charged a service fee of $35 per occurrence. We offer a *time of service discount* when services are paid in full at the time of visit. This discounted amount will be passed on to your insurance company. In some cases, we may have a contract with your insurance company governing how we handle your account. This contract may prevent us from offering you our *time of service discount*. Please ask if you have any questions regarding this. Our intent is to provide you with the highest level of service as well as care. Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding your coverage in no way guarantees that your care here will be covered by your insurance company, and you will be responsible for your account, regardless of insurance. If the patient suspends or terminates care and treatment, any fees for professional services rendered will be immediately due and payable unless specific arrangements are approved in writing by the doctor.

**I hereby state that the information on all pages of this form is true and correct. I have been informed and understand that in the practice of chiropractic there are some extremely rare risks to treatment including, but not limited to, muscle strains, joint sprains and disc injuries. I do not expect the doctor to be able to anticipate and explain all risks and complications. I authorize Millennium Chiropractic to examine, x-ray, and utilize any means necessary to diagnose my condition in accordance with the state statutes, for the care and management of my condition. I am giving my consent to Millennium Chiropractic to cover the entire course of treatment for my present and any future conditions for which I seek treatment.**

**Patient/Spouse/Guardian Signature** _____ **Date** _____

MILLENNIUM CHIROPRACTIC
**Alex Zylstra DC**
**7517 Custer Road West**
**Lakewood, WA 98499**
**(253) 473-7777**

# TERMS OF ACCEPTANCE

**When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.**

Chiropractic has only one goal. It is 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.

**Adjustment**: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health**: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation**: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

Signature Date

# HIPAA Notice of Privacy Practices

**Trinity Chiropractic, Inc.**
**DBA: Millennium Chiropractic**
**7517 Custer Rd W**
**Lakewood, WA. 98499**
**(253) 473-7777**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## 1. Uses and Disclosures of Protected Health Information

**Uses and Disclosures of Protected Health Information**
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

**We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.**

Other Permitted and Required Uses and Disclosures **Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights**

Following is a statement of your rights with respect to your protected health information

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**State Mandated Exemptions**

- We are required by Washington State Law to disclose health information to the Department of Labor and Industries or a self-insured employer for workers' compensation or crime victims' claims.
- We can disclose health information to an employer about light duty work without a patient authorization.
- We can disclose health information to an employer without a patient authorization if that information is about a workplace injury or illness, a workplace medical surveillance, or a return-to-work examination.
- Because this disclosures to the department or self-insurer are required by law, patients cannot object to or request that we restrict those disclosures, (45 CFR §§ 164.512,164.522(a)(1)(v)).

**Complaints**

**You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.** We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

**Print Name:**_____ **Signature:**_____ **Date:**_____