



Date: \_\_\_\_\_

Full Legal Name: \_\_\_\_\_ Name you prefer: \_\_\_\_\_

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

Phone: (home) (\_\_\_\_) \_\_\_\_\_ (work) (\_\_\_\_) \_\_\_\_\_ (mobile) (\_\_\_\_) \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: S M W D Sep DP

Spouse's Name: \_\_\_\_\_ # Children: \_\_\_\_\_ Education: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Your Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Job Title: \_\_\_\_\_ Supervisor Name: \_\_\_\_\_

Referred By: \_\_\_\_\_

**MEDICAL HISTORY** (please be complete)

List any surgeries (include dates & reason): \_\_\_\_\_

List any hospitalizations (include dates & reason): \_\_\_\_\_

List any Motor Vehicle Collision injuries (include dates): \_\_\_\_\_

List any On The Job injuries (include dates): \_\_\_\_\_

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.): \_\_\_\_\_

List all over-the-counter and prescription medications used (include reason used): \_\_\_\_\_

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.): \_\_\_\_\_

Have you been under a physician's care in the past year?  No  Yes

When was your last physical examination? \_\_\_\_/\_\_\_\_/\_\_\_\_ Dr: \_\_\_\_\_

Have you ever been under chiropractic care?  No  Yes (describe): \_\_\_\_\_

If female, is there any possibility that you are pregnant?  No  Yes

Do you smoke/use tobacco?  No  Yes Exercise habits:  Never  Occasional  Frequent

**Check any of the following symptoms you have noticed: (  =Previously,  =Now)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Low back pain                   | <input type="checkbox"/> Sensitivity to light or sound                      |
| <input type="checkbox"/> Dizziness or light-headed     | <input type="checkbox"/> Leg/foot numbness/tingling      | <input type="checkbox"/> Visual or hearing disturbances                     |
| <input type="checkbox"/> Jaw pain, clicking or locking | <input type="checkbox"/> Leg/foot fatigue/weakness       | <input type="checkbox"/> Memory loss/problems                               |
| <input type="checkbox"/> Pain or difficulty swallowing | <input type="checkbox"/> Leg pain with walking           | <input type="checkbox"/> Irritability or depression                         |
| <input type="checkbox"/> Neck pain or stiffness        | <input type="checkbox"/> Abdominal pain                  | <input type="checkbox"/> Fatigue or loss of energy                          |
| <input type="checkbox"/> Shoulder pain                 | <input type="checkbox"/> Nausea or vomiting              | <input type="checkbox"/> Fainting or convulsions                            |
| <input type="checkbox"/> Mid back pain                 | <input type="checkbox"/> Diarrhea or constipation        | <input type="checkbox"/> Trouble w/ balance or coordination                 |
| <input type="checkbox"/> Chest pain or cough           | <input type="checkbox"/> Blood in urine or stool         | <input type="checkbox"/> Sleep disturbances/problems                        |
| <input type="checkbox"/> Pain/trouble breathing        | <input type="checkbox"/> Difficulty or pain w/ urination | <input type="checkbox"/> Rashes (face, body, limbs)                         |
| <input type="checkbox"/> Arm/hand numbness/tingling    | <input type="checkbox"/> Difficulty w/ sexual function   | <input type="checkbox"/> Joint pain or swelling                             |
| <input type="checkbox"/> Arm/hand fatigue/weakness     | <input type="checkbox"/> Abnormal menstrual periods      | <input type="checkbox"/> Pain w/ exertion (activity, climbing stairs, etc.) |

**HAVE YOU HAD ANY OF THE FOLLOWING:**

- |  |   |   |
|--|---|---|
| <b>NOW:</b> <input type="checkbox"/> Pain worse at night   | <input type="checkbox"/> Recent bacterial infection (30 days) | <b>EVER:</b> <input type="checkbox"/> History of cancer |
| <input type="checkbox"/> Constant pain unrelated to motion | <input type="checkbox"/> Loss of bowel or bladder control     | <input type="checkbox"/> History of IV drug use         |
| <input type="checkbox"/> Unexplained weight loss           | <input type="checkbox"/> Urinary discharge                    | <input type="checkbox"/> History of blood transfusion   |
| <input type="checkbox"/> Recent fever or chills (30 days)  | <input type="checkbox"/> Recent surgery (30 days)             |   |

