NEW PATIENT INTAKE FORM ***MUDRYK FAMILY-CHIROPRACTIC**, PA*

Legal Name:____ Date:______________________

Address:______________________________ City:______________________ State:_____ Zip:______________

Home Phone:_______________Work Phone:________________ Mobile Phone Carrier:__________Cell#:__________

Employer:____________________ Single Married Widowed Divorced # of Children_____________

Nickname?_________________Occupation:____________________ How long?___________

Birth date:_____/_____/_______ Age:_______ Email(used for appointment reminders):__________________________

How did you hear about us? Referred by:____________________ Found us on the web?____________________

Who is your primary medical doctor?____________________ City____________ State_____Phone:____________

Have you ever seen a Chiropractor before? NO YES Name:____________________Date Last Seen:______________

Do you have personal Health Insurance? Y N (Please bring card with you) Company name:__________________________

Is this Health Insurance Policy in your name? YES If NO, please fill in information on next line:

Policy Holder's Name:_________________________Date of Birth:__________Relationship to Patient:___________

WORKERS COMPENSATION ONLY:

Is this related to a **Work related injury**?: YES NO If yes are you still under a Work-Comp Claim? YES NO

AUTO ACCIDENT ONLY: Is this related to an **Automobile Injury**?: YES NO Date of injury: ________________

Your Auto Insurance Company Name:_______________Contact Name:_________________Phone number: ___________

Do you have Medical Payments (MEDPAY) on YOUR car insurance? NO YES DON'T KNOW? **Please call to find out**

MEDPAY Claim number:_________________________

Liable Party's Auto Insurance Name: __________________Contact:_________________

Phone number____________________Claim number: __________________________

Do you have an Attorney? NO YES: ________________________Phone number:____________________

Financial Agreement and Consent to examination:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I am ultimately responsible for understanding what my policy covers and does not cover. We will do our best with a phone call directly to your insurance carrier to determine what your policy does and does not cover with regards to our office.

If applicable, I understand that Mudryk Family-Chiropractic, PA will bill my health insurance directly and prepare any necessary reports and forms to file claims to my insurance company. Any amount authorized to be paid to this Chiropractic Office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account if an insurance company pays a check to my name for services rendered. However, I clearly understand that I am personally responsible for payment regarding services rendered at this office if my insurance does not cover it. Every attempt will be made by this office to notify you what may or may not be covered by your insurance.

I hereby authorize and allow the doctor and his assistants to administer treatment, physical examinations, x-ray studies, laboratory procedures, Chiropractic care or any other services that he deems safe and necessary in my case. I further authorize Mudryk Family-Chiropractic, PA to disclose all or part of my patient record to any pertinent entity which is or may be liable under a contract to the office, or to the patient or to a family member or employer of the patient for all or part of the services rendered to me including and not limited to hospital or medical service companies, health insurance companies, car insurance carriers, worker's compensation carriers, welfare funds or employers.

Acknowledgement of understanding: I acknowledge that understand and agree to the above:

______________________Signature ______________Date

Patient Contact Authorization:

I hereby allow Mudryk Family-Chiropractic, PA to contact me regarding my appointments, including future or missed appointments by means of telephone, US mail, voicemail, text message, or email if I so provided this information on this form. I understand that the privacy of my appointment time could be at risk if someone else has access to my mail, email, or voicemail. No health related information will be disclosed during these contacts from our office unless you give us permission to do so.

______________________Signature ______________Date

Current Health Challenges

Primary Problem: ________________________________ When did this episode start? ______________________________

Any instances of this problem previously in life? YES NO When? ____

Did the problem come on GRADUALLY OR SUDDENLY? What time of day do you feel it the most? __________________

What makes it worse? ____

What makes it better? ____

Does the pain feel? Sharp Dull Achy Tight Stiff Stabbing Burning Numb Tingly Deep Cramping ___________________

Rate the degree of problem 1-10 (10 unbearable) Generally______ At worst______ Is it getting **Worse**, **Better**, or **Same**?

Does problem spread or shoot to other areas? ____

Any previous care for this problem? ____

How much of the day do you experience problem? 100% 90% 80% 70% 60% 50% 40% 30% 20% 10%

Secondary Problem: ____________________________ When did this episode start? ______________________________

Any instances of this problem previously in life? YES NO When? ____

Did the problem come on GRADUALLY OR SUDDENLY? What time of day do you feel it the most? __________________

What makes it worse? ____

What makes it better? ____

Does the pain feel? Sharp Dull Achy Tight Stiff Stabbing Burning Numb Tingly Deep Cramping ___________________

