Please PRINT YOUR NAME HERE ON JUST THIS FIRST PAGE – THANK YOU!

Spine & Scoliosis Rehab Health Application

Welcome to Callen Chiropractic – Spine & Scoliosis Correction Clinic! It is well known that families who maintain strong healthy well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attaches, strokes & cancer.

Name____ ***Circle the best number to reach you***

Phone_____________________ Work ____________________ Cell_____________________
Cell Phone Carrier (for text reminders) ____

E-mail Address__________________________ Birth Date____________ Age_____ SS#________________________
Mail Address____________________________________ City ____________________ State _____ Zip ___________

Occupation________________________ Employer_________________________ Marital Status: M W Sep. D Sin.
Spouse Name___________________________ No. of Children_____ Child's name(s) __________________________

Health Insurance Yes No **If, yes please give your photo ID and Insurance card to front desk. If, no we have affordable payment options available.**

---

1. Most patients are referred to our office by a caring family member or friend or medical doctor. What made you decide to visit our office? Friend/Family or Medical Doctor Name: ______________________________________
☐ Web Site ☐ Facebook ☐ Sign ☐ Presentation ☐ E-mail ☐ Other ____________________________
2. **Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? ____________ ☐ Never**
3. When was your last complete spinal examination including x-rays? ____________ ☐ Never
4. **Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem?**
☐ Yes ☐No __________________________________
5. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? ☐ Yes ☐No
6. **Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or back? ☐ Yes ☐No**
7. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?
Poor – 1 2 3 4 5 6 7 8 9 10 – Excellent
8. **Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.**
Low – 1 2 3 4 5 6 7 8 9 10 – High
9. 9. Please list any health symptoms or health complaints you are experiencing:
1. _______________________ 2. _______________________ 3. _______________________
10. **Prescription medication may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking? ____________________________________**
____
11. Auto and work-related injuries can cause serious spinal problems.
Is this visit related to an accident or injury? ☐ Yes ☐No Do you have an open case? ☐ Yes ☐No
12. **Spinal health is especially important during pregnancy. Is there any chance you are pregnant? ☐ Yes ☐No**
Due Date ____________________
13. Have you ever been diagnosed with cancer? ☐ Yes ☐No Type _________________________ Year ________
14. **If the doctor feels that chiropractic will help you, are you willing to follow his recommendations? ☐ Yes ☐No**

Please complete and sign other side of this form.

Please PRINT YOUR NAME HERE ON JUST THIS FIRST PAGE – THANK YOU!

15. What is your primary complaint or reason for visit?____
16. **When did your problem start? ______________________**
17. Is the problem getting progressively worse? □ Yes □No
18. **Rate the severity of your pain: Least Pain – 1 2 3 4 5 6 7 8 9 10 – Severe**
19. How often do you have this pain? □ Constant □ Comes & Goes □ Other __________________________
20. **Does it interfere with your □ Sleep □ Work □ Recreation □ Daily routine □ Other _______________**
21. Activities or movements that are painful to perform □ Sitting □ Standing □ Walking □ Lying down □ Other ____
22. **Is the condition worse at certain times of the day? □ Morning □ Evening □ Other______________________**
23. Does the problem/condition refer anywhere? (ex: into the right arm)__________________________________
24. **What have you done for the problem/condition? (ex: used ice/heat)__________________ Is it helping? □ Yes □No**

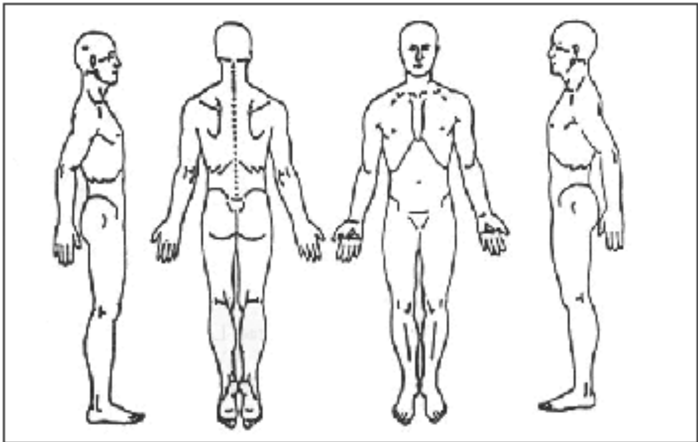
Health History & Other Past or Present Concern *(Please circle YES or NO)*