What is your primary complaint/problem? \_\_\_\_\_

List other symptoms: \_\_\_\_\_

When did your symptoms first begin? (give date if possible): \_\_\_\_\_

How did your symptoms first begin? \_\_\_\_\_

Pain is: Constant Intermittent      Is your condition getting: Better Worse Not Changing

What activities aggravate your condition? (list) \_\_\_\_\_

What activities lessen your symptoms? (list) \_\_\_\_\_

List all Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Have you had: Xray MRI or CAT Scan EMG Bone Scan Blood Work

Who is your family medical doctor? \_\_\_\_\_

List all home remedies tried for this problem: \_\_\_\_\_

Is your condition worse in the morning or evening, explain: \_\_\_\_\_

Does your condition interfere with: work: No Yes    Sleep: No Yes    Normal daily routine: No Yes

Have you had symptoms like this before? No Yes, describe: \_\_\_\_\_

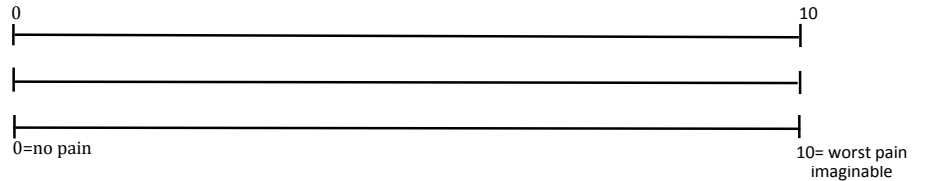
How bad is your pain?

(please mark all 3 scales)

1. RIGHT NOW:

2. ON AVERAGE:

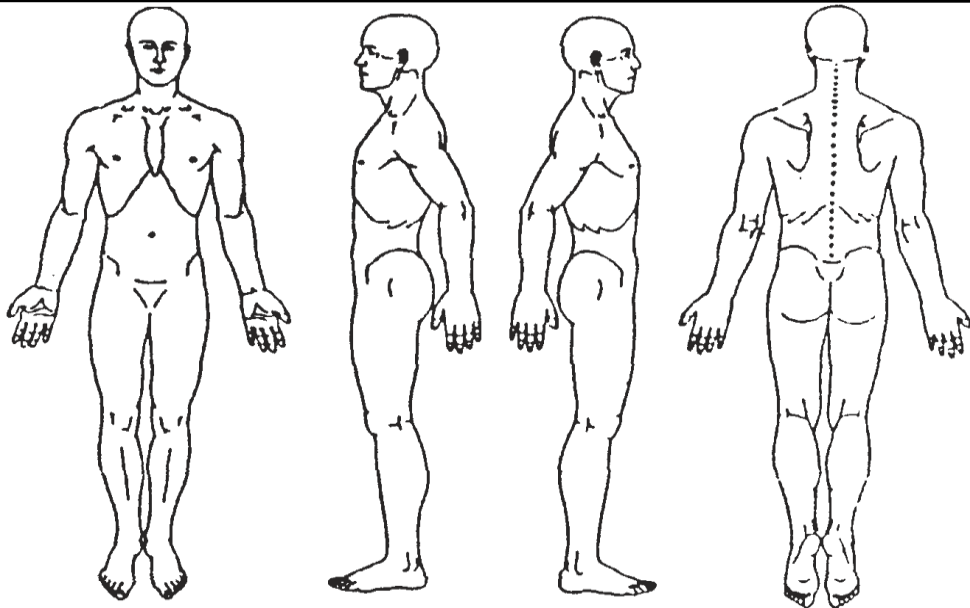
3. AT WORST:



Draw the location of your symptoms using these symbols:

(mark on the figures)

- XXX = ache
- \* = sharp/stab
- ooo = numb/tingle
- = shooting
- /// = stiff/tight



**NOTICE TO ALL NEW PATIENTS:** Payment in full for chiropractic services rendered is due in full at end of each visit. If, for any reason, this request cannot be met, arrangements must be made prior to seeing the physician. I understand it is my responsibility to verify insurance coverage and that I am ultimately financially responsible for any and all services performed. As a result of our focus on improving our care, the information contained in your record may be used to assist in that process. We value and protect your privacy. I grant Dr. Ilk permission to use information in my medical record to assist in the improvement process. I also authorize Dr. Ilk to release appropriate and necessary medical records for insurance billing purposes to first party insurance providers (eg: personal injury insurance, group medical insurance, Labor and Industries).

