MURRY CHIROPRACTIC & ASSOCIATES, P.S.

PATIENT CASE HISTORY

Name_____ Date _____

Address_____ City_____ State _____ Zip_____

Cell phone #_____ Home #_____ Work # _____

SSN_____ DOB _____ Occupation _____

Emergency Contact/Phone_____

Who is responsible for this account? _____

Please circle: SINGLE MARRIED PARTNER DIVORCED WIDOWED

Who referred you to our practice? _____

Inform staff if this is a work or auto injury

Primary Health Complaint _____

What health goals are you seeking? *injury treatment* *wellness care* *range of motion* *mobility or flexibility* *spinal and body alignment* *strengthening/exercise* *pain management* *healthy lifestyle education* *massage therapy* *acupuncture* *nutritional consulting* *ergonomic/posture assessment*

_____

How long have you experienced this primary complaint? _____ Any prior episodes? _____

What do you believe is causing this? _____

How often do you experience? CONSTANTLY DAILY WEEKLY MONTHLY YEARLY

Circle type of pain: SHARP DULL LOCAL REFERRING RADIATING When is it worse? A.M. P.M.

What makes it better _____

What makes it worse _____

Who have you seen for this? CHIROPRACTOR NATUROPATH PHYSICAL THERAPIST MD LMP

OTHER _____ Results _____

List other health complaints _____

_____

_____

_____

- OVER -

Lifestyle

STRESS LEVEL

Rate your stress: Low Moderate High Describe the cause of your stress _____

What do you do to manage your stress _____

OCCUPATION

Circle all that apply in your occupation: SIT STAND LIFT TWIST COMPUTER PHONE DRIVE REPETITIVE

Hours per week worked _____ Number of years _____

REST & RESTORE

Age of mattress _____ Type and condition of mattress _____

Hours of sleep per day _____ Type of pillow _____

Rate your sleep: POOR FAIR GOOD GREAT Sleep position: STOMACH SIDE BACK

NUTRITION

Rate your diet: POOR FAIR GOOD GREAT

Servings vegetables per day _____ Servings fruit per day _____ Servings protein/type _____

Ounces of water per day _____ Cups coffee per day _____ Soda _____ Tea_____ Nicotine_____

Other sources of caffiene _____ Amount of Alcohol per day _____

Over the counter drugs _____

Prescription drugs _____

Side effects _____

HEALTH & FITNESS

Describe your exercise program_____

_____ Frequency _____

Overall health POOR FAIR GOOD GREAT

Are you satisfied with your level of health? poor 1 2 3 4 5 6 7 8 9 10 great

Comment _____

Have you been diagnosed with any health conditions _____

_____

_____

_____

Patient Name _____

MURRY CHIROPRACTIC & Associates, PS

412 Girard St • Bellingham, WA 98225 • P (360) 734-9525 • F (360) 734-9505

System Review

Circle and indicate with a **c**=current, or **p**=past if the following conditions are of significant concern for you:

General

fainting	chills	fever	depression	insomnia
weight gain	fatigue	night sweats	headache	nervousness
weight loss	nerve pain	convulsions	dizziness	irritability

Gastro-intestinal

constipation	nausea	vomitting blood	hemorrhoids	poor digestion
rectal bleeding	vomitting	liver problems	poor appetite	jaundice
diarrhea	stomach pain	gall bladder	voracious appetite	eating disorder

Eye/Ear/Nose/Throat

asthma	sore throat	frequent colds	flu or pneumonia	sinusitis
ringing in ears	tonsilitis	hearing loss	hay fever	hoarseness
ear ache	nose bleeds	sinus congestion	vertigo	thyroid

Respiratory

chest pain	chronic cough	spitting blood	spitting phlegm	difficulty breathing

Cardiovascular

ankle swelling	high blood pressure	low blood pressure	pain in chest	stroke
poor circulation	rapid heart rate	slow heart rate	heart trouble	angina

