CONFIDENTIAL CASE HISTORY FILE

Date: _____ Full Legal Name: _____

Address: _____ City/State/Zip _____

Phone: (home) (____) _____ (work) (____) _____ (cell)(____) _____

Soc Sec#: ___ - ___ - ____. Birth date: ___/___/___ Age: ___ Sex: ___ Email: _____

Marital Status: S M W D Sep Spouse's Name: _____

Emer. Contact: _____ Phone: (____) _____ Cell: (____) _____

Your Employer: _____ Email: _____

How were you referred to us? _____

☐ **By checking this box:** I inform Myers Chiropractic that I do **not** want to receive occasional newsletters with health and wellness tips.

MEDICAL HISTORY

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any auto accident injuries (include dates): _____

List any on the job injuries (include dates): _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):

List all current over-the-counter and prescription medications used (include reason used): _____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.) _____

Have you been under a physician's care in the last 12 months? If yes, why? _____

Do you smoke/use tobacco? ☐ no ☐ yes: How much: _____

Exercise habits? What and how often? _____

Check any of the following symptoms you have noticed: (■ = Previously, ☐ = Now)

- ■ ☐ Headaches
- ■ ☐ Dizziness or light-headed
- ■ ☐ Jaw pain, clicking, or locking
- ■ ☐ Pain or difficulty swallowing
- ■ ☐ Neck pain or stiffness
- ■ ☐ Shoulder pain
- ■ ☐ Mid back pain
- ■ ☐ Chest pain or cough
- ■ ☐ Pain/trouble breathing
- ■ ☐ Arm/hand numbness/tingling
- ■ ☐ Arm/hand fatigue/weakness
- ■ ☐ Low back pain
- ■ ☐ Leg/foot numbness/tingling
- ■ ☐ Leg/foot fatigue/weakness
- ■ ☐ Leg pain with walking
- ■ ☐ Abdominal pain
- ■ ☐ Nausea or vomiting
- ■ ☐ Diarrhea or constipation
- ■ ☐ Blood in urine or stool
- ■ ☐ Difficulty or pain w/ urination
- ■ ☐ Difficulty with sexual function
- ■ ☐ Abnormal menstrual periods
- ■ ☐ Sensitive to light or sound
- ■ ☐ Visual or hearing disturbance
- ■ ☐ Memory loss/problems
- ■ ☐ Irritability or depression
- ■ ☐ Fatigue or loss of energy
- ■ ☐ Fainting or convulsions
- ■ ☐ Trouble with balance or coordination
- ■ ☐ Sleep disturbances/problems
- ■ ☐ Rashes (face, body, limbs)
- ■ ☐ Joint pain or swelling
- ■ ☐ Pain with exertion (activity, climbing stairs, etc.)

HAVE YOU HAD ANY OF THE FOLLOWING:

NOW:

- ☐ Pain worse at night
- ☐ Constant pain
- ☐ Unexplained weight loss
- ☐ Recent bacterial infection (30 days)
- ☐ Loss of bowel or bladder control
- ☐ Recent surgery (30 days)

EVER:

- ☐ History of cancer
- ☐ History of IV drug use
- ☐ History of blood transfusion

Patient Name: _____

Claim #: _____

CURRENT COMPLAINTS

What is your primary complaint/problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

Pain is: Constant ☐ Intermittent ☐ Is your condition getting worse? _____

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

List all Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. _____
2. _____
3. _____

Have you had: ☐ Xray ☐ MRI or CAT Scan ☐ EMG ☐ Bone Scan ☐ Blood Work

Who is your primary care physician? _____

List all home remedies tried for this problem: _____

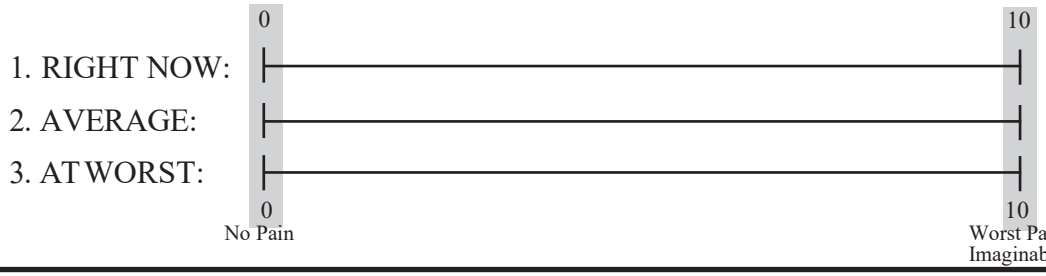
Is your condition worse at certain times of the day or night? _____

Does your condition interfere with: (yes/no) work _____ sleep _____ normal daily routine? _____

Have you had symptoms like this before? ☐ no ☐ yes (describe) _____

Regarding your main complaint:

How bad is your pain?
(Place on **X** on all 3 lines)