Arthritis	Yes	No	Diabetes	Yes	No	Kidney disease	Yes	No	Prosthesis	Yes	No
Asthma	Yes	No	Diarrhea	Yes	No	Liver disease	Yes	No	Pins & Needles	Yes	No
Anemia	Yes	No	Depression	Yes	No	Loss of Balance	Yes	No	Stroke	Yes	No
Allergy Shot	Yes	No	Emphysema	Yes	No	Loss of Smell	Yes	No	Stress	Yes	No
Anorexia	Yes	No	Epilepsy	Yes	No	Loss of Taste	Yes	No	Thyroid Problem	Yes	No
Alcoholism	Yes	No	Ear Ring	Yes	No	Loss of Memory	Yes	No	Tonsillitis	Yes	No
AIDS/HIV	Yes	No	Fractures	Yes	No	Migraines	Yes	No	Tuberculosis	Yes	No
Bronchitis	Yes	No	Fainting	Yes	No	Miscarriage	Yes	No	Tension	Yes	No
Bleeding Disorder	Yes	No	Fatigue	Yes	No	Multiple Sclerosis	Yes	No	Ulcers	Yes	No
Back Discomfort	Yes	No	Fever	Yes	No	Nervousness	Yes	No	Visual Problems	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Neck Stiffness	Yes	No	Whooping Cough	Yes	No
Cataracts	Yes	No	Gout	Yes	No	Numbness	Yes	No			
Chest Pain	Yes	No	Heart Disease	Yes	No	Osteoporosis	Yes	No	Other:_______________		
Cold Hands	Yes	No	Hernia	Yes	No	Pacemaker	Yes	No	____________________		
Constipation	Yes	No	Herniated Disk	Yes	No	Parkinson's	Yes	No	____________________		
Cold Sweats	Yes	No	High Cholesterol	Yes	No	Pinched Nerves	Yes	No	____________________		
Cold Feet	Yes	No	Headaches	Yes	No	Pneumonia	Yes	No	____________________		
Dizziness	Yes	No	Irritability	Yes	No	Prostate Problem	Yes	No	____________________		

Past Medical/Accident History *(Please Give Details)*

Have you ever been diagnosed with any medical condition?____
Have you been under drug and medical care?____
List all accidents (Minor & Major):____
List all fractures/surgery or other:____

Pain Diagram – Please circle your problems and indicate the type of pain on the diagram to the right: Ache = AAA, Numbness = NNN, Pins & Needles = OOO, Burning = XXX, Stabbing = ///



Exercise □ None □ Moderate □ Daily □ Heavy

Work Activity □ Sitting □ Standing □ Light labor □ Heavy labor

Diet □ Excellent □ Good □ Poor

Habits □ Smoking-Packs/Day_____ □ Alcohol-Drinks/Week______
□ Caffeine/Coffee Cups/Day_____ □ Fast Food Times/Week____
□ Stress Reason____

The above information is true and accurate to the best of my knowledge.

Patient Signature____ Date_________________

Please PRINT YOUR NAME HERE ON JUST THIS FIRST PAGE – THANK YOU!

OFFICE POLICY
CALLEN CHIROPRACTIC/CALLEN'S ESSENTIALS, P.C.

When we accept you as a patient it is important that you understand the objectives of our care. Chiropractors provide a unique service that other healthcare providers do not offer. Chiropractors specialize in the location and correction of vertebral subluxations for the purpose of improving the health and function of your spine and nervous system.

A Vertebral Subluxation is a misalignment or distortion of your spinal column and/or related structures that can affect your health and overall body functioning. Chiropractors spend years studying how to locate and correct this destructive condition. The correction is performed using specialized techniques called "chiropractic or spinal adjustments" over a period of time. When your spine is free of the nerve and musculoskeletal stress caused by subluxations your body can function more efficiently and your body's natural ability to heal can work more optimally.

