McCracken Chiropractic and Wellness Center

284 Central Way | Kirkland, WA. | 98033 | P (425) 605-8508 | F (425) 605-1288

CONFIDENTIAL PATIENT INFORMATION FORM

NAME: _____
Last Name First Name Middle Initial Preferred Name

ADDRESS: _____ **GENDER:** ☐ Male ☐ Female

CITY: _____ **STATE:** _____ **ZIP:** _____

EMAIL: _____ (Statements emailed when possible.)

PHONE: **[H]** (_____) _____ - _____ **[W]** (_____) _____ - _____ **[C]** (_____) _____ - _____

DATE OF BIRTH: _____ / _____ / _____ **KIDS /AGES:** _____

EMPLOYER: _____ **JOB TITLE:** _____ **HOW LONG?** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

MARITAL STATUS: ☐ S ☐ M ☐ D ☐W ☐ SEP **PARTNERS' NAME:** _____

EMERGENCY CONTACT: _____ **PHONE:** (_____) _____ - _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR CLINIC? _____

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the office of **McCracken Chiropractic & Wellness Center** to release to the insurance company agencies any information requested by the insurance company to process a claim for payment of treatment received from this office. I understand records may be faxed, delivered by courier, mailed, and/or or e-mailed.

ASSIGNMENT OF BENEFITS I hereby assign payment directly to **McCracken Chiropractic & Wellness Center** for the benefits available under my insurance policy for treatment and/or expenses incurred at this office. Furthermore, I request all benefits allowable under my insurance policy be issued directly to **McCracken Chiropractic & Wellness Center**.

I understand I am financially responsible for all costs incurred in the office, whether my insurance pays or not. I also understand there may be certain procedures which are not covered under my insurance policy/MVA/Labor & Industries and/or third party accidents, and agree to be financially responsible for any accumulated charges. Examples of possible non-covered charges may include but are not limited to: supplies, manual traction, manual modalities, re-exams, exercise instruction, maintenance/palliative care, and/or application of heat/ice. I agree this 'Assignment of Benefits' is irrevocable and wave the statute of limitations for payment.

_____ **INITIAL FOR CONSENT OF TREATMENT FOR A MINOR/CHILD**: As the parent and/or legal guardian, I have the authority to authorize, and do hereby grant the **McCracken Chiropractic & Wellness Center**, to administer chiropractic care as he/she deems necessary to my son/daughter/ward.

Name of minor _____ Name of parent/guardian: _____.

I understand the Authorization to Release Information and Assignment of Benefits, and agree to the terms and conditions stated above. By initialing above, I authorize treatment of a minor. **By refusing to sign below I understand I and/or my child/minor will not receive care from the McCracken Chiropractic & Wellness Center.**

PATIENT SIGNATURE: _____ **DATE:** _____

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INSURANCE VERIFICATION PAGE

FOR THE MOST ACCURATE BENEFIT INFORMATION
WE REQUEST PATIENTS TO CONTACT THEIR INSURANCE DIRECTLY.

Use this form for reference when contacting your insurance company to confirm benefits. Please note; it is the responsibility of you, the patient, to know your benefits when receiving care at our office.*

Is chiropractic care covered under my plan? ☐ No ☐ Yes

Plan effective date: _____ Yearly deductible: _____

Does my deductible apply to chiropractic? ☐ No ☐ Yes

Do you have a copay or coinsurance? ☐ No ☐ Yes: _____

How many visits are allowed under my plan? _____

Is authorization required? ☐ No ☐ Yes: _____

Is my coverage combined with other therapies? ☐ No ☐ Yes: _____

What is your maximum out of pocket? _____

Does my policy renew on a calendar year? ☐ Yes ☐ No, renews: _____

*PLEASE BE AWARE: Unless otherwise required by state law, the information you have obtained from your insurance is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts such as deductible may change as additional claims are processed.

X _____ _____

Signature *Date*

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GENERAL INSURANCE & FINANCIAL POLICY AGREEMENT

ENSURE YOU HAVE READ ALL OF THE INFORMATION BELOW BEFORE SIGNING.