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

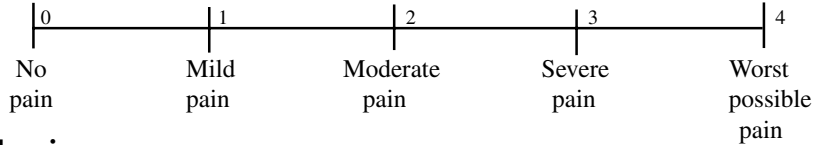
# Functional Rating Index

For use with **Neck and/or Back Problems** only.

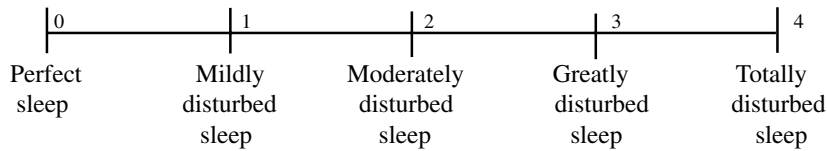
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, please circle the number which most closely describes your condition right now.

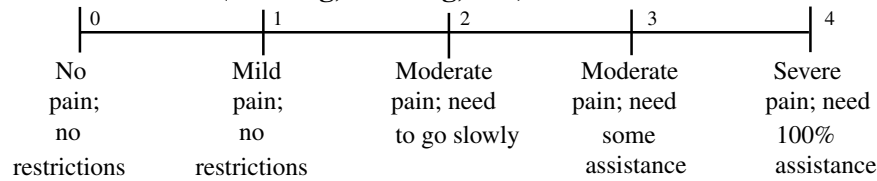
## 1. Pain Intensity



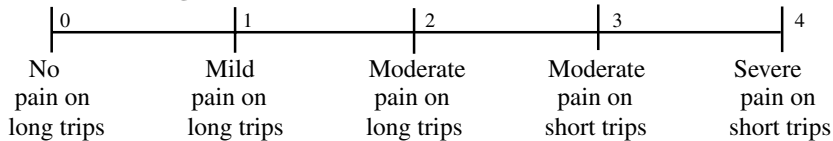
## 2. Sleeping



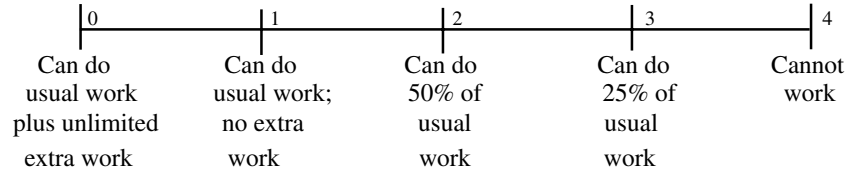
## 3. Personal Care (washing, dressing, etc.)



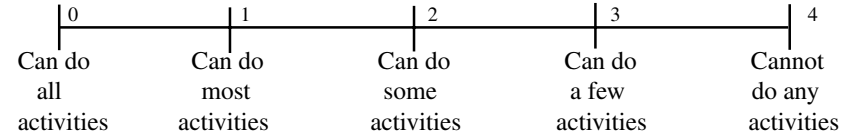
## 4. Travel (driving, etc.)



