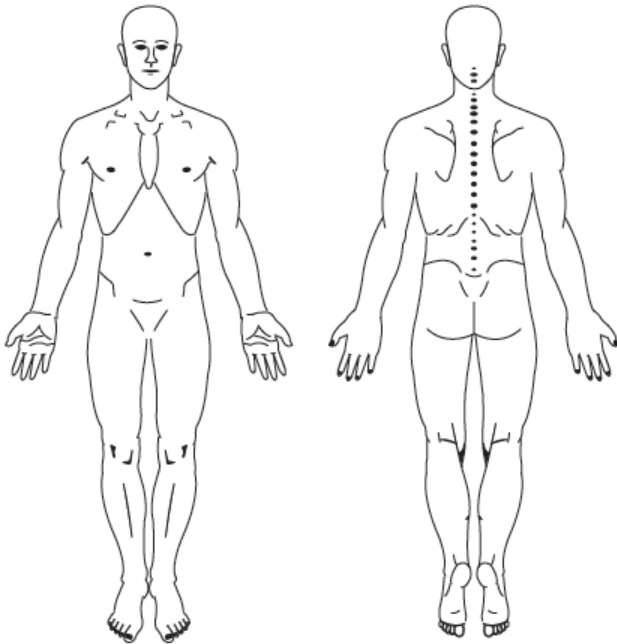


Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Marital Status: Single Married Other Spouse/Significant Other Name: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Names/Ages of Children: \_\_\_\_\_  
 Primary Care Doctor: \_\_\_\_\_ Contact to integrate care if necessary: Yes No If yes, initial here: \_\_\_\_\_  
 How did you hear about our office: \_\_\_\_\_  
 Have you ever seen a chiropractor? Yes No If yes, who, when, and for what: \_\_\_\_\_

**Health Evaluation**

Using the diagram below, mark the areas of your body where you currently feel pain or other abnormal sensation. Also indicate where your pain travels (if applicable). Then, please answer the questions to the right by circling the number that best represents your pain, where **1 is no pain and 10 is worst pain you can imagine**.



Rate your pain by circling the one number that best describes your pain at its **WORST** in the past 24 hours.

1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the one number that best describes your pain at its **LEAST** in the past 24 hours.

1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the one number that best describes your pain on **AVERAGE** for the past **WEEK**.

1 2 3 4 5 6 7 8 9 10

**Complaint**

What is the reason for your appointment today: \_\_\_\_\_  
 \_\_\_\_\_

When did this condition begin: \_\_\_\_\_

Has your condition been getting: Better Worse Same How did this happen: Sudden Gradual Unknown  
 Due to: Injury/Overuse Sickness/Illness Car Accident Work Accident Unknown

Have you ever experienced anything like this before: No Yes (explain): \_\_\_\_\_

What do your symptoms feel like? (circle all that apply)

Ache	Stiff	Stabbing	Sharp	Shooting	Throbbing
Tingling	Weak	Burning	Numb	Swelling	Dull

Do you feel the sensation/pain anywhere else: No Yes (explain): \_\_\_\_\_

Does coughing or sneezing affect your condition: No Yes (explain): \_\_\_\_\_

Do you feel this sensation: Constantly (76-100%) Frequently (51-75%) Occasionally (26-50%) Comes/Goes (0-25%)

When is your condition more pronounced: Morning Afternoon Evening Night With Activity

What makes your condition feel worse: \_\_\_\_\_

What makes your condition feel better: \_\_\_\_\_

Have you seen other health care provider(s) for this condition: No Yes (explain): \_\_\_\_\_

Have you tried over the counter medication for this condition: No Yes (explain): \_\_\_\_\_

Were any diagnostic images taken for this condition: No Yes (explain): \_\_\_\_\_

Has your condition affected your daily activities: No Yes (explain): \_\_\_\_\_

Does your condition affect your sleep: No Yes (explain): \_\_\_\_\_

### Goals

What are your goals for coming to this office: \_\_\_\_\_

### Stress Level

Stress can come in forms such as overwork, relationships, health concerns, etc.