Skin or Allergies

bruise easily	sensitive skin	dryness	hives	exzema

Women

cramps	excessive flow	hot flashes	irregular cycle	painful periods

Muscles/joints/bones

subluxation	stiffness	weakness	tingling	numbness
neck	upper back	mid back	low back	sacroiliac
hip	thigh	leg	foot	toes
shoulder	ribs	arms	hands	fingers

sprain/strains_____ Fractures _____

Female Chiropractic Patients

X-rays are contraindicated during pregnancy. Murry Chiropractic does not knowingly x-ray women who may be or who are, regardless of stage of pregnancy. If there is a chance that you are pregnant, let the doctor or the Chiropractic assistant know at this time.

Are you pregnant?_____
What date did your last period begin?_____
Do you want to take a pregnancy test now?_____
Office Use Only - result of clinic pregnancy test - +

Circle the following information if it pertains to you:
tubal ligation partial or complete hysterectomy
partner had a vasectomy taking birth control pills
other birth control method

Contract for Care

Chiropractic

I understand and agree to the following: A case history, consultation, examination and x-rays are conducted for diagnostic and information purposes and I am requesting these services.

* It is my responsibility to complete the forms accurately.
* it is my responsibility to notify the doctor if any information has changed or requires updating,
* Clinic x-rays and chart notes are the property of Murry Chiropractic & Associates, P.S.

Copies of this information can be obtained upon written request, and at the cost of the patient.

_____
Name of patient or guardian (printed)

_____
Signature

_____
Date

Massage Therapy

It is my choice to receive massage therapy, and I give my consent to receive treatment. I have reported all known health conditions. I promise to inform my practitioner of any changes in my health.

