DR. RAYMOND SICILIA
611 W. GARLAND AVE.
SPOKANE, WA 99205
PH: (509)489-2883 FAX: (509)487-0898

Patient Name: ______________________________ Date of Birth: ____________ Gender: ◯ M ◯ F
Last Name First Name

Address ______________________________ City ______________ State _____ Zip Code _________

Phone # ______________ ◯ Cell ◯ Work ◯ Home May we leave a message for you at this phone number? ◯ Yes ◯ No

Social Security # ____________________ Email Address ______________________________

How did you hear about us? ◯ A friend ______________________ ◯ Ad in CDA Living ◯ Other ____________
Who is the friend?

Who is your Primary Care Provider? ______________________ PCP Ph# ______________________

Have you ever received Chiropractic Care? ◯ Yes – when? ______________ ◯ No

INSURANCE INFORMATION

Insurance Plan Name ______________________ Policy # ______________________

Please provide your insurance and we will photocopy it for our records

PERSONAL HISTORY

Do you have any allergies? ◯ No ◯ Yes – If yes, List your allergies ______________________

What is your level of exercise? ◯ 1-2 days a week 20mins or more ◯ 3 or more days a week 20mins or more ◯ Very little

What do you do for exercise? ______________________________

SURGERIES – Please list surgeries you have had.

	Area of surgery – indicate right or left	Approx. date of surgery
1		
2		
3		
4		

Is there a previous trauma or injury still affecting you? ◯ No ◯ Yes – Briefly describe ______________________

____

MEDICATIONS – List medications you are taking and doses. A printed list can be provided if necessary.

Name of Medication	How many times per day?	Dosage and route of administration

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other ___________ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other ___________
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _______________ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other ________________ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other ______________________ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _________ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _______________ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other __________ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other ______________________ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other ____________ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? __________________________

Patient Name ______________________________ Date of Birth ____________________

MEDICAL, FAMILY AND SOCIAL HISTORY Continued…

Family History (Check any illnesses that any **blood relatives** have ever had):

- ☐ Allergies/Asthma
- ☐ Anemia
- ☐ Blood Clotting Problems
- ☐ Arthritis
- ☐ Prostate/Breast/Colon Cancer
- ☐ Glaucoma
- ☐ Alcoholism
- ☐ Stomach/Ulcer Problems
- ☐ Genetic Disease/Type
- ☐ Kidney/Bladder Problems
- ☐ Epilepsy
- ☐ High Blood Pressure
- ☐ Nervous Breakdown
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Other: ______________________________

Father: ☐ Living ☐ Deceased Age: ______ Medical Problems: ______________________

Mother: ☐ Living ☐ Deceased Age: ______ Medical Problems: ______________________

Sisters: # Living ______ # Deceased ______ Medical Problems: ______________________

Brothers: # Living ______ # Deceased ______ Medical Problems: ______________________

Your Medical History (Check all you have ever had):

- ☐ Asthma
- ☐ Allergies
- ☐ Anemia
- ☐ Blood Disease
- ☐ AIDS
- ☐ Diabetes
- ☐ Cancer/Tumor
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ TB
- ☐ Genetic Disease
- ☐ Alcoholism
- ☐ Kidney Disease
- ☐ Stomach Problems
- ☐ Hernia
- ☐ Ulcers
- ☐ Nervous Breakdown
- ☐ Arthritis
- ☐ Heart Trouble
- ☐ Colitis
- ☐ Eye Trouble
- ☐ Skin Trouble
- ☐ Lung Disease
- ☐ Stroke
- ☐ Pneumonia
- ☐ Liver Disease
- ☐ Convulsions
- ☐ Hepatitis A, B, C
- ☐ Migraine
- ☐ Thyroid Disease
- ☐ Gallbladder Disease
- ☐ Blood Transfusion
- ☐ Breast Lump
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Sexually Transmitted Disease
- ☐ Abnormal Menstrual Bleeding
- ☐ Childhood Disease (list):
- ☐ Other:

Social History (Please answer the following questions as completely as you can):

Do you smoke: ☐ YES ☐ NO How much: ________ How long: ________ When did you quit: ________

Do you drink alcohol: ☐ YES ☐ NO How much/often: ______________________

Do you use recreational street drugs: ☐ YES ☐ NO Which ones/how much: ______________________

Do you take any form of caffeine: ☐ Coffee ☐ Soda ☐ Tea Other: ________ How much/often: ________

I authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to INLAND WELLNESS dba SICILIA CHIROPRACTIC for services provided.

Patient Signature ______________________________ Today's date ____________________

Guardian Signature (if the patient is a minor) ______________________________

NEW PATIENT HISTORY FORM

Patient Name: ____ **Date:** ________________

Symptom 1 ______________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
  - How did the symptom begin? ____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): ________________________

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): ________________

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ____________________________

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other __________.

