

BEAR MOUNTAIN CHIROPRACTIC AND HEALING ARTS

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PATIENT INFORMATION SHEET

**PLEASE PRINT!!**

**You are responsible to pay in full at each appointment. If we submit insurance claims on your behalf, we will collect your co-payment at the time of the appointment.**

**If your deductible has not been satisfied we will collect that amount at the time of your visit.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone(Home): \_\_\_\_\_ (Cell): \_\_\_\_\_ (Work) \_\_\_\_\_ email: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

**If Minor:** Guardian Name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Phone: \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Member Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ID# \_\_\_\_\_ Group #: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Member Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ID# \_\_\_\_\_ Group #: \_\_\_\_\_

**In Case of Emergency: Nearest living relative/friend not living with you:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Whom May we thank for your referral?**

Name: \_\_\_\_\_

**Consent to Treat:**

I hereby authorize my health care providers to render whatever services are necessary for the care of me and/or my family and I agree to assume all financial obligations incurred for such care not covered by my insurance.

I hereby authorize the release of information to insurance carriers concerning my illness and treatments and I also hereby assign to the physician(s) payments for medical services rendered to myself and my dependents.

Chiropractic examination and therapeutic procedures (including chiropractic manipulation, ultrasound, heat or cold application, and manual muscle therapy massage) are considered safe and effect methods of care.

Occasionally, however; complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them.

These may include, but are not limited to:

*Soreness, inflammation, soft tissue injury, dizziness, burns, flu like symptoms, or a temporary worsening of symptoms.*

More serious complications are extremely rare. Additional information of side-effects and complications is available upon request. It is also our policy to inform you of the procedure being performed, the risks, and alternative treatments available. If you physician does not explain to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side-effects. I give my consent for Dr. Cynthia D. Hatton to provide treatment for my condition within the scope of her chiropractic license, and other therapies she prescribes necessary for my treatment.

Signature\_\_\_\_\_Date\_\_\_\_\_

***“DEDICATED TO WHOLE BODY HEALTH”***

# Health History

Bear Mountain Chiropractic & Healing Arts  
907-688-3688

Name \_\_\_\_\_ Age \_\_\_\_\_ Today's date \_\_\_\_\_

Occupation \_\_\_\_\_ E-mail address \_\_\_\_\_

What is the reason for your visit to our office? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What results would you like to achieve with our work? \_\_\_\_\_  
\_\_\_\_\_

Have you seen a doctor or another health practitioner regarding this or similar conditions? \_\_\_\_\_

List their names and phone numbers. \_\_\_\_\_  
\_\_\_\_\_. Do I have permission to contact them? Y N Initial \_\_\_\_\_

Date of last physical exam \_\_\_\_\_

When did you first notice the condition and what started it? \_\_\_\_\_  
\_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

List infectious and childhood diseases \_\_\_\_\_

List congenital or acquired disability \_\_\_\_\_

List injuries or accidents causing injury \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any other medical or health conditions \_\_\_\_\_  
\_\_\_\_\_

List all medications, remedies, herbs, and supplements you use \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you use any of the following: List frequency and amount.

Caffeine \_\_\_\_\_ Nicotine \_\_\_\_\_ Alcohol \_\_\_\_\_

Sugar \_\_\_\_\_ Recreational drugs \_\_\_\_\_ Water \_\_\_\_\_

List stress relieving activities you participate in. Include type and frequency; that is, exercise, massage, hobbies, sports, etc. \_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

List any activities you do repetitively \_\_\_\_\_

List any other comments or concerns regarding your health status or well-being. \_\_\_\_\_

Have you had chiropractic care before? When \_\_\_\_\_

What would you like from your treatment? \_\_\_\_\_

Have you had massage before? When \_\_\_\_\_

What would you like from your massage? \_\_\_\_\_

**Please place and “X” on any of the following conditions that apply to you that are current and a “P” for past conditions.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chronic pain, where<br>_____    | <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Learning difficulties    |
| <input type="checkbox"/> Joint pain, where<br>_____      | <input type="checkbox"/> Fatigue                          | <input type="checkbox"/> Depression               |
| <input type="checkbox"/> Muscle pain, where<br>_____     | <input type="checkbox"/> Frequent respiratory<br>illness  | <input type="checkbox"/> Trouble sleeping         |
| <input type="checkbox"/> Other pain, where<br>_____      | <input type="checkbox"/> Lung or respiratory<br>condition | <input type="checkbox"/> Trouble concentrating    |
| <input type="checkbox"/> Headache                        | <input type="checkbox"/> Cold hands or feet               | <input type="checkbox"/> Memory loss              |
| <input type="checkbox"/> Numbness, where<br>_____        | <input type="checkbox"/> Swollen ankles                   | <input type="checkbox"/> Hearing problems         |
| <input type="checkbox"/> Broken bones, where<br>_____    | <input type="checkbox"/> Varicose veins                   | <input type="checkbox"/> Vision problems          |
| <input type="checkbox"/> Sprains/strains, where<br>_____ | <input type="checkbox"/> High blood pressure              | <input type="checkbox"/> Contacts                 |
| <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Low blood pressure               | <input type="checkbox"/> Paralysis                |
| <input type="checkbox"/> AIDS/HIV                        | <input type="checkbox"/> Lymphedema                       | <input type="checkbox"/> Nervous system condition |
| <input type="checkbox"/> Osteoporosis                    | <input type="checkbox"/> Heart condition                  | <input type="checkbox"/> Allergies                |
| <input type="checkbox"/> Bursitis                        | <input type="checkbox"/> Indigestion                      | <input type="checkbox"/> Rashes                   |
| <input type="checkbox"/> Tendonitis                      | <input type="checkbox"/> Loss of appetite                 | <input type="checkbox"/> Skin conditions          |
| <input type="checkbox"/> Scoliosis                       | <input type="checkbox"/> Diarrhea                         | <input type="checkbox"/> Tumors/cancer            |
| <input type="checkbox"/> Bone disease                    | <input type="checkbox"/> Constipation                     | <input type="checkbox"/> Shingles/herpes          |
| <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Gas/bloating                     | <input type="checkbox"/> Pregnancies # _____      |
| <input type="checkbox"/> Sinus conditions                | <input type="checkbox"/> Ulcers                           | <input type="checkbox"/> Pregnant now             |
| <input type="checkbox"/> Other                           | <input type="checkbox"/> Digestive condition              | <input type="checkbox"/> PMS                      |
|  | <input type="checkbox"/> Bowel condition                  | <input type="checkbox"/> Hysterectomy             |
|  | <input type="checkbox"/> Eating disorders                 | <input type="checkbox"/> Menopause                |
|  | <input type="checkbox"/> Panic attacks/anxiety            | <input type="checkbox"/> Birth control            |
|  | <input type="checkbox"/> Hyperactivity                    | <input type="checkbox"/> Prostate problems        |
|  |   | <input type="checkbox"/> Reproductive concerns    |
|  |   | <input type="checkbox"/> Difficulty breathing     |

To the best of my knowledge, I have disclosed all of my past and current health conditions. I will inform the doctor and/or therapist of any changes in my health status. I understand I will be receiving a therapeutic massage for the purpose of maintaining good health and physical condition. I also understand massage therapists do not diagnose illness, disease, physical or mental disorders; nor do they prescribe medical treatment or medication, and massage should not take place of a doctor's care when indicated. I will update my practitioner with any changes in my health status.

Signature \_\_\_\_\_ Date \_\_\_\_\_