FINANCIAL POLICY

1. Patients are responsible for the payment of all charges incurred for their treatment.
2. If your insurance card lists a co-pay amount, the co-pay will be due at the time of service. (If our billing department can verify services are not subject to the co-pay, your account will be credited).
3. With the exception of pre-fabricated foot orthotics/inserts, most supports and supplies which our office sells are not covered by insurance. As a courtesy we will attempt to bill your insurance however, you will be responsible for any non-payment. While our cash price for orthotics/inserts is lower than the allowed amount of most insurance, we are contractually required to submit to insurance for pre-fabricated foot orthotics/inserts. The insurance's allowed amount will prevail over our cash rate.
4. Overdue accounts past ninety (90) days will be assigned to a collection agency of our choosing.
5. Interest of 1.0% per month may accrue on past due accounts.
6. There is a $15 charge for returned checks.
7. No show or late cancellations (less than 24 hours' notice) of an appointment are subject to a $35 fee.

INSURANCE POLICY

1. THE OFFICE **DOES NOT VERIFY INSURANCE BENEFITS**. It is your responsibility to know your benefits.
2. Patients are responsible for providing a current address, phone number as well as, valid ID and insurance card. Statements will be sent monthly for services billed to your insurance. Insurance is a contract between the patient and their carrier; your involvement may be requested on an unpaid claim older than 90 days. Services which have been unpaid after 90 days from the date of service will be billed to the patient as we cannot accept responsibility for collecting on insurance claims or negotiating a disputed claim.
3. Our office is unable to determine how/when claims will be processed until payment has been received from your insurance. Services rendered will be billed under the appropriate code(s) per insurance requirements and national billing guidelines. We will not re-code (change a procedure or diagnostic code) and re-bill any service(s) unless a gross coding error has been made on our part.

SUPPLEMENTAL INFORMATION

1. Our providers may offer/render services for your treatment which may be processed under a separate therapy or rehabilitation benefit. This may subject you to your deductible and/or additional copays/coinsurances which may count against your rehabilitation benefit limit. Examples include but are not limited to: manual traction and/or massage, NMR (neuromuscular re-education), exercises, and/or myofascial release. You may decline these additional services however; these services are performed as a means of adding your treatment and improving your recovery. As noted above, our office is unable to determine how a claim will be processed until payment has been received from your insurance. If you have questions or concerns regarding how treatments/services are billed, they must be addressed either before or during your visit.

ATTENTION REGENCE, PREMERA, AND UNITED HEALTHCARE PATIENTS

Your insurance plan may require pre-notification or pre-authorization before covering your visit. Unfortunately, due to the internal structure of insurance companies and/or subcontractors, we are required to submit these requests after you have been seen by the doctor. If a request for pre-authorization or pre-notification is denied, patients are financially liable for the visit. A copy of the denial may be made available upon request.

	x	
PATIENT NAME	**PATIENT SIGNATURE** (Parent/guardian signature for minors)	**DATE**

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HIPAA POLICY

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may collect, use and/or disclose your personal information, and your rights regarding said information. Under the Health Insurance Portability and Accountability Act of 1996, health care providers must take measures to protect the privacy of your personal information.

We are required by law to:

- Protect the privacy of personal information.
- Provide this Notice explaining our duties and privacy practices.
- Abide by the terms of this notice.

WAYS WE PROTECT YOUR PERSONAL INFORMATION

The staff of McCracken Chiropractic & Wellness Center will be the only allowed persons granted access to records and use of personal information to the extent necessary to conduct the practice of healthcare services. The building is secured at the end of each business day, along with patient charts and computer records. Our staff has been trained on our written confidentiality policy and procedures and will be subject to discipline if they are violated. Your privacy will be protected even if you are no longer a patient; old documents are shredded prior to discarding.

HOW WE COLLECT YOUR PERSONAL INFORMATION

Your information is used to determine appropriate care during your treatment. The use of patient information (such as x-ray records and/or charting information) may be used to determine and render the best treatment. This information may be shared with other chiropractic specialists to assist in determining your treatment. Social Security numbers, birth date(s) and/or employer information may be used to identify you with healthcare insurance groups. Your phone number(s) and/or address will only be used to communicate with you regarding appointments and/or billing for services. Unless otherwise requested, we may not discuss your information with immediate family such as a spouse or sibling. The care/treatment of minors/dependents may be discussed with parents/guardians. In some incidents we may be court ordered to release information and are required to do so if requested.

