

MIDWAY CHIROPRACTIC
23100 Pacific Hwy. So. Ste 201
Des Moines, WA 98198
[P] (206) 824-9500 : [F] (206) 824-9654

General Information (Please Complete ALL fields):

Name: _____ DOB: ___/___/___ Social Security#: _____
Sex: _____ Marital Status: _____

Please fill out and put a check next to the best number to contact you.

Home Phone: _____ Cell Phone: _____ Work Phone _____

Address: _____ City: _____ State: _____ ZIP: _____

Work Information (in case the doctor has to take you off of work due to injury):

Your Job Title: _____ Employer Name: _____

Work Address: _____ State: _____ ZIP: _____

Phone: _____ FAX: _____ Manager Name: _____

Your Insurance Information (This information is required, if you don't have auto insurance, please notify the receptionist.):

Date of Accident: _____ Name of YOUR Auto Insurance Company: _____

Claim Number: _____

Billing Address: _____

Name of Insurance Adjustor: _____ Phone Number: _____

Other Party's Information (This information is required, please notify the receptionist if you do not have this information):

Name of other party involved: _____ Multiple Car Accident? YES ___ NO ___

Other party's Insurance Company: _____ Claim Number: _____

Address: _____ Phone Number: _____

Health Insurance information (This information is required, though we may not bill this insurance, we must keep it on file.):

Name of your Health Insurance Carrier: _____ ID Number: _____

Please allow the receptionist to take a copy of your health insurance card for our records.

Attorney Information (If applicable):

Your Attorney's Name: _____ Phone Number: _____

Address: _____ Paralegal Name: _____

I, the undersigned, do hereby agree that I am responsible for all fees accrued during my treatment at Midway Chiropractic. I also agree that said fees will be paid in a timely manner, unless otherwise arranged in writing. I realize that any dispute in payment is between my insurance company and I, and that Midway Chiropractic cannot be held responsible for such.

Signature: _____

Date: _____

Note: The above MUST be signed to begin treatment.

Health History

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

Name: _____ Today's Date: _____

Have you ever been treated by a chiropractor before? Yes No

If yes please explain: _____

The reason for this visit is a result of (please circle): sports, trauma, chronic other _____

(explain what happened) _____

Please describe the discomfort and it's location: _____

When did the condition begin: _____ / _____ / _____

Is the condition getting worse? yes no constant comes and goes

Is this condition interfering with your: work sleep daily routine, Please explain: _____

Have you been to another health provider for this condition? Y or N

If yes whom and where? _____

Are you taking any of the following medications?

_____ Nerve pills _____ Pain killers (including aspirin) _____ Muscle relaxers _____ Stimulants
_____ Blood Thinners _____ Tranquilizers _____ Insulin _____ Others _____

Have you ever had any of the following diseases/medical condition(s)?

- | | | |
|--------------------------------|-----------------------------|-----------------------|
| Y N Heart Attack / Stroke | Y N Heart Surg/Pacemaker | Y N Heart Murmur |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse | Y N Artificial Valves |
| Y N Alcohol / Drug Abuse | Y N Venereal Disease | Y N Hepatitis |
| Y N HIV+ / AIDS | Y N Shingles | Y N Cancer |
| Y N Frequent Neck Pain | Y N Emphysema/Glaucoma | Y N Anemia |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever |
| Y N Severe/Frequent Headaches | Y N Kidney Problems | Y N Ulcers / Colitis |
| Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Asthma |
| Y N Diabetes / Tuberculosis | Y N Difficulty Breathing | Y N Chemotherapy |
| Y N Lower Back Problems | Y N Artificial Bones/Joints | Y N Arthritis |

Please list any other serious medical condition(s) you have or ever had: _____

List previous surgeries/treatments with dates: _____

List any past serious accidents with dates: _____

Are you wearing _____ Heel lifts, _____ Sole lifts, _____ Inner soles, _____ Arch supports

Women -- Taking birth control? Y N, Pregnant NO Yes/How long _____ Nursing? Y N

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. I understand it is my responsibility to inform this office of any changes in my medical status.