_____
Name of patient or guardian (printed)

_____
Signature

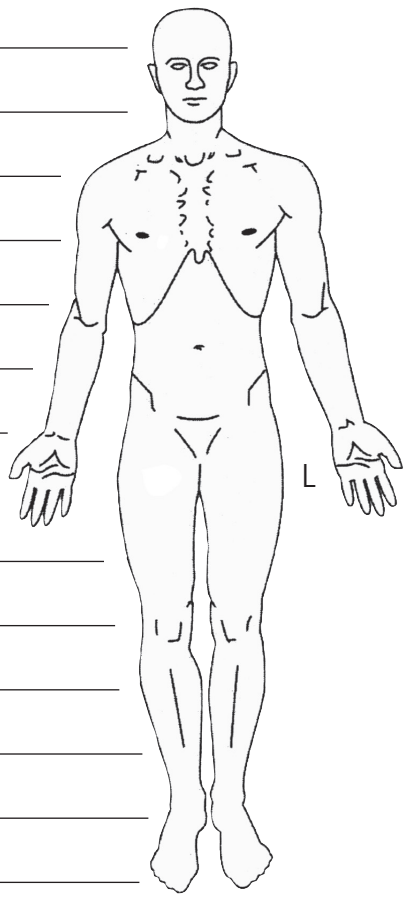
_____
Date

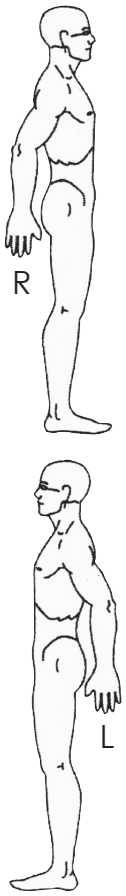
Name: _____ Date: _____

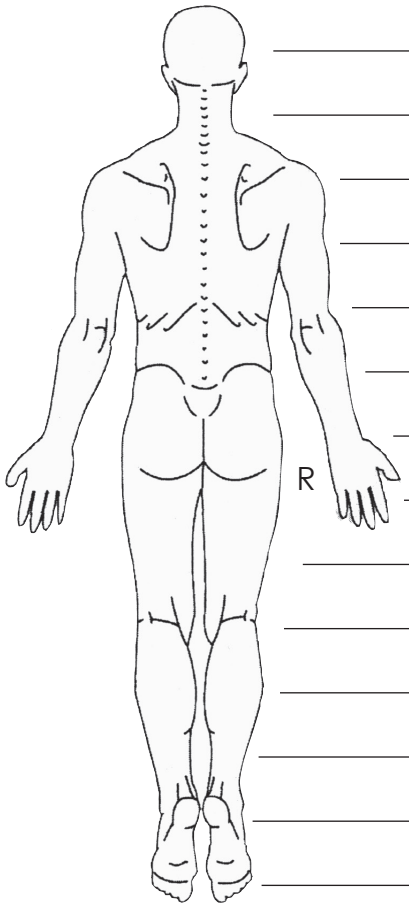
CIRCLE the location of your pain or dysfunction on the images below.
Use the letters below to represent the type(s) of dysfunction or pain.

B = Burning
C = Cramping
D = Dull
S = Stabbing/Sharp
T = Tingling (pins & needles)
N = Numb
SP = Spasm
ST = Stiff

DC/LMP notes:







DC/LMP notes:

Circle the number representing your dysfunction or pain.

Rate the dysfunction or pain you have right ***NOW***:

0 1 2 3 4 5 6 7 8 9 10
None Unbearable

Rate your dysfunction or pain at its ***BEST*** in the past week:

0 1 2 3 4 5 6 7 8 9 10
None Unbearable

Rate your ***WORST*** dysfunction or pain in the past week:

0 1 2 3 4 5 6 7 8 9 10
None Unbearable

Rate your ***AVERAGE*** dysfunction or pain in the past

0 1 2 3 4 5 6 7 8 9 10
None Unbearable

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MURRY CHIROPRACTIC & Associates, PS

Mid/Low Back Pain & Disability Index (Revised Oswestry)

Patient Name: _____ **Date:** _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes you problem

Section 1 - Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

Section 2 - Personal Care

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

Section 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

Section 4 - Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking, but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

Section 5 - Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

Section 6 - Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight away.

Section 7 - Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

Section 8 - Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Section 9 - Travelling

- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while travelling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

Section 10 - Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but is definitively getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

_____

Signature of patient

MURRY CHIROPRACTIC & Associates, PS

_____

Date

Neck/Upper Back Pain & Disability Index (Vernon-Mior)

Patient Name: _____ **Date:** _____

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes you problem.

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 - Personal Care

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of my self care.
- ☐ I do not get dressed, I wash with difficulty, and stay in bed.

Section 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 - Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 6 - Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 - Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 - Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 - Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 - Recreation

- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I can't do any recreational activities at all.

_____

Signature of patient

_____

Date

MURRY CHIROPRACTIC & Associates, PS

Terms of Acceptance

The intention of this form is to ensure that patients are well informed about Chiropractic procedures, including the potential benefits and risks. Please read the documentation and have all questions answered prior to signing.

Chiropractic Treatment

Chiropractic and other clinical procedures used in our practice seldom cause any problems and the majority of patients experience improvement. Stiffness or discomfort may occur during the adjustment, post adjustment, or after soft tissue procedures or with engaging in prescribed self-care activities. This typically resolves in a few days.

Chiropractic has extremely low risk of complications. In rare cases, underline physical defects, deformities or pathologies, surgeries or medication use may increase risk factors for dislocations, spinal disc injury, fractures, neurovascular complications or aggravations of pre-existing conditions. Inform your Chiropractor about your health history, current conditions and medications. The incidence of neurovascular conditions associated with Chiropractic is exceedingly rare, estimated to occur 1 in 1-5 million cervical manipulations and 1 in 1 million lumbar manipulations.

I, (print name) _____ have read and fully understand the above statements. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Chiropractic care on this basis.