YOUR RIGHTS AS A PATIENT

You may inspect records we retain regarding personal information and amend them if you feel they are in error. You may request we restrict the sharing of your information except on a case-by case basis. You may request we only contact you at specific locations, i.e. work. You may also request records; we may charge a reasonable fee for this service. You may ask questions regarding your Personal information here.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing below, you agree to and have reviewed the Privacy Practices notice as required by HIPAA, and have been given the opportunity to ask/resolve any questions.

x _____ _____

PATIENT SIGNATURE (Parent/guardian signature for minors) **DATE**

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CONSENT FOR TREATMENT

I hereby request and consent to chiropractic treatment(s) and procedures performed by Dana McCracken and/or an associate working under Dana McCracken at McCracken Chiropractic and Wellness Center. Treatment may include various chiropractic adjustments, physical therapies, massage and/or at home exercises to be performed on/by myself (or the patient named below for whom which I am legally responsible for).

I have been given the opportunity to discuss any questions and/or a concern I may have in regards to my treatment and the practice of chiropractic care. I understand that with any medical treatment, there are some risks associated. Risks may include but are not limited to fractures, disc injuries, strokes, dislocations, sprains, temporary soreness, bruising, and/or discoloration.

I understand and am informed results from treatment may vary and are not guaranteed. In addition, I understand my compliance with dietary recommendations, supplements, prescribed exercises, and/or lifestyle modifications will increase the effectiveness of my care and enhance or maintain my results. I understand a referral to another physician or specialist may be necessary due to the nature of my condition and limitations within the scope of chiropractic treatment(s).

I have been informed some techniques such as neuromuscular re-education, Graston, and/or myofascial release may involve working on muscles located near the breasts, buttocks, and/or groin area. Special care will be exercised in keeping sensitive areas draped during such procedures. If at any time I am uncomfortable with the work being performed, I will inform the doctor before or during the treatment. A written documentation of my request will be noted within my chart which will then be signed by the patient, the doctor, as well a witness at the time of treatment.

I do not expect the doctor to anticipate and or explain all risks and/or complications. I will rely upon the doctor's professional opinion and judgment to determine the best course of care.

I have read (or have had the above information read to me), understand, and consent to the terms of treatment performed by McCracken Chiropractic & Wellness Center. I (or the patient whom which I am legally responsible for) have been given the opportunity to address questions/concerns regarding my consent for treatment. By signing below, I agree to the terms outlined within this document and give consent for the entire course of treatment related to the present condition and/or future condition(s) for which I seek treatment.

PRINTED NAME(S) (Parent/guardian for minors)

SIGNATURE (Parent/guardian signature for minors)

STAFF SIGNATURE

DATE

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NOTICE TO OUR PATIENTS

COMPLETE THIS SECTION *ONLY* IF YOU:
A.) DO NOT HAVE CHIROPRACTIC COVERAGE WITH YOUR INSURANCE
B.) DO NOT HAVE INSURANCE*

As healthcare professionals, we strive to provide the best service for your physical care as well as, finically.

We are aware certain medical plans have high deductibles and many patients may not meet their deductible. With thi said, if an insurance card is presented to our office with active coverage, we are contractually obligated to submi claims and/or bill your insurance company as well as, collect payment(s) towards your plans deductible, copays and/o coinsurance. We are unable to offer discounted fees at the time of service when active insurance has been presented b the patient.

Please be aware, this may result in an increased out-of-pocket cost to you, the patient. Due to our contractual agreement with insurance companies, any increased costs to patients is outside of our control as we do not set the terms and conditions of insurance plans. If you object to this mandate in our provider-insurance contract, we strongly encourage patients to contact their insurance company to file a complaint. As stated above, we are required to submit all claims/bills to your insurance for processing when presented with an insurance card.

*For patients who've exhausted their chiropractic benefits, have insurance but do not have chiropractic coverage, do not have insurance; they may pay our usual discounted time of service rate for care. For initial appointments the fee is $130 with follow-up appointments at $60/visit.

By signing below, you acknowledge McCracken Chiropractic and Wellness Center is contractually obligated to submit all medical claims/bills to your insurance carrier for services which are rendered by our clinic.