Rate your stress level currently on a scale from 1-10 (10 being the most stress): 1 2 3 4 5 6 7 8 9 10

Main reason for stress: \_\_\_\_\_

### Sleep Quality

How is your sleep? (circle all that apply)

Restful	Restlessness	Hard to get to sleep	Wake up often
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### Exercise:

Do you exercise? No Yes If yes, how often: \_\_\_\_\_ For how long per session: \_\_\_\_\_

What type of exercise do you do: \_\_\_\_\_

### Smoking

Do you smoke? No Yes If yes, how much: \_\_\_\_\_ How long have you smoked: \_\_\_\_\_

### Daily Habits

For each of these items listed below specify if you consume them and how often (i.e. 2 cups/day):

Coffee/Tea: Yes No How often: \_\_\_\_\_ Soda: Yes No How often: \_\_\_\_\_

Alcohol: Yes No How often: \_\_\_\_\_ Water: Yes No How often: \_\_\_\_\_

Fast Food: Yes No How often: \_\_\_\_\_

### Allergies

Please list any known allergies, including food allergies, environmental, seasonal, drug, etc:

\_\_\_\_\_

In the space provided please enter "C" if you currently or "P" if you have ever had this problem.

**General**

- Weight loss/gain
- Allergies
- Bleeding problem
- Anemia
- Diabetes
- Cancer
- Thyroid disease
- Alcoholism
- Drug abuse
- HIV risk factor

**Eye, Ear, Nose & Throat**

- Poor vision
- Loss of vision
- Pain in eyes
- Deafness/difficulty hearing
- Nosebleeds
- Dental problems
- Hoarseness
- Tonsillectomy

**Cardiovascular**

- Irregular heart beat
- Pain over heart
- High blood pressure
- Previous heart trouble
- Myocardial infarction
- Ankle swelling
- Varicose veins
- Rheumatic fever
- Stroke

**Skin**

- Itching
- Bruises easily
- Changes in mole(s)
- Skin cancer

**Health Habits**

- Drinking
- Recreational drug use

**Other**

- Tropical infection
- Parasitic infection

**Respiratory**

- Difficulty breathing
- Chronic cough
- Spitting phlegm
- Spitting blood
- Wheezing/Asthma
- Pneumonia
- Tuberculosis

**Genitourinary**

- Frequent urination
  - Painful urination
  - Blood in urine
  - Kidney disease
  - Urinary infection
  - Inability to control urine
  - Difficulty starting urine flow
  - Breast lump or pain
  - Venereal disease
  - Sexual difficulty
- Get up \_\_\_\_\_ times/night to urinate

**Neurologic**

- Weakness
- Twitching
- Tremors
- Headache
- Dizziness/vertigo
- Epilepsy
- Numbness/tingling
- Arm/leg pain
- Mental disorder
- Partial or complete paralysis

**Men Only**

- Testicular pain
- Prostate problems

**Women Only**

- Live births
- Miscarriage
- Painful period
- Excessive flow
- Irregular cycle
- Hot flashes
- / \_\_\_ / \_\_\_ Date of last period
- / \_\_\_ / \_\_\_ Date of last PAP
- / \_\_\_ / \_\_\_ Date of last mammogram

**Gastrointestinal**

- Poor appetite
- Poor digestion
- Difficulty swallowing
- Vomiting blood
- Pain over abdomen
- Ulcer
- Bloody stool
- Liver problems
- Gallbladder problems
- Jaundice
- Hernia
- Loss of bowel control
- Diarrhea
- Constipation
- Hemorrhoids
- Appendicitis

**Musculoskeletal**

- Neck stiffness/pain
- Pain in upper back
- Low back pain
- Swollen joints
- Painful joints
- Muscle ache
- Muscle soreness
- Scoliosis
- Arthritis
- Osteoporosis
- Slipped/Herniated disc

**Family History**

- Diabetes
- Thyroid disease
- Kidney disease
- High blood pressure
- Heart disease
- Cancer
- Epilepsy
- Stroke
- Gout
- Allergies
- Blood disease
- Other

Medications/Prescriptions (list): \_\_\_\_\_

Vitamins/Supplements (list): \_\_\_\_\_

Welcome! Please take the time to review the following office guidelines and policies for Rindal Sports Chiropractic, so that we may better serve you. This information outlines our terms for providing service and will help clarify any questions you may have before your first appointment.