It is not our objective to medically diagnosis or treat any disease, symptom or condition. If you desire diagnosis or treatment for a specific symptom or treatment of a specific symptom, disease or condition or advice on taking or stopping medications, we recommend you consult a healthcare provider who specializes in that area.

If we discover unusual findings during the course of our chiropractic examination(s) we will let you know of them. You may then decide whether you wish to investigate further and discuss your healthcare options with other health professionals. We will cooperate with you and them in your goals. It is our sole objective to improve and maintain the health and normal function of your spine and nerve system to the maximum degree possible for you.

X-Ray Consent Form – In the event that x-rays are needed:
The doctor will explain that x-rays are to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing x-ray, you will be informed. You then must determine if you should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation corrective care provided by this office.

Diagnostic X-rays may be recommended by the doctor. You will be given a prescription to get your x-rays/images done by Callen Chiropractic, Mt Baker Imaging or a different imaging center. When you choose to get those x-rays done you fully understand and consent to chiropractic spinal x-rays to be taken.

Regaining Your Youth and Vitality Workshop: is a brief workshop to go over your spinal health after you have completed a minimum of three (3) office visits. You will meet with the doctor or practice manager to review your options of care in the office. We encourage bringing your friends and family.

Financial Policy: We are pleased that you have chosen us for your healthcare needs and are committed to providing you with the best possible care. We are happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

Your Appointment time (s) is reserved exclusively for you. If you are unable to keep this appointment, please give us **48 hours' notice phone call** (**NOT by text** – we will not accept a cancellation notice by text) so that we may accommodate another patient. If you fail to give us notice, there will be a **$25 charge** automatically deducted from your credit card on file, which will not be covered by your Health Insurance Company or coupon.

Patients under a "Crisis or Corrective or Lifestyle Care Plan" Office Visit Time for Chiropractic and/or Rehab is reserved exclusively for you. If you are unable to keep this appointment, we would like you to make up your appointment the week of the missed appointment. Please give us 48 hours' notice so that we may accommodate another patient.

Please PRINT YOUR NAME HERE ON JUST THIS FIRST PAGE – THANK YOU!

Staying on track with your care plan will allow you to obtain your optimal pain management, healing and correction of your spine. If you do not maintain the recommended visit frequency you may not achieve your goals or the spinal correction estimated.

Full Attention: We are going to give you our full attention whenever you have a visit with us. We also want you to be able to give us your full attention. **We therefore ask you to turn off all cell phones before your visit. We also ask for your consideration in not bringing food, candy, or non-water beverage to your visit with us.**

Children in the office: Please no food, drink or candy in the office. For the safety of your children, all children under 10 years of age are not permitted to be unattended without adult supervision in our office.

Insurance: Please scan or take a picture of your insurance card **prior to your appointment** and email to us or we can copy your insurance card at your first appointment. Please advise the office if your insurance coverage changes. For those of you who do not have insurance coverage, we offer affordable time of service plans or extended care plans which will be arranged by you and the doctor or practice manager.

Patients are responsible for all charges not covered by their insurance plan, including co-payments and deductibles. Payments are due at time of service with the exception of extended care plan agreements between you and the Doctor or practice manager. Patients understand that any unpaid balance may be turned over to a collection agency. The patient is responsible for all costs of collections, including attorney's fees, collection fees and court costs. Any unpaid balance will be assessed interest at the rate of 18% per annum (1.5% monthly).

If your insurance company has not paid a claim within sixty (60) days, you will be responsible for following up on the status of payment or you will be responsible for the payment.

We accept cash, checks and Visa/MasterCard/Discover/American Express as payment for our services. On your first visit the Front Desk will ask you to file your credit/debit card or checking/savings account in our secure database.

Checks: There is a $35.00 charge for returned checks. Our practice manager will contact you if a check does not clear the bank. The amount of the returned check and the $35.00 service charge must be paid in cash or money order within five (5) days of the notification.

Copies of your medical records are provided to each patient upon receipt of a signed release form or letter. There will be a charge for copying.

We sincerely appreciate the opportunity to provide you with quality services at the Spine & Scoliosis Clinic. We trust you will feel free to contact us with any concerns or questions you may have concerning your account or care.