BY INITIALING BELOW, I CERTIFY:

A. _____ I have health insurance however; chiropractic care is not a covered service.

B. _____ I do not have health insurance and will pay the "*Time Of Service*" fee for my care.

x _____ _____

PATIENT SIGNATURE (Parent/guardian signature for minors) **DATE**

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A. HEALTH HISTORY

PATIENT NAME: _____ **DATE:** _____

Mark your complaint(s) by section for each area of the body below:

NECK AND BACK	Side	Pain	Numbness	Tingling	Stiffness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Neck	L																							
	R																							
Upper Back	L																							
	R																							
Mid Back	L																							
	R																							
Low Back	L																							
	R																							
Ribs	L																							
	R																							

When did your neck/back complaint(s) begin? _____

UPPER BODY	Side	Pain	Numbness	Tingling	Stiffness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Shoulder	L																							
	R																							
Arm	L																							
	R																							
Elbow	L																							
	R																							
Forearm	L																							
	R																							
Wrist	L																							
	R																							
Hands/ Fingers	L																							
	R																							

When did your upper extremity complaint(s) begin? _____

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LOWER BODY	Side	Pain	Numbness	Tingling	Stiffness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Hip	L																							
	R																							
Buttock	L																							
	R																							
Thigh	L																							
	R																							
Knee	L																							
	R																							
Leg/Calf	L																							
	R																							
Ankle	L																							
	R																							
Foot	L																							
	R																							

When did your upper extremity complaint(s) begin? _____

B. PATIENT COMPLAINTS

1. How did your complaints begin? ☐ Unknown ☐ Suddenly ☐ Gradually

2. What happened to cause or re-aggravate your complaint(s)?

☐ Unknown ☐ Auto accident ☐ Personal injury ☐ Work accident/Injury

☐ Home accident ☐ Sports injury ☐ Other: _____

_____

3. How would you rate your pain today? [0 = no pain and 10 = worst pain]

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain possible

4. When are your symptoms worse?

☐ Always the same ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

5. What makes your condition better? ☐ Nothing ☐ Rest ☐ Heat

☐ Stretching ☐ Sitting ☐ Exercise ☐ Standing ☐ Ice

☐ Medications ☐ Other: _____

6. What makes your condition worse? ☐ Nothing ☐ Coughing ☐ Reaching

☐ Standing ☐ Sneezing ☐ Lifting ☐ Sitting ☐ Pulling

☐ Bending ☐ Walking ☐ Straining ☐ Turning

☐ Other: _____

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7. Have any of your complaint(s) existed in the past? ☐ No ☐ Yes (Please indicate below)

☐ Ribs	☐ Neck	☐ Upper back	☐ Mid back	☐ Low Back
☐ Wrist	☐ Forearm	☐ Elbow	☐ Arm	☐ Shoulder
☐ Knee	☐ Hip	☐ Thigh	☐ Hands/Fingers	☐ Buttock
☐ Foot	☐ Ankle	☐ Leg/Calf	☐ Other: _____	

8. Have you had any recent treatment for your condition <u>outside</u> of this office? ☐ No ☐ Yes

If yes, list dates, treatments and doctors: _____

_____

_____

9. Since your symptoms began, have you noticed a change in:

☐ Bowel function ☐ Bladder function ☐ Sexual function ☐ No to all

C. HEADACHES

COMPLETE THIS SECTION <u>ONLY</u> IF YOU EXPERIENCE HEADACHES.

1. Where is the pain located in association with your headache?

☐ Behind eyes	☐ Left side of head	☐ Left jaw joint	☐ Base of skull
☐ Over eyes	☐ Right side of head	☐ Right jaw joint	☐ Over sinuses

2. What date did your headaches begin? _____ ☐ Same as neck/back complaints

3. How does the intensity if your headaches rate?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain possible

4. What describes your pain? ☐ Dull ☐ Sharp ☐ Deep ☐ Aching ☐ Stabbing
☐ Vice-like ☐ Burning ☐ Throbbing/Pulsating ☐ Other: _____

5. When do your headaches usually start?

☐ Constant ☐ Midday ☐ Evening ☐ Wake up with in the morning.

6. What seems to bring on your headaches?

☐ Alcohol ☐ Certain foods ☐ Menstrual period ☐ Physical activity
☐ Caffeine ☐ Excessive stress ☐ Other: _____

7. How often do they occur? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____

8. How long do your headaches last? ☐ Less than an hour ☐ 1-3 hours ☐ 3+ hours
☐ Several hours to days ☐ All waking hours ☐ Other: _____

9. Do your headaches wake your from your sleep? ☐ No ☐ Yes ☐ Sometimes

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10. Do any of the following occur with your headaches?