_____ _____

Signature *Date*

Authorization to treat a minor

I, (print name) _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

_____ _____

Signature *Date*

MURRY CHIROPRACTIC & Associates, PS
412 Girard Street
Bellingham, WA 98225
(360) 734-9525

Notice of Privacy Practice Summary

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To That Information. Please Review This Notice Carefully.

Murry Chiropractic & Associates, P.S. (Practice), in accordance with applicable federal and state law, is committed to maintaining the privacy of your protected health information (PHI). In other words, the private information about your health condition an the care and treatment you receive from the Practice. We will use and disclose elements of your PHI the following ways:

- *Treatment*
- *Payment*
- *Health Care Operations*
- *When release is required by law, including judicial settings and to health oversight regulatory agencies and law enforcement*
- *In emergency situations or to avert serious health/safety situations*
- *To medical examiners, coroners or funeral directors to aid in identifying you or to help them in their duties*
- *To organ, tissue and other donation organizations, upon or proximate to your death, if we have no indication on hand about your donation preferences*

Special Cases:

- *Appointment reminders, treatment alternatives and other health related benefits and services*
- *Office newsletter*
- *Sponsor of your health plan*

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your Rights: You have the following rights concerning your PHI:

- ***Restrictions:*** *To request restricted access to all or part of your PHI. To do this, please make the request in writing. We are not required to grant your request.*
- ***Confidential Communications:*** *To receive correspondence of confidential information by alternative means or location. To do this, please make a request in writing.*
- ***Access:*** *To inspect or receive copies of your PHI. To do this, please make a request in writing.*
- ***Amendments:*** *To request changes to be made to your PHI. To do this, please make a request in writing.*
- ***Accounting:*** *To receive an accounting of the disclosures by us of your PHI in the six years prior to your request. To do this, please make a request in writing.*
- ***This Notice:*** *To get updates or re-issue of this notice, at your request.*
- ***Complaints:*** *To complain to your office or the U.S. Department of Health and Human Services if you feel your privacy rights have been violated. To register a complaint with us, please submit your request in writing. The law forbids us from taking retaliatory action against you if you complain.*

Our Duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy Contact: To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Dr. Theresa Murry, Murry Chiropractic & Associates, P.S., 412 Girard St., Bellingham, WA 98225.

Effective Date: This notice is in effect as of June 1, 2006. A complete copy of the Notice of Privacy Practice is available at the reception desk.

Patient Acknowledgement: By subscribing my name below, I acknowledge receipt of a copy of the Notice, and my understanding and my agreement to its terms.

_____ _____

Signature *Date*

_____

Patient Name (Print)

MURRY CHIROPRACTIC & Associates, PS
412 Girard Street
Bellingham, WA 98225
(360) 734-9525

Payment, Cancellation & No Show Policy

Payment

All payments including co-pays and deductibles are due at the time of service. Please see your financial agreement provided by us for details. *For your convenience we accept MasterCard & Visa, CareCredit, cash or checks.* Our office is fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa or MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

We will gladly bill your insurance provider, but it is not a guarantee of payment. Any remaining balance from insurance will be your responsibility.

Cancellation/No Show Policy

Murry Chiropractic requires 24 hour cancellation notice. There will be a $50 charge for missed, no-show or less than 24 hour cancellation notice. Please note we are unable to bill insurance for any services not rendered. We understand your health goals and know the value in following your treatment plan.

We appreciate you choosing Murry Chiropractic for your health care needs.

I certify that I have read and understand the above financial policy. ***I HAVE READ AND AGREE TO THE THESE POLICIES:***

_____ _____

Signature *Date*

_____

Print Name

E-mail or Text Messaging Authorization

Please send my appointment confirmations via e-mail or text messaging.

Name: _____

E-mail: _____

Phone Number: _____ **Carrier:** ☐ Verizon ☐ Sprint ☐ AT&T ☐ T-Mobile ☐ Other _____

Note: Standard message rates and data charges from your carrier may apply.
Check with your carrier if you have questions about your plan and costs.

_____

Signature of patient

_____

Date

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