Responsible Party **Print** Name Date

Responsible Party **Signature** Date

Please PRINT YOUR NAME HERE ON JUST THIS FIRST PAGE – THANK YOU!

NOTICE OF PRIVACY PRACTICES

Elizabeth Callen, D.C.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent
You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, 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 may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You nay revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made with Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Please PRINT YOUR NAME HERE ON JUST THIS FIRST PAGE – THANK YOU!

NOTICE OF PRIVACY PRACTICES CONTINUED

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

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.

You have the right to inspect and copy your 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, health operations or additional uses listed above in paragraph 8. 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 chiropractor is not required to agree to a restriction that you request. If your chiropractor 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. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

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 electronically.

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. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact: Dr. Elizabeth Callen, Office Manager / Production Manager (360) 305-3231

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Dr. Elizabeth Callen, D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

"You May Refuse to Sign This." THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 14, 2003.

Printed Patient Name ____ Date ____________________________________

Signature ____

Printed Name of Parent/Guardian ____

Signature of Parent/Guardian ____

Please PRINT YOUR NAME HERE ON JUST THIS FIRST PAGE – THANK YOU!

OUR PURPOSE….

Our purpose is to educate and adjust as many ***families*** as possible toward optimal health, with natural chiropractic care. We take pride in the fact that we only offer corrective chiropractic care – which allows us to return your spine back to its healthiest position. The adjustments are safe, effective, and specific to each individual's problems and needs. We know that you had the choice of choosing from several fine chiropractors in the area- ***Thank you for choosing us!***

ENTRANCE CONSULTATION & EXAM

In order to find out if you have vertebral subluxation (misaligned vertebrae) a specific chiropractic exam is performed on all new patients during their initial visit. These tests involve a postural examination, orthopedic & neurological testing, complete range of motion exam, and a specific history and consultation regarding your spinal health. If necessary, we will perform two to seven x-rays which will help determine the amount of time you have been suffering from vertebral subluxation. Your Doctor's Report will be on the second visit.

READING YOUR X-RAYS AND BEGINNING CARE

After we have had a chance to develop and analyze your x-rays we will know if we can accept your case for care. **On your second visit, we will go over the result of our recent exam and x-rays. We will do this with you and your "support team", a spouse or whoever shares your health concerns, so that you both best understand your problem and its severity. If you are a candidate for chiropractic care, we will begin care immediately**. How you respond to your initial adjustments will help us determine how much care will be necessary to correct your problem. **Recommendations for your specific case and correction rehabilitation cost will be presented to you after our Youth and Vitality Workshop.** The Youth and Vitality Workshop is exclusively for you and your family. Please schedule during your first weeks of care.

HOW LONG? HOW OFTEN? HOW MUCH?

After your initial adjustments, we can: determine how long your correction will take, how often you will need to be adjusted, and how much the total correction will cost. **If you are not the sole financial decision maker in your household, it is imperative that your spouse or whoever handles your finances attends these appointments with you. It is here when our best recommendation for care will be provided, and all financial decisions will be made.**

- If you have insurance, we will gladly verify your coverage for you. Insurances we will bill out include: Blue Cross Blue Shield, Cigna, Aetna, United Health Care and many more.
- If you do not have insurance, we have affordable payment plans available (Ask about our Platinum Plan). Major credit and debit cards accepted.

We look forward to giving you the safest and most effective care available today. Thank you for making your health a priority!

Dr. Betty Callen, D.C. & Cory Callen, C.A. & Team

Please PRINT YOUR NAME HERE ON JUST THIS FIRST PAGE – THANK YOU!

NEW PATIENT WORKSHOP HEALTH GOALS

As you now know, our office is completely unique and different. The system is a predictable and the person who has control over its predictability is YOU!

The only way you will make permanent changes in your health is if you chart a course. Please ponder what your true health goals are by answering the questions below. We anticipate phenomenal results. So should you.

1. **Where do you want your health to be in the next 20-50 years?**

   ____
   ____
   ____

2. **What do you want your life to look like?**

   ____
   ____
   ____

3. **What do you want your activity levels to be like?**

   ____
   ____
   ____

4. **Write down your goals.**

   ____
   ____
   ____