

Welcome to Midway Chiropractic!

Today's Date: _____

206-824-9500 / Fax 206-824-9654

Your path to wellness begins now! Please complete this packet as best as you can. If you have any questions please let the staff know.

Last Name:		First:		Middle Initial:	Name you go by:
Birthdate:		Sex:	SSN:		<i>Please present a valid photo ID to the receptionist.</i>
Street Address:			City:	State:	ZIP:
Phone:		Mobile:	Email:		
How did you find out about us?	<input type="checkbox"/> Clinic: _____		<input type="checkbox"/> Family/Friend: _____		<input type="checkbox"/> Phone Book <input type="checkbox"/> Insurance <input type="checkbox"/> Other: _____

Billing Information

Please provide us with any insurance information you have. It is our clinic policy to retain all private health insurance information regardless of claim type.

<input type="checkbox"/> I will be paying cash.		<i>We accept cash, debit, credit, and personal checks.</i>			
<input type="checkbox"/> I have health insurance.		<input type="checkbox"/> My own insurance	<input type="checkbox"/> My family insurance	<input type="checkbox"/> I have secondary coverage.	<input type="checkbox"/> I have Medicare.
<input type="checkbox"/> I was in an auto accident.	Date of Accident:	Name of your insurance:			<input type="checkbox"/> I don't have insurance.
Claim Number:		Insurance Adjustor:		Their Phone:	
Person who hit you:			Their Insurance Name:		<input type="checkbox"/> More than 2 car accident?
Their claim number:		Any other information you have on the other party.			
<input type="checkbox"/> This is a workplace injury.	Date of Injury:	<input type="checkbox"/> I want to open a claim. (Please ask for a state report of accident form.)			
<input type="checkbox"/> I already have an open claim	Claim Number:	Name of employer insurance:			
Name of employer:			Employer Phone:		

Informed Consent

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

I understand the massage given here is for the purpose of relief from muscular tensions or spasm, and for increasing circulation. I understand the massage practitioner does not diagnose illness, disease, or other physical or mental disorder. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor perform spinal manipulations. I understand massage is not a substitute for medical examinations and diagnosis, and that it is recommended to see a physician for any physical ailment I may have. Because a massage practitioner must be aware of existing conditions, I have stated all of my known medical conditions and take it upon myself to keep the practitioner updated on my physical, mental, and emotional health.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I have read and fully understand the above statements and therefore accept chiropractic care on this basis. I agree that financial responsibility for my treatment is ultimately my own. **I am also aware that a fee may be charged if I cancel my appointment less than 24 hours before it begins.**

Print Name:	Signature:	Today's Date:
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Consent to evaluate and adjust a minor child:

I, the above signed, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

<i>Emergency Contact Information</i> Name of contact:	Relation to Patient:	Phone:
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Health History

Please answer the following questions to help us better evaluate your condition for the best healthcare possible.

Have you ever been treated by a chiropractor before? YES NO

If yes how long ago and why? _____

Do you know what may have caused today's pain? (Brief Summary, please include estimated dates if possible)

Have you seen any other medical provider for this condition? YES NO

If yes, please list

Did the above listed providers help improve your condition? (Brief Explanation of your experience)

Please list all the medications or supplements, that you are currently taking, as well as any you have taken in the recent past.

Have you ever had any of the following medical conditions?

Eruption (rash) hives	Y	N	Asthma/hay fever	Y	N	Back or neck problems	Y	N
Glaucoma	Y	N	Persistent cough or sore throat	Y	N	Arthritis/rheumatism	Y	N
Loss of Hearing	Y	N	Difficulty breathing while laying down	Y	N	Hepatitis	Y	N
Ringing in ears	Y	N	Diabetes	Y	N	Ulcers	Y	N
Frequent nosebleeds	Y	N	Thyroid condition/goiter	Y	N	Kidney disease	Y	N
Sinus problems	Y	N	Chest pain/discomfort	Y	N	Venereal disease	Y	N
Stroke	Y	N	Heart attack/trouble	Y	N	Radiation therapy	Y	N
Headaches	Y	N	Shortness of breath	Y	N	Tumors or growths	Y	N
Convulsions/epilepsy	Y	N	High blood pressure	Y	N	Cancer	Y	N
Fainting	Y	N	Congenital heart disease	Y	N	A.I.D.S.	Y	N
Psychiatric treatment	Y	N	Artificial heart valve	Y	N	H.I.V. positive	Y	N
Tuberculosis	Y	N	Pacemaker	Y	N	Other _____		
Emphysema	Y	N	Heart surgery	Y	N			

Please list any other medical conditions you suffer, or have suffered from in the past.