MIDWAY CHIROPRACTIC

23100 PACIFIC HWY. So ~ Ste 201 ~ Des Moines, WA 98198

(206) 824-9500 ~ Fax (206) 824-8145

PAIN/DISCOMFORT RATING SCALE

NAME: _____

DATE: _____

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

1. What is your pain/discomfort RIGHT NOW? (0= No Pain 10= Unbearable Pain)

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

2. What is your pain/discomfort TYPICAL OR AVERAGE? (0= No Pain 10= Unbearable Pain)

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

3. What is your pain/discomfort AT IT'S WORST? (0= No Pain 10= Unbearable Pain)

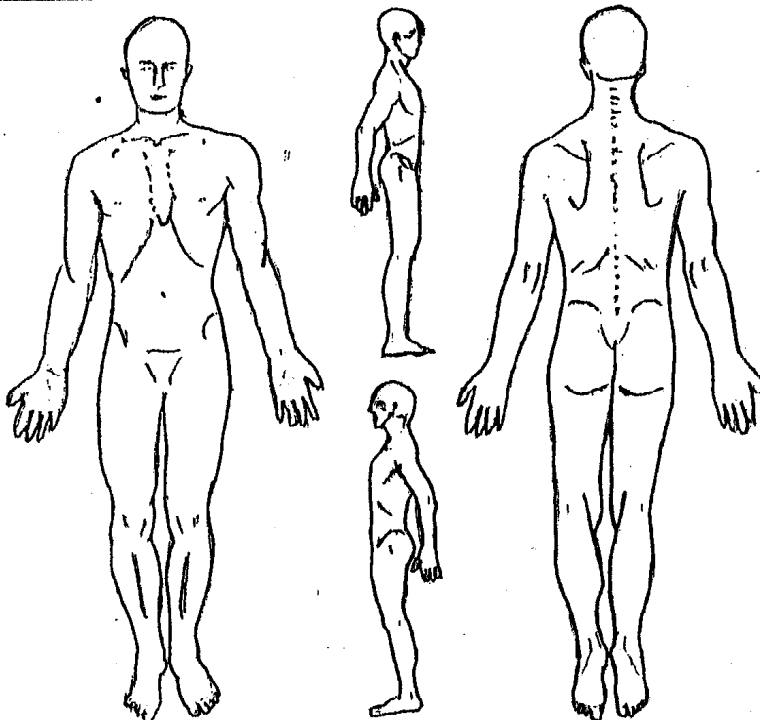
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Upper back	0	1	2	3	4	5	6	7	8	9	10
Low back	0	1	2	3	4	5	6	7	8	9	10

PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE USE THE LETTERS TO MARK THE AREAS IN WHICH YOU FEEL SENSATIONS. CIRCLE ALL THAT APPLY TO YOU.

A = ACHE B = BURNING N = NUMBNESS
 S = STABBING P = PINS & NEEDLES
 O = OTHER

PLEASE CLEARLY INDICATE AREAS OF BRUISING.



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

Patient Specific Activity Scoring scheme (Point to one number):

0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity									Able to perform activity at same level as before injury or problem	

Activity #2

Patient Specific Activity Scoring scheme (Point to one number):

0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity									Able to perform activity at same level as before injury or problem	

Activity #3

Patient Specific Activity Scoring scheme (Point to one number):

0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity									Able to perform activity at same level as before injury or problem	

(MDC and MCID = 3)

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

MIDWAY CHIROPRACTIC

NECK PAIN DISABILITY QUESTIONNAIRE

Name: _____

Date: _____

This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by checking **THE ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CHECK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 - PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I was with difficulty and stay in bed.

SECTION 3 - LIFTING

- I can lift heavy weights, without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights, at the most.

SECTION 4 - READING

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- I cannot read as much as I want because of severe pain in my neck.
- I cannot read at all.

SECTION 5- HEADACHES

- I have not headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

SECTION 6 - CONCENTRATION

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7 - WORK

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

SECTION 8 - DRIVING

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I cannot drive my car at all.

SECTION 9 - SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 - RECREATION

- I am able to engage in all of my recreational activities, with no-neck pain at all.
- I am able to engage in all of my recreational activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I cannot do any recreational activities at all.

COMMENTS: _____