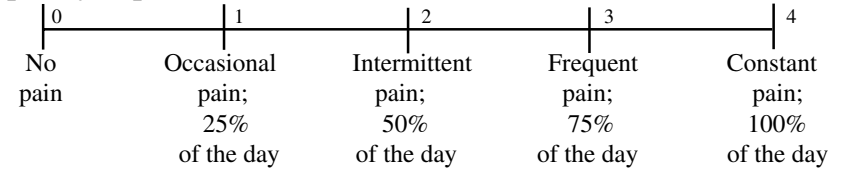
## 5. Work



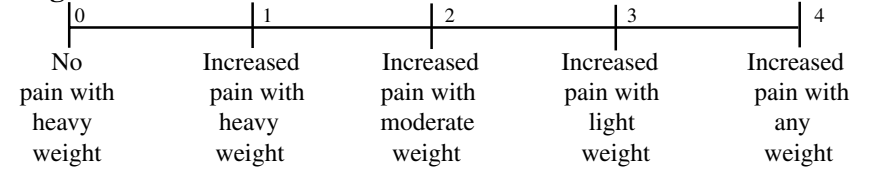
## 6. Recreation



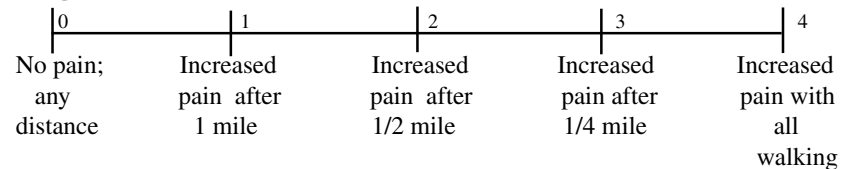
## 7. Frequency of pain



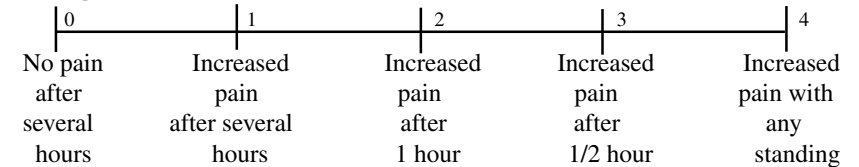
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_

PRINTED

Total Score \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

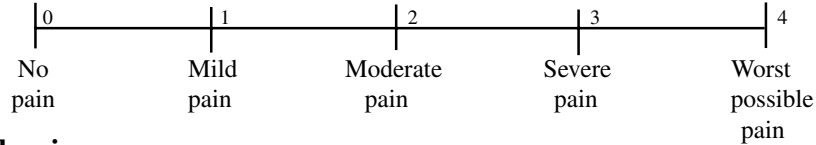
# Functional Rating Index

For use with **Neck and/or Back Problems** only.

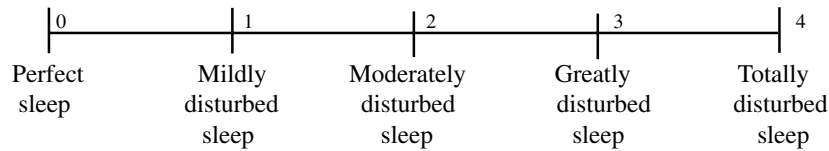
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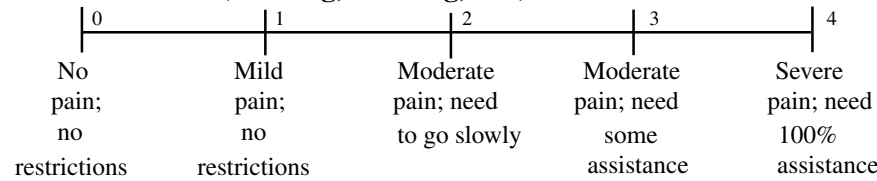
## 1. Pain Intensity



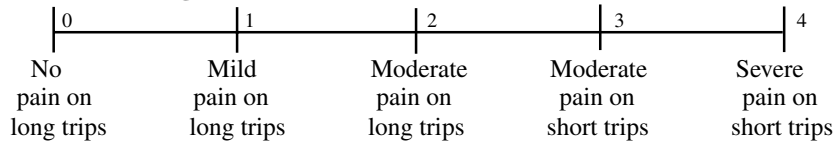
## 2. Sleeping



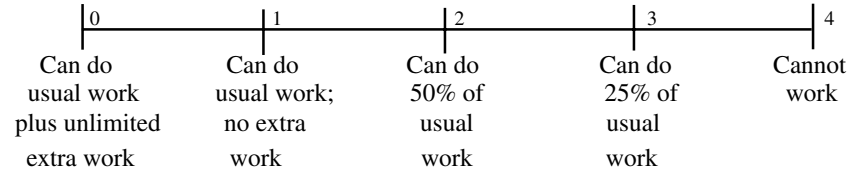
## 3. Personal Care (washing, dressing, etc.)