☐ Nausea/Vomiting ☐ Dizziness ☐ Tremors ☐ Weakness
☐ Light/Sound sensitivity ☐ Vision problems ☐ Other: _____

11. What makes your headaches better?

☐ Massage ☐ Rest ☐ NSAIDS (Aspirin, Tylenol, etc.) ☐ Lying down
☐ Standing ☐ Ice ☐ Nothing ☐ Other: _____

D. OTHER COMPLAINTS

Do you have any other complaints not covered on this form? ☐ No ☐ Yes, please describe:

_____

_____

E. REVIEW OF SYMPTOMS

ARE YOU CURRENTLY SUFFERING FROM ANY OF THE SYMPTOMS BELOW?

☐ **None**

☐ General/chronic fatigue
☐ Weakness
☐ Fever, continuous
☐ Loss of sleep
☐ Chills, continuous
☐ Unexplained weight change
☐ Night sweats
☐ Headaches
☐ Dizziness
☐ Fainting
☐ Convulsions
☐ Nervousness
☐ Anxiety
☐ Prolonged depression
☐ Phobias
☐ Memory loss
☐ Mood swings, excessive
☐ Nose/sinus pain

☐ Chronic wheezing
☐ Difficulty breathing
☐ Swollen extremities
☐ Blue extremities
☐ Varicosities (visible veins)
☐ Rapid heart beat
☐ Chest pain
☐ Heart palpitations
☐ Heart murmur
☐ Decreased appetite
☐ Increased appetite
☐ Abdominal pain
☐ Hemorrhoids
☐ Excess gas
☐ Excessive vomiting
☐ Excessive diarrhea
☐ Excessive constipation
☐ Heartburn/Indigestion

☐ Goiter (enlarged thyroid gland)
☐ Tremors/shaking
☐ Redness of skin
☐ Skin itching
☐ Urinary retention
☐ Bed-wetting
☐ Sterility
☐ Impotence
☐ Other: _____

☐ Hearing trouble ☐ L ☐ R
☐ Ringing in ears ☐ L ☐ R
☐ Pain in ears ☐ L ☐ R
☐ Ear discharge ☐ L ☐ R
☐ Vision trouble ☐ L ☐ R
☐ Pain in eyes ☐ L ☐ R
☐ Eye discharge ☐ L ☐ R

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☐ Excessive drainage
☐ Chronic nose bleeds
☐ Absence of smell
☐ Skin rash
☐ Skin dryness
☐ Eczema (red inflamed skin)
☐ Hair changes, unplanned
☐ Nail changes, unplanned
☐ Bruise easily
☐ Chronic cough
☐ Painful urination
☐ Mouth sores
☐ Bleeding gums
☐ Enlarged glands
☐ Absence of taste
☐ Abnormal taste sensation
☐ Tonsillitis/Infected tonsils
☐ Difficult swallowing
☐ Heat/cold intolerance
☐ Sugar in urine

WOMEN ONLY:
☐ Irregular menstruation
☐ Painful menstruation
☐ Abnormal vaginal bleeding
☐ Lumps in breasts
☐ Redness/Itching of breasts
☐ Dimpling of breasts
☐ Discharge from breasts
☐ Breast pain
☐ Other: _____

F. HABITS/ACTIVITIES

WHAT ARE YOUR CURRENT HABITS?

Smoking packs/day. ..... ☐ None ☐ <1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+
Caffeinated drinks glasses/day..... ☐ None ☐ <1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+
Alcoholic drinks glasses/day..... ☐ None ☐ <1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+
Drug/Substance Abuse..... ☐ No ☐ Yes* **If yes, please discuss with doctor.*
Exercise days/week..... ☐ None ☐ <1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+

Kinds of exercise you do:

☐ Walking ☐ Jogging ☐ Cycling ☐ Swimming ☐ Strength training
☐ Tennis ☐ Golf ☐ Other: _____

G. MEDICAL HISTORY

1. HEALTH CARE

A. Have you ever been to a chiropractor? ..... ☐ No ☐ Yes
B. Have you been hospitalized in the past? ..... ☐ No ☐ Yes*
*Date/reason for hospitalization: _____
_____
C. Have you ever had surgery? ..... ☐ No ☐ Yes*
*Date, reason and result of surgery: _____
_____

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D. Have you ever had a serious accident/injury? ……..…… ☐ No ☐ Yes*