If you have had any surgeries or major medical treatments, please list them here with approximate dates.

Have you ever had any serious injuries? Please list them with approximate dates.

Are you currently wearing any kind of foot support? (Heel lifts, Arch Supports, etc.)

Women - Are you pregnant? YES NO If yes, how long? _____ Nursing? YES NO Are you taking oral contraceptives? YES NO

Do you exercise regularly or participate in any sports? YES NO

Have you ever had a professional massage? YES NO

Functional Rating Index

For use with neck and/or back problems only. For each item below, please circle the number which most closely describes your condition right now.

Patient Name _____ Date _____

1. Pain Intensity

0- No Pain 1- Mild Pain 2- Moderate Pain 3- Severe Pain 4- Worst Possible Pain

2. Sleeping

0- Perfect Sleep 1- Mildly Disturbed 2- Moderately Disturbed 3- Greatly Disturbed 4- Totally Disturbed Sleep

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

0- No Pain
No Restrictions 1- Mild Pain;
No Restrictions 2- Moderate Pain;
Go Slowly 3- Moderate Pain;
Some Assistance 4- Severe Pain;
100% Assistance

4. Travel (driving, etc.)

0- No Pain on
Long Trips 1- Mild Pain on
Long Trips 2- Moderate Pain on
Long Trips 3- Moderate Pain on
Short Trips 4- Severe Pain on
Short Trips

5. Work

0- Usual Work + Extra 1- Usual Work, No Extra 2- 50% of Usual Work 3- 25% of Usual Work 4- Cannot Work

6. Recreation

0- All Activities 1- Most Activities 2- Some Activities 3- Few Activities 4- No Activities

7. Frequency of Pain

0- No Pain 1- Occasional (25%) 2- Intermittent (50%) 3- Frequent (75%) 4- Constant (100%)

8. Lifting

0- No Pain with
Heavy Weight 1- Increased Pain with
Heavy Weight 2- Increased Pain with
Moderate Weight 3- Increased Pain with
Light Weight 4- Increased Pain with
Any Weight

9. Walking

0- No Pain with
Any Distance 1- Increased Pain after
1 Mile 2- Increased Pain after
½ Mile 3- Increased Pain after
¼ Mile 4- Increased Pain after
Any Distance

10. Standing

0- No Pain with
Any Time 1- Increased Pain after
Several Hours 2- Increased Pain after
1 Hour 3- Increased Pain after
½ Hour 4- Increased Pain after
Any Time

Patient or Guardian Signature _____ Date _____

PATIENT SPECIFIC FUNCTIONAL AND PAIN SCALES (PSFS)

Name _____

Date _____

In your visits here we want to know what 3 activities in your life you are unable to do or having the most difficulty with as a result of your chief problem (_____).

Please list 3 activities you are unable to perform or having the most difficulty with because of your chief problem.

1. _____

2. _____

3. _____

Activity #1

(Point to one number):

Able to perform activity without difficulty	0	1	2	3	4	5	6	7	8	9	10	Unable to perform the activity
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Activity #2

(Point to one number):

Able to perform activity without difficulty	0	1	2	3	4	5	6	7	8	9	10	Unable to perform the activity
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Activity #3

(Point to one number):

Able to perform activity without difficulty	0	1	2	3	4	5	6	7	8	9	10	Unable to perform the activity
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Our goal is to work together with you to “problem-solve” ways to return you to the activities which **you have told us** you are either unable to perform or are giving you the most difficulty since this problem began.

Signature

Chatman AB, Hyams SP, Neel JM, Binkley JM, Stratford PW, Schomberg A, Stabler M. The patient-specific functional scale: Measurement properties in patients with knee dysfunction. Phys Ther 1997;77:820-829.

Pain/Discomfort Rating Scale

Please choose the number which best describes your pain in each of the questions below

(0= No Pain 10= Unbearable Pain)

What is your pain/discomfort RIGHT NOW?

HEADACHE	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10
UPPER BACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10

What is your pain/discomfort TYPICAL OR AVERAGE?

HEADACHE	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10
UPPER BACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10

What is your pain/discomfort AT ITS WORST?

HEADACHE	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10
UPPER BACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10

PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE USE THE LETTERS BELOW TO MARK THE AREAS IN WHICH YOU FEEL THE CORRESPONDING SENSATIONS.

- A** = ACHE **B** = BURNING
- S** = STABBING **P** = PINS/NEEDLES
- O** = OTHER **N** = NUMBNESS

COLOR IN AREAS TO INDICATE BRUISING