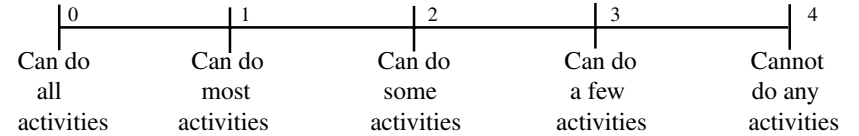
## 4. Travel (driving, etc.)



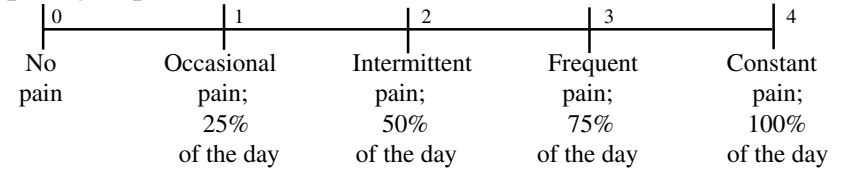
## 5. Work



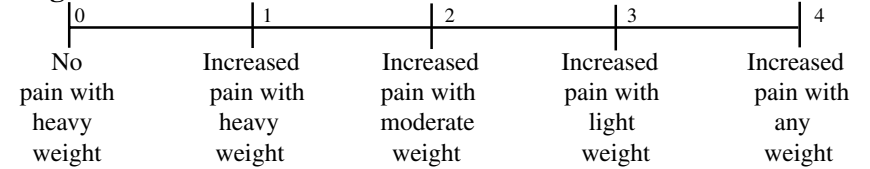
## 6. Recreation



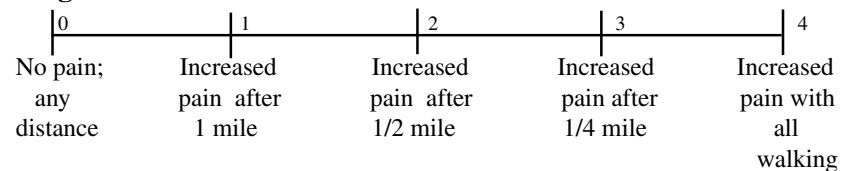
## 7. Frequency of pain



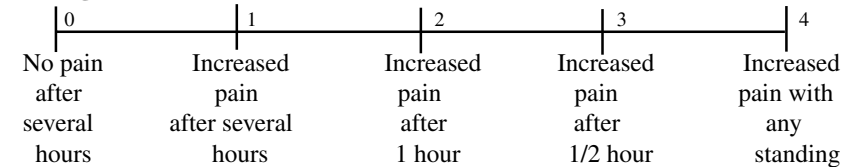
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_

PRINTED

Signature

Total Score \_\_\_\_\_

Date



**Aaron Ilk, DC**  
Chiropractic Physician

1750 112<sup>th</sup> Ave NE  
Suite E-165  
Bellevue, WA 98004

425-827-2302 voice  
425-454-2579 fax  
Dr.Ilkk@BellevueSpine.com

### Release of Information

1. I authorize **Bellevue Spine** to directly bill my insurance company for services rendered at **Bellevue Spine**.
2. I authorize the release of any medical records or other information necessary for the expressed purpose of processing claims for payment.
3. I authorize insurance benefits to be paid directly to **Bellevue Spine** for all services rendered. I understand that I am ultimately financially responsible for payment of any balance in the event my insurance denies any part of my claim.

### Office Policy

As stated in your contract with your insurance company, co-pays are due at the time of service. If a co-pay is not paid at the time of service, I acknowledge/agree to pay a \$25 administrative fee added to cover the cost of sending a statement.

If you have co-insurance that is billed after your insurance payment, a statement will be sent. **Balances are due in 21 days.** I agree acknowledge/agree that a \$25 billing fee will be added to my account per statement to cover the cost of collecting unpaid balances.

I acknowledge/agree to pay a \$25 'no show' fee for missing any scheduled appointment. Please call 24 hrs in advance to cancel/reschedule any appointment.

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

Office Staff \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient if patient is a minor: \_\_\_\_\_

### Email

**Bellevue Spine** will guard your email address. It will not be shared with or sold to any 3<sup>rd</sup> parties. We value your privacy.

