Health Questionnaire
McCracken Chiropractic & Wellness Center
284 Central Way
Kirkland, WA 98033

A. PATIENT INFORMATION

Patient Name: _____ **Date:** ____/____/_____

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Sex:
- ☐ M
- ☐ F

Children:
☐ 0 ☐ 1 ☐ 2 ☐ 3
☐ 4 ☐ 5+

Patient Lives With:
- ☐ Alone
- ☐ Spouse
- ☐ Children
- ☐ Other: _____
- ☐ Parents
- ☐ Roommate(s)
- ☐ Assisted Living

B. PATIENT'S COMPLAINTS

☐ Examination with no complaints

1. Mark Your Present Complaints Below

Neck/Back

		Same as Left	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Neck	Left																									
	Right	☐																								
Upper Back	Left																									
	Right	☐																								
Mid Back	Left																									
	Right	☐																								
Low Back	Left																									
	Right	☐																								
Ribs	Left																									
	Right	☐																								

When did your neck/back complaints begin?
Date: ___/___/_____

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Upper / Lower Extremities

		Same as above	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
LEFT	Shoulder																									
	Arm	☐																								
	Elbow	☐																								
	Forearm	☐																								
	Wrist	☐																								
	Hnds/Fingrs	☐																								
RIGHT	Shoulder																									
	Arm	☐																								
	Elbow	☐																								
	Forearm	☐																								
	Wrist	☐																								
	Hnds/Fingrs	☐																								
LEFT	Hip																									
	Buttock	☐																								
	Thigh	☐																								
	Knee	☐																								
	Leg/Calf	☐																								
	Ankle	☐																								
	Foot	☐																								
RIGHT	Hip																									
	Buttock	☐																								
	Thigh	☐																								
	Knee	☐																								
	Leg/Calf	☐																								
	Ankle	☐																								
	Foot	☐																								

When did your **upper** extremity complaint begin?
Date: ___/___/_____

When did your **lower** extremity complaint begin?
Date: ___/___/_____

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B. PATIENT'S COMPLAINTS (CONTINUED)

2. How Did Your Complaints Begin?

☐ Unknown ☐ Suddenly ☐ Gradually

3. What Happened To Cause Or Re-Aggravate Your Complaint(s)?

☐ Unknown ☐ Work Accident/Injury ☐ Personal Injury
☐ Auto Accident ☐ Home Accident ☐ Sports Injury
☐ Other – Describe: _____

_____

_____

4. How Would You Rate Your Pain Today Where 0 Is No Pain And 10 Is The Worst Pain?

No Pain	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	Worst Pain Possible

5. When Are Your Symptoms Worse?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night
☐ Always the Same

6. What Makes Your Condition Better?

☐ Nothing ☐ Stretching ☐ Heat ☐ Rest
☐ Sitting ☐ Exercise ☐ Ice ☐ Standing
☐ Medications ☐ Other: _____

7. What Makes Your Condition Worse?

☐ Nothing ☐ Coughing ☐ Reaching ☐ Standing
☐ Sneezing ☐ Lifting ☐ Sitting ☐ Pulling
☐ Bending ☐ Walking ☐ Straining ☐ Turning
☐ Other: _____

8. Have Any Of Your Complaint(s) Existed In The Past? ☐ Yes ☐ No

If Yes, Indicate below

☐ Neck ☐ Upr Back ☐ Mid Back ☐ Low Back ☐ Ribs
☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm ☐ Wrist
☐ Hnd/Fngrs ☐ Buttock ☐ Hip ☐ Thigh ☐ Knee ☐ Leg/Calf
☐ Ankle ☐ Foot ☐ Others: _____

9. Have You Had Any Recent Treatment For Your Conditions OUTSIDE Of This Office? ☐ Yes ☐ No If Yes, List Dates, Treatments And Doctors.

_____

_____

_____

_____

_____

10. Since Your Symptoms Began, Have You Noticed A Change In?

☐ Bowel Function
☐ Bladder Function ☐ No To All
☐ Sexual Function

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C. HEADACHES

If You Are Experiencing Headaches, Please Fill Out This Section Otherwise Skip To Section D.

1. **Where Is The Pain Associated With Your Headaches Located?**
   ☐ Left Side Of Head ☐ Right Side Of Head ☐ Base Of Skull ☐ Left Jaw Joint
   ☐ Right Jaw Joint ☐ Over Eyes ☐ Behind Eyes ☐ Over Sinuses
2. **On What Date Did Your Headaches Begin?**
   Date: ____/____/_____ ☐ Same As Neck/Back Complaints
3. **How Does The Intensity Of Your Headaches Rate?**

No Pain	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐	Worst Pain Possible

4. **What Describes Your Pain?**
   ☐ Dull ☐ Sharp ☐ Aching ☐ Stabbing ☐ Deep ☐ Vice-like ☐ Burning
   ☐ Throbbing/Pulsating ☐ Other: _____
5. **When Do Your Headaches Usually Start?**
   ☐ Constant ☐ Midday ☐ Wake Up With In Morning ☐ Evening
6. **What Seems To Bring On Your Headaches?**
   ☐ Physical Activity ☐ Excessive Stress ☐ Caffeine ☐ Certain Foods
   ☐ Alcohol ☐ Menstrual Period ☐ Other: _____
7. **How Often Do They Occur?**
   ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____
8. **How Long Do Your Headaches Last?**
   ☐ Less Than An Hour ☐ From 1-3 Hours ☐ Longer Than 3 Hours
   ☐ All Waking Hours ☐ Several Hours To Days ☐ Other: _____
9. **Do Your Headaches Wake You From Sleep?**
   ☐ Yes ☐ No ☐ Sometimes
10. **Do Any Of The Following Occur With Your Headaches?**
    ☐ Nausea/Vomiting ☐ Weakness ☐ Tremor ☐ Vision Problems
    ☐ Dizziness ☐ Light/Sound Sensitivity ☐ Other: _____
11. **What Makes Your Headaches Better?**
    ☐ Nothing ☐ Rest ☐ Lying Down ☐ Ice ☐ Massage
    ☐ Standing ☐ NSAIDS (Aspirin, Tylenol, etc.) ☐ Other: _____