Mark your symptoms on the adjacent figures using the symbols below

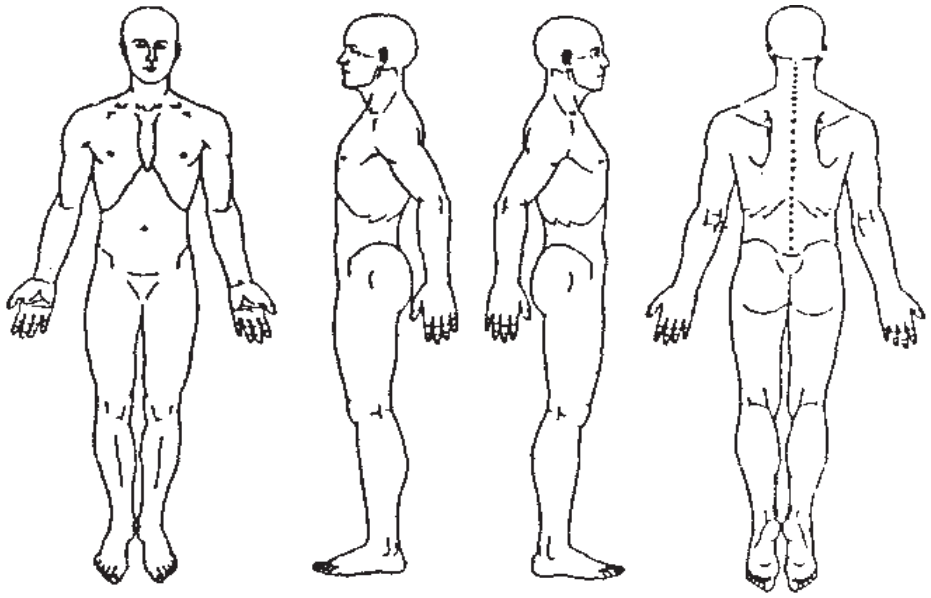
XXX = ache

* = sharp/stab

ooo = numb/tingle

>>>= shooting

/ / / / = stiff/tight



James Myers, DC Myers Chiropractic 8088 160th Ave. NE Redmond, WA 98052 (425) 883-2245

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to receive all benefits to which my dependents or I are entitled to under my auto insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. The undersigned agrees that he/she signs as an agent that is obligated to pay for the account. Should the account exceed an amount that the undersigned is unable to pay in full, agreed upon payments by the undersigned and the clinic can be established with a 1% interest per month (RCW 19.52) on the unpaid balance. Should the account be referred for collections, the undersigned, or their agent, shall pay all reasonable collection expenses, interest on unpaid balance at 1% per month from the date of service, and/or reasonable attorney fees and court costs.

Signed: _____ Date: _____
(Patient – Parent or Guardian if under 18 years of age)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Myers Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____
Date Signature

_____
Print Name

INFORMED CONSENT

Before beginning treatment, it is our office policy to inform you of what to expect, possible complications of chiropractic, as well as complications of other approaches. Remember that all forms of treatment (including non-treatment!) have associated risks. **If you have any questions, please ask the doctor.**

What to Expect

The treatment at our office will consist of manipulation of the joints and soft tissues, using the hands and/or a mechanical instrument. You may feel joint movement, and you may hear joint clicks or other noises. Physical therapy methods, along with therapeutic exercise may also be used.

Chiropractic Risks

Chiropractic treatment is one of the safest methods of treating back pain. Still, unexpected problems can occur. Minor, temporary problems, such as soreness and stiffness can occur, especially in the beginning of a treatment plan. Slightly more serious problems are local burns from hot packs or ice packs. More significant problems, such as fracture of weakened bone or sprain/disc injuries are rare. A stroke following neck manipulation is an extremely rare complication, occurring less than 1 per million treatments. Stroke has also been the result of ordinary activities, such as head turning or stargazing.

Other Treatments and Risks

Medications: Many commonly used medications, such as NSAIDs (e.g. Advil, Aleve) or Tylenol, carry risks of tissue damage, including stomach ulcers or kidney damage. This damage can occur quickly and may be irreversible. There is a significantly higher risk of developing a serious complication with NSAIDs as opposed to chiropractic. Other medications are habit-forming and may mask pain to allow further tissue damage.
Surgery: surgery is the treatment of choice in less than 1% of back pain patients. Your doctor has screened for surgical "red flags" and will refer you for a surgical opinion if indicated. Clinical results of surgery for mechanical back pain have been disappointing and expose you to unnecessary hospital and medication risk.
Rest/non-treatment: Bed rest has been shown to increase the likelihood of re-occurrence of back episodes and make chronic pain more likely. Likewise, non-treatment may cause a permanent mechanical problem to develop, causing future back problems.

I have read the above and give my consent to begin chiropractic treatment.

Printed Name _____ Date _____

Signature _____