**Email address** \_\_\_\_\_



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## If you were involved in a Motor Vehicle Collision-

Please fill out the following to the best of your ability:

Year, Make & Model of YOUR car: \_\_\_\_\_

Year, Make & Model of OTHER car: \_\_\_\_\_

Were you struck from (circle): Behind / Right Side / Left Side / Front

Were you moving? Y / N                      If YES, Approximate Speed: \_\_\_\_\_

Were your brakes applied? Y / N

Type of Transmission (circle): Standard / Automatic

Were you the driver or a passenger? \_\_\_\_\_

Other persons in the car: \_\_\_\_\_

Were you using (circle): Lap belt / Seatbelt with shoulder harness / Nothing

Is there a head restraint on your seat? Y / N                      Did an airbag deploy? Y / N

Road conditions (circle): Wet / Dry / Snow / Ice

Position of head at impact? \_\_\_\_\_

Position of hands at impact? \_\_\_\_\_

Were you aware of the impending collision? Y / N

Did you strike anything inside the car (describe)? \_\_\_\_\_

Did you feel more than one impact (describe)? \_\_\_\_\_

Were you unconscious? Y / N / Uncertain

Were you dazed? Y / N

Where did you go after the collision? \_\_\_\_\_

If you went to the Hospital, what was done there (tests, X-rays)? \_\_\_\_\_

Was a police report filed? Y / N    Official *estimated* property damage? \$ \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## Motor Vehicle Collision: Insurance Companies Involved

Date of Collision: \_\_\_\_\_

YOUR Health Ins Co: \_\_\_\_\_

Address: \_\_\_\_\_

PH# \_\_\_\_\_ Policy/Member # \_\_\_\_\_

YOUR Auto Ins Co: \_\_\_\_\_

Address: \_\_\_\_\_

PH# \_\_\_\_\_ Policy# \_\_\_\_\_

Claim # \_\_\_\_\_ Contact Name: \_\_\_\_\_

Other Party's Auto Ins Co: \_\_\_\_\_

Address: \_\_\_\_\_

PH# \_\_\_\_\_ Policy # \_\_\_\_\_

Claim # \_\_\_\_\_ Contact Name: \_\_\_\_\_

Has an Attorney advised you on this matter? **Y / N**

Have you retained an Attorney? **Y / N**

Name of Attorney: \_\_\_\_\_

Address: \_\_\_\_\_

PH# \_\_\_\_\_

File # (if applicable) \_\_\_\_\_



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## OFFICE FINANCIAL POLICY

### **Medicare Patients**

Medicare is your primary insurance carrier. We will bill Medicare from our office. Medicare will only pay for services that it determines to be “reasonable and necessary.” If Medicare determines that a particular service is not “reasonable and necessary” under Medicare standards, Medicare will deny payment for that service.

Current Medicare regulations will NOT reimburse for the following services: examinations, physical therapy, x-rays or supports.

If Medicare denies any services, your secondary insurance may cover the service, however, non-covered services will be charged directly to you and you will be responsible for payment.

### **Motor Vehicle Collision Patients**

If you have PIP we will bill your insurance carrier directly. If the collision was not your fault, there are laws in place that prevent your insurance company from increasing your rates. Should you have ANY questions regarding these laws, please contact an Attorney. These carriers often pay up to 100% of billed charges. If your carrier does not, we will notify you. You will be responsible for unpaid charges.

If you do not have PIP coverage, our office will carry a medical lien up to \$1000.00. Balances over \$1000.00 are to be paid in full, while balances less than \$1000.00 require minimum monthly payments of \$100.00. This policy will also be in effect should your PIP benefits become exhausted.

### **Workers Compensation (On the Job Injury) Patients**

We will bill the workers compensation carrier. In an accepted claim, insurance may pay up to 100% of all charges.

### **Time of Service Patients**

Payment for services is due at time of service. We do not bill for services after the fact. Your doctor will discuss fees with you at the time of service.

### **Health Plans**

We will bill your insurance carrier for you.

If your plan is a managed care plan, and requires a physician referral, we will help you obtain one. However, the responsibility for this referral lies with you. If your plan requires pre-authorization, we will work to obtain this on your behalf.

If your plan requires a co-pay, we expect this to be paid at the time of service. We will collect your deductible portion after billing your insurance company and obtaining an Explanation of Benefits to determine the exact amount.

**Please ask your doctor or a staff member if you have ANY questions on the above items.**

I have read, understand and accept this financial policy.

Signed \_\_\_\_\_ Date \_\_\_\_\_