**Medical Records**

If applicable, please bring copies of your latest imaging (x-ray, MRI, CT) reports—no film required—on the day of your initial exam. If your doctor requires an ‘Authorization to Release Medical Records’ form please contact our office and we will provide one for you. Often your imaging reports can be emailed directly to you by your doctor.

**Rates**

Our goal is to provide you with exceptional, personalized health care. Payment for each visit is required at the time of service.

**Health Insurance (Non-Medicare)**

We are “out-of-network” for all\* insurance companies. To find out about your out-of-network benefits, call the customer service number on your insurance card and inquire about your chiropractic and physical therapy coverage. We do not bill or directly communicate with insurance companies; however, upon your request we are happy to provide you with a “superbill” listing all diagnosis and treatment codes, as well as office charges. You then mail this “superbill” to your insurance company. Any reimbursement will then be mailed directly to you from your insurance company. If you have a Health Savings Account (HSA) or Flexible Spending Account (FSA) we are happy to provide a receipt, or “superbill” that is usually requested by those entities for validation of your expenses in our health care office.

**Medicare**

We are an “opt-out provider” and do not accept Medicare. We have signed an agreement to be excluded from the program, and will not bill Medicare for services you receive. Medicare will not pay for care you receive from an opt-out provider. You are responsible for the entire cost of your care, and will not be able to bill Medicare for services you receive. Prior to your appointment, we will provide you with a contract describing the charges for your visit and confirming that you understand you are responsible for the full cost of your care and that Medicare will not reimburse you.

**Labor & Industries (L&I)**

We are “out-of-network” for the Washington State L&I Medical Provider Network.

\*There is no out-of-network reimbursement for Medicare, Tricare or Kaiser/HMO patients.

**Retail Sales**

Depending on the nature of your case, Dr. Rindal may recommend nutritional and/or support products such as vitamins, minerals, orthotics, botanicals, joint braces, etc. Although he does suggest commercial products (health food stores, online, etc.), most are recommended from our office for several reasons. Clinical experience and a growing body of research shows that most commercial products are poor quality and/or do not contain what the label states is in the supplement. Dr. Rindal carefully selects ‘professional grade’ products from various reputable manufacturers. Please note that no patient is required to purchase products from our office, however if you choose to purchase over-the-counter products of lesser quality, you should not be surprised if you obtain sub-optimal results.

**Return Policy**

Product returns must be made within thirty (30) days of purchase. Unopened products (supplements, orthotics, and/or orthopedic supports/supplies) that are returned within 30 days will be given a full refund. All supplement returns must be unopened and sealed inside the original packaging. Opened supplements may not be returned. No refunds are offered on services rendered.

**No Show & Cancellation Policy**

Dr. Rindal is committed to offering exceptional patient care during every visit. He has invested in equipment, training, and systems to make your visit comfortable and effective. He prides himself on consistently running on time. He will be ready for your appointment with his full attention and energy. We ask that you prepare for your appointment accordingly. Please silence your cell phone prior to your visit. Please come dressed appropriately for the area to be treated (ex: don’t wear tight jeans if we are going to be working on your knee). We have a 24-hour cancellation policy on all appointments. No-shows or cancellations with less than a 24-hour notice will be charged a fee of \$45 for the missed appointment that cannot be represented on a “superbill”. Dr. Rindal will make every attempt to remind you of your appointment, but it is ultimately your responsibility to remember.

If you are running late please call to let us know when you anticipate arriving for your visit. We will do our best to accommodate your revised visit time into the doctor’s schedule. However, our office makes a policy of not pushing the entire day’s schedule out because a single patient is late to their appointment. We will run on time as a rule and we ask that you show up on time for your appointments.

**Payment Agreement**

Payment for the initial consultation and subsequent treatments with Dr. Rindal is required at the time of service. For your convenience, we accept cash, check, debit, Visa, MasterCard, American Express, and Discover.