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other ________________________________

Symptom 2 ________________________________ ☐ Does Not Apply

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ________________________________
  - How did the symptom begin? ________________________________

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): ________________________

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): ________________

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ________________________________

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ________________________

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other ________

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other ________________________________

Symptom 3 ______________________________ ☐ Does Not Apply

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ______________________________
    - How did the symptom begin? ______________________________

- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): ______________________

- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): ________________

- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ______________________________

- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? ______________________________

- Is the symptom worse at certain times of the day or night? (please circle)
    - No difference Morning Afternoon Evening Night Other __________

- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other ______________________________

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HIPAA NOTICE OF PRIVACY PRACTICES

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 describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our 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, pay your health care bills, to support the operations 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 health care 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 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, marketing, and fundraising activities, and conduction 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 included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you 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.

____ ____________________________
Signature of Patient of Representative Date

____
Printed Name

DR. RAYMOND SICILIA
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TODAY'S DATE: ____________________

PATIENT NAME: ____________________________________ DOB: ________________

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

The signatures below represent both request and consent to the administering of spinal manipulative therapy, and other chiropractic procedures, including diagnostic tests, x-rays and various modes of ancillary therapies within the scope of chiropractic practice, recommended to me (or the person named, for whom I am legally responsible) by Dr. Raymond Sicilia and staff who assist in the delivery of Inland Wellness dba Sicilia Chiropractic (including other licensed doctors of chiropractic or assistants).

I have had the opportunity to discuss the nature and purpose of chiropractic spinal manipulation and other ancillary procedures with the Doctor and/or other provider of services within the clinic.

I understand and am informed that, as with any form of treatment, there are some inherent risks to chiropractic treatment. These risks include, but are not limited to fractures, dislocations, strain/sprain injury and stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the expertise and judgement of the doctor in the planning and administering of those treatments/therapies which the doctor recommends, based on the information I have provided, are appropriate and in my best interest.

Regardless of what the disease is called, we do not offer to treat the disease nor does our office offer advice regarding treatment prescribed by other providers. THE GOAL OF YOUR PROVIDER is to eliminate major interference to the expression of the body's innate wisdom. Spinal manipulation services delivered by a chiropractor is the method used to specifically adjust or correct vertebral sublaxation.

I have read, or have had read to me, the above information. I have also had the opportunity to ask questions about its content and by signing below, agree to the above named procedures and services. I intend this consent form to cover the entire course of treatment for present and future conditions delivered by provides at Inland Wellness dba Sicilia Chiropractic.

PATIENT'S SIGNATURE: ____

WHAT TO EXPECT AFTER STARTING CHIROPRACTIC CARE

★ **Increased pain and stiffness:** Depending on how long your condition has been going on, your body will experience a huge change. During the time you were experiencing an increase in sypmtoms and pain, your body became used to functioning a certain way. Living your daily life through this has become your body's "normal" function. A spinal manipulation, or adjustment, completely changes how your body will now move by increasing the range of motion of the spine. The previously strained muscles, ligaments and tendons in those areas will now work to function normally but need some time to adjust to newly aligned areas. Your body will react to this through inflammation of the muscles, ligaments and tendons. For these reasons, you could experience MORE discomfort than you presented with when you first walked in. 10% – 20% of patients who undergo care experience this.

- X ***If this happens to you, here's what you do:***
  - Ice the area involved 15 minutes on and 15 minutes off while maintaining good posture.
  - If the problem area is your low back, use pillows underneath your knees if you sleep on your back and pillows in between your knees if you sleep on your side.
  - Be consistent with the treatment plan prescribed by your provider. Consistent adjustments to KEEP the spine aligned is critical in the early stages so those muscles, ligaments and tendons can heal.

★ **Increased popping of the joints in your neck and/or back:** The quick stretch of the adjustment will decrease the spasm in some of the tiny segmental muscles that attach to the spine, though others take longer to relax. If there is a tight muscle on one side of the vertebrae while you rotate or laterally bend your neck and/or back, you could experience the release of the joint which is best described as a "pop".

- X ***What do I do? Should I be concerned?*** Do not be concerned. Be consistent with the treatment plan prescribed by your provider. Consistent adjustments will eventually allow for the spine and the muscles attached to function as your body originally intended.

★ **Headaches may develop:** The muscles in the upper neck (at the base of the skull) may inflame or go into spasm, for all the reasons previously noted.

- X ***What do I do?*** Lie down comfortably and place ice on your neck – 15 minutes on and 15 minutes off. Be consistent with the treatment plan prescribed by your provider.

SICILIA
CHIROPRACTIC

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