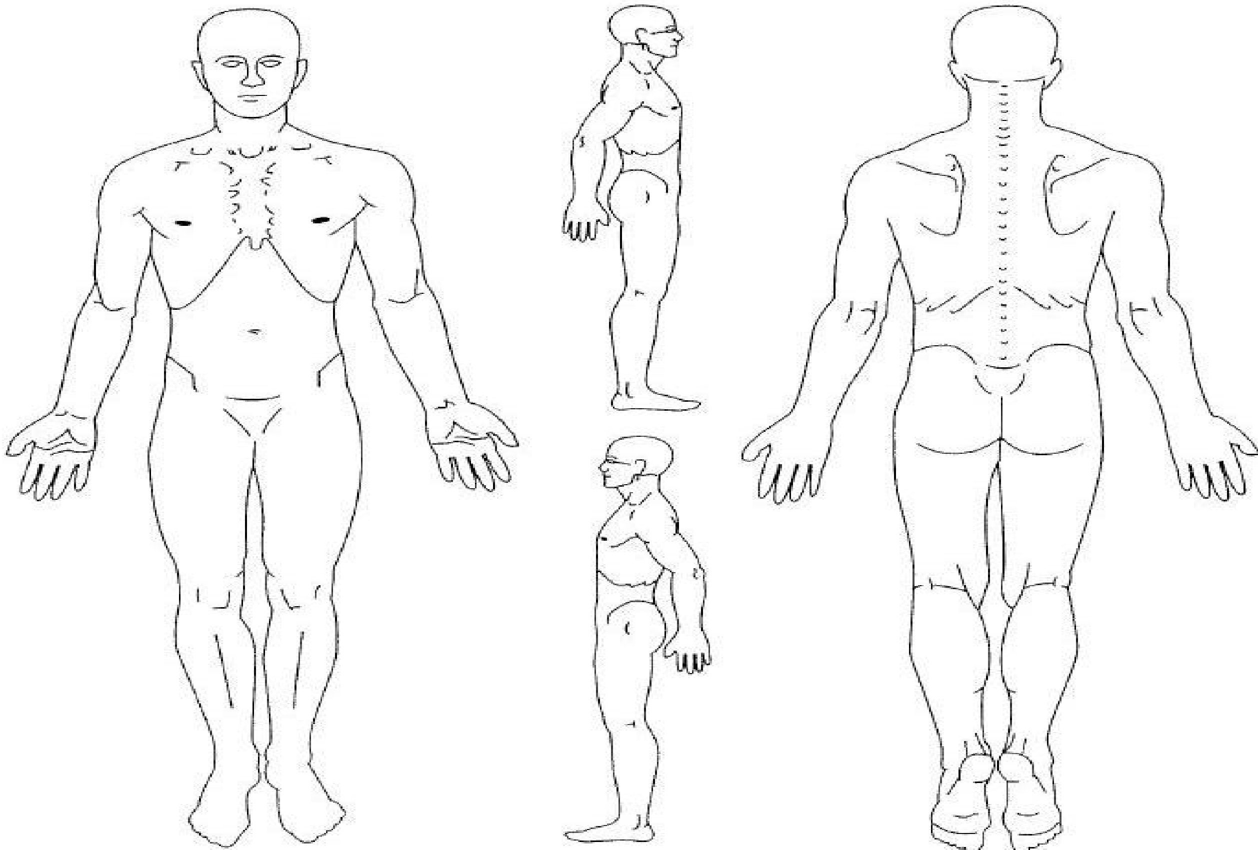
Rate the degree of problem 1-10 (10 unbearable) Generally______ At worst______ Is it getting **Worse**, **Better**, or **Same**?

Does problem spread or shoot to other areas? ____

Any previous care for this problem? ____

How much of the day do you experience problem? 100% 90% 80% 70% 60% 50% 40% 30% 20% 10%

By Using the key below, SHADE IN EXACTLY where you are experiencing the following symptoms.
Label each region with a letter to indicate what the pain feels like.
D=Dull Ache S=Sharp/Stabbing T=Tight/Stiff X=Tingling N=Numbness B=Burning



The following items are about activities you might do during a typical day. **Does your health now limit you** in these activities? If so, how much? **CHECK ONE BOX ON EACH LINE**

1 . Condition's Effect On Job Performance: **No Effect** **Mild** (painful, but can do 100%) **Mod** (painful and limited ability) **Mod/Sev** (limited duty) **Sev** (very limited duty) **Sev** (can't do limited duty)

Bending:	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Sit to Stand	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Standing	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Laying down	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Climb Stairs	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Driving	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Computer Use	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Yard work	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Housework	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Kneeling	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Lifting	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Carrying	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Dressing	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Bathing	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Reading	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Sleeping	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Walking	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform
Exercise	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perforrm
Sports	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform

Social History:

Sleep:	Hours per night__________________			
Fruits & Veget.	Never	Rarely	Occasionally	Everyday
Water:	Never	Rarely	Occasionally	Everyday
Exercise:	Never	Rarely	Occasionally	Everyday
Caffeine use:	Never	Daily	Weekly	Monthly
Drink Alcohol:	Never	Daily	Weekly	Monthly
Chew Tobacco:	Never	Daily	Weekly	Monthly