*Date/description of injury: _____

☐ Auto: _____ ☐ Personal: _____

☐ Work-related: _____ ☐ Sports injury: _____

☐ Other: _____

E. Are you currently taking any vitamins, minerals, and/or herbs? ……..……☐ No ☐ Yes*

If yes, list supplements: _____

_____

F. Are you currently taking any medications? ……..……..…… ☐ No ☐ Yes*

***Which condition(s) are you taking medication(s)?**

☐ Anti-inflammatory (Aspirin, Ibuprofen, Motrin): _____

☐ Pain/Analgesics: _____

☐ Anti-depressants: _____

☐ Muscle relaxants: _____

☐ Blood pressure pills: _____

☐ Antibiotics: _____

☐ Birth control pills: _____

☐ Corticosteroids: _____

☐ Other: _____

In the past have you used any of the following? ☐ Birth control pills ☐ Corticosteroids

G. Are you currently allergic to any medication(s)? ……..……..…….. ☐ No ☐ Yes*

*List medication(s): _____

_____

I. <u>WOMEN ONLY</u>

To your knowledge, are you pregnant? ……..……..…… ☐ No ☐ Yes*

*If pregnant in the past, were pregnancies normal? ……..……..… ☐ No ☐ Yes

Birth(s) (live/still)? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other: _____

Date of last exam: _____

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2. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	Hypertension	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Genetic Disease	Other	Deceased
Father																		
Mother																		
Brother																		
Sister																		
Children																		

Describe others: _____

3. CONDITIONS OR ILLNESSES

Please indicate if you currently have or previously have had any of the following illnesses:

☐ No current or previous conditions/illnesses

NOW	PAST		NOW	PAST		NOW	PAST	
☐	☐	Sinus trouble	☐	☐	Dizziness/Fainting	☐	☐	Rheumatic fever
☐	☐	Hay fever	☐	☐	Epilepsy/Seizures	☐	☐	Polio
☐	☐	Allergies	☐	☐	Thyroid trouble	☐	☐	Multiple sclerosis
☐	☐	Emphysema	☐	☐	High blood pressure	☐	☐	Ulcer
☐	☐	Tuberculosis	☐	☐	Low blood pressure	☐	☐	Liver trouble
☐	☐	History of infection	☐	☐	Heart trouble	☐	☐	Kidney trouble
☐	☐	Fever (continuous)	☐	☐	Pacemaker	☐	☐	Urinary retention
☐	☐	Cancer /Tumor	☐	☐	Stroke (date):_____	☐	☐	Frequent urination
☐	☐	Diabetes	☐	☐	Aortic aneurism	☐	☐	Prostate trouble
☐	☐	Visual disturbances	☐	☐	Osteoporosis	☐	☐	Dislocated joints
☐	☐	Scoliosis	☐	☐	Spinal disease	☐	☐	Arthritis
☐	☐	Bone fractures	☐	☐	Abnormal weight gain	☐	☐	Anemia
Area/date: _____			☐	☐	Abnormal weight loss	☐	☐	Sex. Trans. Disease
_____			☐	☐	Numbness groin/buttocks	☐	☐	HIV
_____			☐	☐	Mental/emotional difficulty	☐	☐	AIDS/ARC

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H. OCCUPATIONAL INFORMATION
ACTIVITIES OF DAILY LIVING

1. Are you right or left handed? ……..……..……..……..☐ Right ☐ Left

2. Occupation: _____ **3. Hours/week:** _____

4. How many years have you been in your occupation?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

☐ 9 ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ Other: _____

5. Do your present complaints affect the number of hours you work per day? ☐ No ☐ Yes

6. What is your primary work position and location?

Position: ☐ Seated ☐ Standing ☐ Other: _____

Location: ☐ Desk ☐ Counter ☐ Workbench ☐ Other: _____

7. What movements does your job require? ☐ Repetitive hand use ☐ Walking ☐ Turning

☐ Carrying ☐ Stooping ☐ Twisting ☐ Bending ☐ Other: _____

8. Does your job involve lifting? ☐ Never ☐ Occasionally ☐ Intermittently ☐ Frequently ☐ Constantly

How many pounds? ☐ <10 ☐ 10-25 ☐ 26-50 ☐ 51-75 ☐ 76-100 ☐ 100+

9. What best describes your stress level at work? ☐ None ☐ Minimal ☐ Moderate ☐ Extreme

10. How do you rate your physical activity at work? ……. ☐ Light ☐ Moderate ☐ Heavy

11. Do your work activities aggravate your current complaint(s)? ……. ☐ No ☐ Yes

If yes, please explain: _____

x _____ _____

PATIENT SIGNATURE (Parent/guardian signature for minors) **DATE**