Additionally, regarding insurance, please be sure to note:

- Your insurance policy is a legal contract between you, your employer, and the insurance company. We, as health care providers, are NOT a party to that contract.
- Dr. Rindal is not a member of any HMO, PPO, or other provider networks. Therefore, any coverage you may have for services provided in this office will be deemed “out-of-network” by your insurance company.
- Many insurance companies will advise you that your coverage will be a percentage of the office fees (e.g. 80% of treatment charges) after a yearly deductible amount has been fulfilled. What is often not specified by the insurance company are plan fee schedules, annual maximums, and other limitations that will have a direct bearing on the reimbursement they allow. For details on your health insurance “out-of-network” chiropractic benefits please contact your insurance company directly.

**Release of Information**

I authorize the release of any information concerning my health and health care services to my insurance companies or pre-paid health plans.

I, the undersigned, agree to all the above Office Guidelines and Policies. I have asked, and had answered to my satisfaction, any questions I have regarding these policies.

By my signature, I acknowledge receipt of the provider’s Notice of Privacy Practices (HIPPA) and the provider’s Patient Rights and have been given the opportunity to read them. I understand that this information is available to me upon my request.

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Patient’s Signature

Date

I, the undersigned, have voluntarily requested that Dr. Rindal assist me in the management of my health concerns. I have understood and agree to all policies and terms provided in the Office Guidelines and Policies. I understand that Dr. Rindal is a chiropractor and that his services are not to be construed or serve as a substitute for standard medical care. Dr. Rindal recommends that I undergo regular routine medical check-ups by my medical doctor.

Medical doctors, doctors of chiropractic, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. I, the undersigned, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues. Physiotherapy modalities (ex: IASTM technique, etc), in-office exercises, taping, nutritional supplements/dietary recommendations, among others, may also be used.

Routine chiropractic examination and treatment involve some of the following methods:

- **Observation and Inspection:** Viewing/looking at body parts. Visualization includes general body viewing in a standing position from the front, back, and side. All symptomatic (painful) body parts may be viewed. Although not usually required, if clothing interferes with examination or treatment of an area patient gowning will be utilized. Women may request a female observer be present at any time during examination and/or treatment, just give us prior notification so we can make arrangements.
- **Auscultation:** Using a stethoscope to listen for blood pressure and other body sounds.
- **Palpation:** This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, nodularity, laxity/integrity of tissues, and other abnormalities.
- **Percussion:** Using a rubber hammer and tapping on bones or tendons
- **Orthopedic/neurological testing:** These are standard tests to assess your neuromusculoskeletal systems.
- **Muscle testing:** testing muscles for weakness and/or pain with contraction.
- **Myofascial and/or IASTM technique:** muscle work sometimes involving tools to increase flexibility and break up adhesions in muscle or myofascial tissues.

Chiropractic doctors employ various manually applied treatment procedures when caring for patients, the most common being an adjustment. A chiropractic adjustment involves the application of a quick, precise and usually painless force directed over a very short distance to a specific body part. Adjustments can be performed by hand, by hand-guided instruments, and with the use of specially designed equipment. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

**Risks from Treatment**

**Soreness:** I am aware that like exercise it is possible to experience muscle soreness in the first few treatments.

**Dizziness:** Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform Dr. Rindal if you experience these symptoms.

**Fractures/Joint Injury:** I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

**Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are extremely rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. A 2009 study of 100 million person-years found “NO evidence of excess risk of stroke associated with chiropractic care compared to primary care.” If you have any questions about this please ask Dr. Rindal. He would be happy to discuss other options and answer any of your questions.

A thorough health history and tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

**Treatment Results**

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor’s choosing.

**Alternative Treatments Available**

Reasonable alternatives to these procedures include rest, home applications of therapy, prescriptions or over-the-counter medications, exercises and possible injections and/or surgery.

**Medication:** Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risk. We cannot advise you regarding any medications, please consult your M.D.

**Rest/Exercise:** Simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value, but are not corrective of injured nerve and joint issues.

**Surgery:** Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

**Non-treatment:** I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Dr. Rindal has also asked me if I want a more detailed explanation; but I am satisfied with the explanation and do not want any further information. I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to this Informed Consent document.

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Patient’s Signature

Date

I discussed the procedures, alternatives, and risk with the patient.

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Doctor’s Signature

Date