Cigarettes: Never Less than 1 pack/day More than 1 pack/day PAST: how many years ago?________ how long?____________

Other ____

Females: Are you currently or possibly pregnant: NO YES Due Date:________________________

When was the last time you saw a Medical Doctor? _____________ Reason:____

____Outcomes____

____

Family History of illness: Parents:____

Brothers/Sisters:____Grandparents:____

____

Supplements (Vitamins) of any kind?____

Shoe Inserts?____________________ Heel Lifts? YES NO Arch Supports? YES NO

Mental / Emotional Stress Index

Do you consider yourself under high stress? If so please explain____

- O Anxiety in social situations
- O Addictions of any sort (alcohol, drugs, gambling, food)
- O Perfectionist attitude
- O Inability to relax or take time for yourself
- O Feelings of being trapped
- O Constant worrying and anxiety
- O Emotionally demanding/taxing job
- O Emotionally taxing spouse or children
- O Constantly ill children or spouse
- O Constantly feeling disorganized or overwhelmed
- O Road Rage

Your Life Review

Mudryk Family Chiropractic, PA

Physical Stresses

Play any sports (high school, current?) NO YES Which?:____

Ever been knocked unconscious? NO YES ____

Ever broken a bone?____

Please list any motor vehicle accidents____

____

____

Any other accidents or injuries?____

____

List any surgeries:____

____

Please check any warning signs even if seemingly un-related to your complaint:

- O Frequent colds/ infections
- O Cold hands/feet
- O Bowel problems
- O Restless sleep
- O Nervousness
- O High Blood Pressure
- O Accelerated aging
- O Heart palpatations
- O Poor expression of emotions
- O Anxiety
- O Ulcers
- O Tight muscles

- O Visual Distrubances
- O Stroke
- O Fainting
- O Seizures
- O Nasal problems
- O Speech problems
- O Difficulty swallowing
- O Mouth/dental problems
- O Swollen Glands
- O Thyroid problems
- O Nose bleeds
- O ADD/ADHD

- O Irritability
- O Confusion
- O Poor concentration
- O Do you worry a lot?
- O Are you impulsive?
- O Easily distracted?
- O Low energy
- O Disorganized
- O Bladder control problems
- O Low blood sugar
- O Difficulty waking up
- O Low pain threshold
- O Forgetfullness

- O Chest pain
- O Difficulty breathing
- O Heart problems
- O Heart murmur
- O Chest congestion
- O Asthma
- O Coughing
- O Indigestion/Heartburn
- O Ulcers
- O Consitpation
- O Diarrhea
- O Kidney stones

- O Headaches
- O Narcolepsy
- O Seizures
- O PMS
- O Sleep walking
- O Hot flashes
- O Allergies
- O Manic depressive
- O Eating disorders
- O Bed wetting
- O Mood swings
- O Panic attacks
- O Bipolar disorder
- O Obsessive Compulsive

- O Sexual difficulties
- O Prostate problems
- O Weight loss
- O Weight gain
- O Night sweats
- O Pain waking up at night
- O Bruise easily
- O Hemmorrhoids
- O Poor circulation
- O Diabetes
- O Cancer
- O HIV/AIDS

- O Fevers
- O Fatigue
- O Multiple Sclerosis
- O Epstein-Barr Syndrome
- O Fibromyalgia
- O Depression
- O Rheumatoid arthritis
- O Chronic Fatigue Syndrome
- O Auto-Immune Disorders
- O Lupus
- O Infertility

- O Osteoporosis/penia
- O Hand problems
- O Elbow problems
- O Arm/Shoulder problems
- O Leg problems
- O Hip problems
- O Foot problems
- O Sciatica
- O Disc herniations
- O Arthritis
- O Sedentary
- O Poor diet

Chemical Stresses: List current medications and reason for taking:______________________________________

____

____

Agreements

The statements I have made on these forms are accurate, to the best of my knowledge, and I agree to allow this office to do an examination of me for further evaluation.

Signature_______________________________________ Date______________

MUDRYK FAMILY CHIROPRACTIC, PA
401 KEISLER DR. SUITE 100
CARY NC 27511
(919)-387-7220

Patient Authorization regarding physical therapy being provided in an "open room" environment

It is the practice of this office to provide some aspects of care in an "open room" environment. An "open room" involves several patients being seen in the same room at the same time during some of the care we deliver. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for physical therapy and exercises and is NOT the environment used for adjusting, taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to receive physical therapy in an open-room environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Mudryk Family Chiropractic, PA or on your relationship with our staff.

Your signature indicates your authorization of this activity.

______________________________	______________________________	____________
Name (printed)	Signature	Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.