Mudryk Family-Chiropractic, PA

539 KEISLER DR
SUITE 104
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, and what charges, including copays and coinsurance, you will be responsible for. We will do our best with an online verification system that links 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: **$35**
- Other Services Missed: **$35 First time and FULL FEE SECOND TIME & 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? NO YES 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? NO YES 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**?

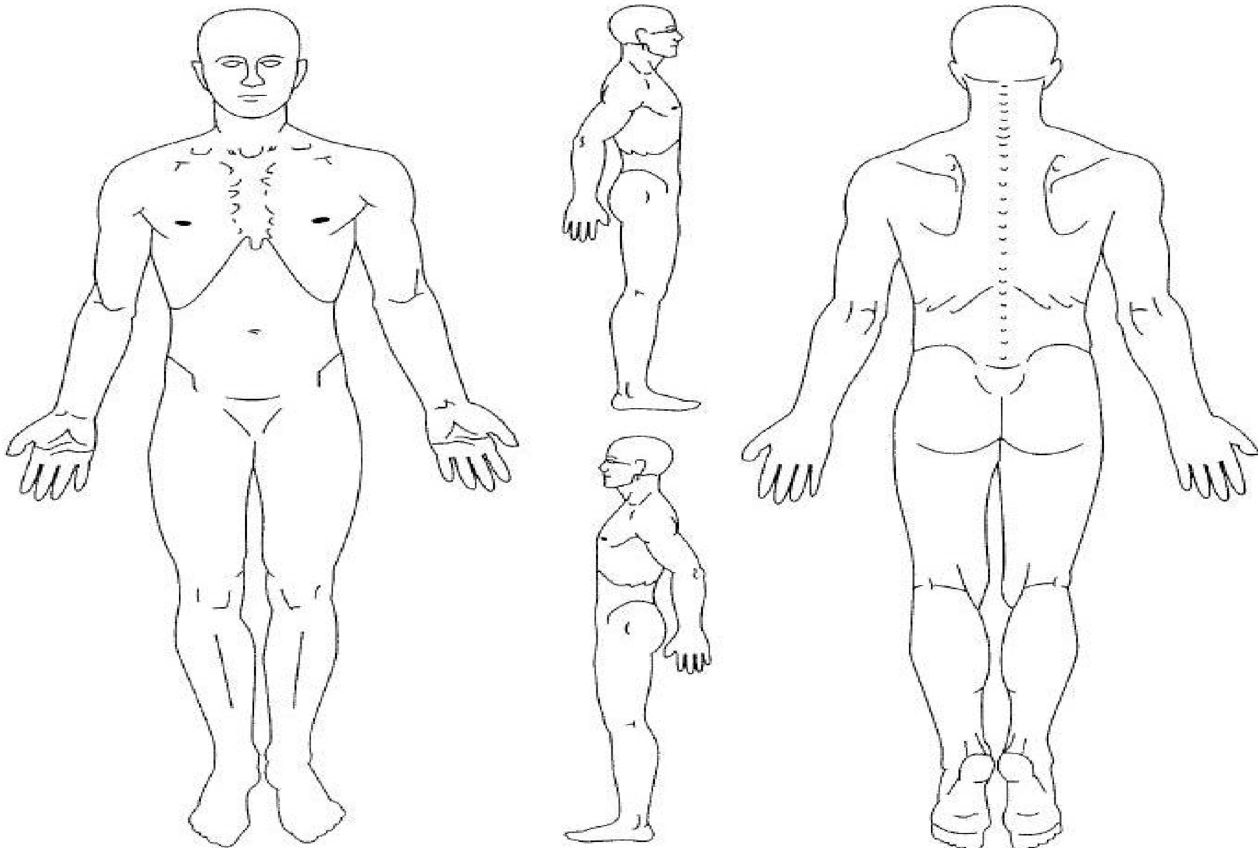
Does problem spread or shoot to other areas? ______________________________

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: ____________________

DIET:

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?____________

SLEEP: Hours per night_____________

Sleeping position: (Circle All That Apply)

Back Side Stomach

Age of Bed:__________________________

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 Disturbances
- 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 Constipation
- 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

Medications	Dose/Frequency

Medications	Dose/Frequency

ALLERGIES	REACTION

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______________