Mudryk Family-Chiropractic, PA
Western Wake Wellness Center

401 KEISLER DR
SUITE 101
CARY NC 27518
919-387-7220
www.GentleChiro.net

Legal Name:_____ Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Birth date:_____/_____/_____ Age:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____Mobile Phone Carrier:_____(used for appointment reminders)

Nickname?_____

Occupation:_____ Full-Time Part-Time How long?_____

Email address: _____

Marital Status: Single Married Divorced Widowed Number of Children:_____

Race: White / American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / I Decline to Answer

How did you hear about us? Referred by:_____Found us on the web? YES NO
Who is your primary medical doctor?_____
Have you ever seen a Chiropractor before? NO YES Name:_____City/State_____
Date Last Seen:_____

Would you like a clinical summary emailed or provided to you EVERY TIME you visit our office?
YES OR NO You may request them at any time if you choose NO.

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?
YES NO 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:_____

OFFICE POLICIES

Financial Agreements

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.

_____Initials

Missed Appointments

I understand that 24 hours notice is required to cancel appointments. If this notice is not given, there will be a missed appointment charge assessed to your account.

- Chiropractic Appointment Missed: **$25**
- Other Services Missed: **$25 First time and Full Fee *Second time* and Thereafter**

_____Initials

Consent to Examination

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:

_____Initials

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 postal mail, email, texts, or voicemail. No health related information will be disclosed during these contacts from our office unless you give us permission to do so.

I hereby understand all items on this page and have reviewed the HIPAA Privacy Practices. HIPAA Privacy Practices are available in the office or online.

_____**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**?

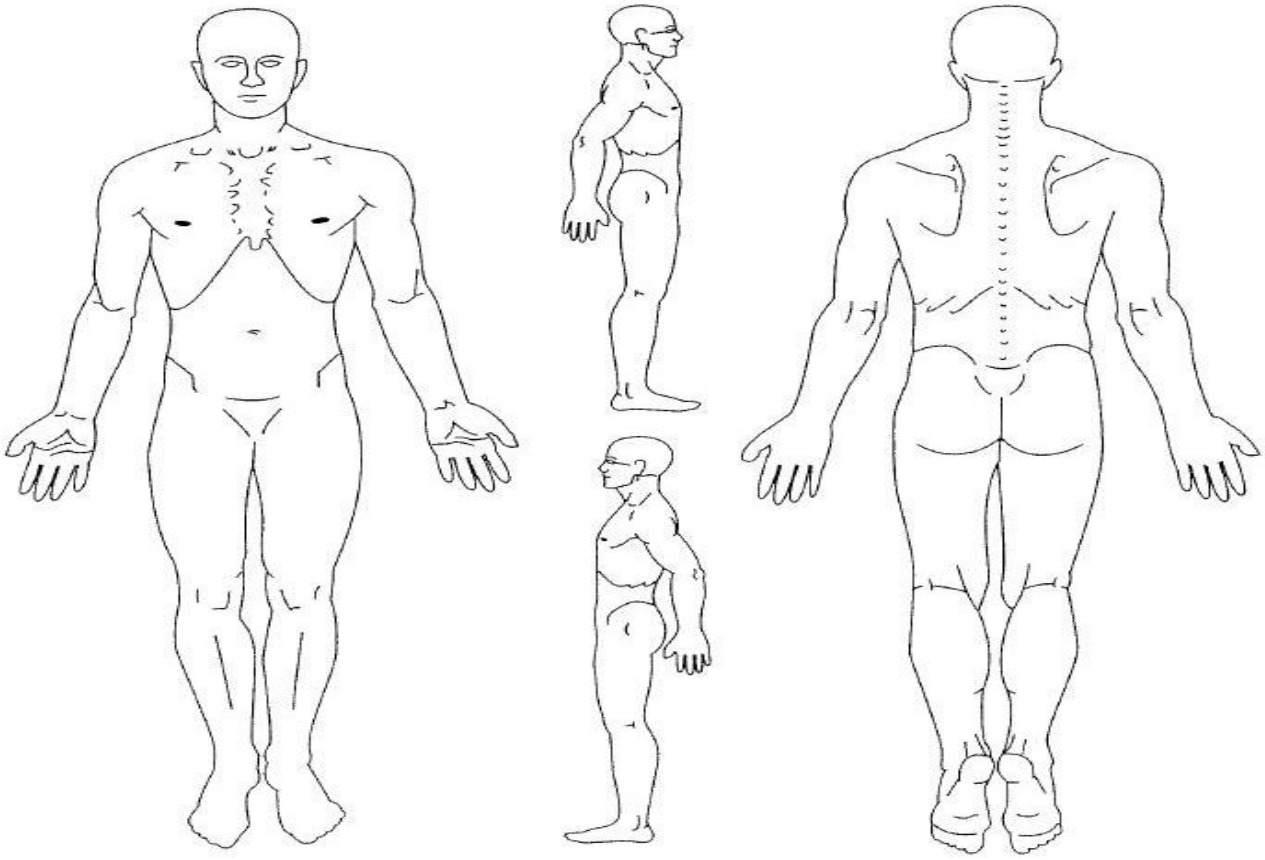
Does problem spread or shoot to other areas?_____

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 Perform
Sports	**No Effect**	**Mild** Painful (can do)	**Moderate** Painful (Limited)	**Severe** Unable to Perform

CURRENT WEIGHT: _____ CURRENT HEIGHT: _____ BLOOD PRESSURE LAST TAKEN: _____

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: PAST 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

List any sports (past and current):_____

Ever broken a bone?_____

List any motor vehicle accidents_____

_____

Any other accidents or injuries?_____

_____

List any surgeries/hospitalizations:_____

_____

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 Tight muscles

- 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 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 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 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 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 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 Osteoporosis/penia
- O TMJ Problems
- 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

Medication Allergies	Reaction

Medications	Dose/Frequency

Medications	Dose/Frequency

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_____