D. OTHER COMPLAINTS

Do You Have Any Other Complaints Not Covered On This Form? ☐Yes ☐ No
If Yes, Describe Other Complaints In Detail

_____
_____
_____
_____
_____
_____

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E. REVIEW OF SYMPTOMS

Are You Currently Suffering From Any Of The Symptoms Listed Below?

- ☐ None of the Symptoms Listed Below
- ☐ General Fatigue (chronic)
- ☐ Weakness
- ☐ Fever (continuous)
- ☐ Loss of Sleep
- ☐ Chills (continuous)
- ☐ Weight Change (unexplained)
- ☐ Night Sweats
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Convulsions
- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression (Prolonged)
- ☐ Phobias
- ☐ Memory Loss
- ☐ Mood Swings (excessive)

	Left	Right
☐ Hearing Trouble	☐	☐
☐ Ringing in Ears	☐	☐
☐ Pain in Ears	☐	☐
☐ Ear Discharge	☐	☐
☐ Vision Trouble	☐	☐
☐ Pain In Eyes	☐	☐
☐ Eye Discharge	☐	☐

- ☐ Nose/Sinus Pain
- ☐ Excessive Drainage
- ☐ Nose Bleeds (chronic)
- ☐ Nasal Infections (chronic)
- ☐ Absence Of Smell
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Enlarged Glands
- ☐ Absence of Taste
- ☐ Abnormal Taste Sensation
- ☐ Tonsillitis/Infected Tonsils
- ☐ Difficulty Swallowing
- ☐ Heat/Cold Intolerance
- ☐ Sugar in Urine
- ☐ Goiter (enlarged thyroid gland)
- ☐ Tremor (shaking)
- ☐ Other: _____
- ☐ Skin Rash
- ☐ Redness of Skin
- ☐ Skin Itching
- ☐ Skin Dryness
- ☐ Eczema (red, inflamed skin)
- ☐ Hair Changes (unplanned)
- ☐ Nail Changes (unplanned)
- ☐ Bruise Easily
- ☐ Cough (chronic)
- ☐ Wheezing (chronic)
- ☐ Difficulty Breathing
- ☐ Swollen Extremities
- ☐ Blue Extremities
- ☐ Varicosities (visible veins)
- ☐ Rapid Heart Beat
- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Heart Murmur
- ☐ Decreased Appetite
- ☐ Increased Appetite
- ☐ Abdominal Pain
- ☐ Hemorrhoids
- ☐ Excess Gas
- ☐ Vomiting (excessive)
- ☐ Diarrhea (excessive)
- ☐ Constipation (excessive)
- ☐ Heartburn/Indigestion
- ☐ Painful Urination
- ☐ Urinary Retention
- ☐ Bed-wetting
- ☐ Irregular Menstruation
- ☐ Painful Menstruation
- ☐ Abnormal Vaginal Bleeding
- ☐ Sterility
- ☐ Impotence
- ☐ Lumps in Breasts
- ☐ Redness/Itching of Breasts
- ☐ Dimpling of Breasts
- ☐ Discharge from Breasts
- ☐ Breast Pain

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F. HABITS/ACTIVITIES

What Are Your Current Habits?

	Never	<1	1-2	2-3	3-4	5+
		Packs/Day				
Smoking ……	☐	☐	☐	☐	☐	☐
		Glasses/Day				
Caffeinated Drinks……	☐	☐	☐	☐	☐	☐
		Glasses/Day				
Alcoholic Drinks……	☐	☐	☐	☐	☐	☐

Drug/Substance Abuse……...☐ No ☐ Yes **If Yes, Discuss With Doctor**

	Never	<1	1-2	2-3	3-4	5+
		Days/Week				
Exercise……..……	☐	☐	☐	☐	☐	☐

Kinds of Exercise You Do:

☐ Walking ☐ Jogging ☐ Cycling ☐ Swimming ☐ Golf
☐ Tennis ☐ Strength Training ☐ Other: _____

G. MEDICAL HISTORY

1. **HEALTH CARE**
   a. **Have You Ever Been To A Chiropractor?** ..... ☐ Yes ☐ No
   b. **Do You Have A Family Physician?** ……..……. ☐ Yes ☐ No
      Date of Last Physical Exam: ____/____/_____
      Physician's Name: _____
      Address: _____
   c. **Have You Been Hospitalized In the Past?** ..…… ☐ Yes ☐ No
      Date and Reason for Hospitalization
      _____
      _____
   d. **Have You Ever Had Surgery?** ……..…..... ☐ Yes ☐ No
      Date, Reason, Results of Surgery
      _____
      _____
   e. **Have You Ever Had A Serious Accident/Injury?** ☐ Yes ☐ No
      List Date & Describe Injury:
      ☐ Auto: _____
      ☐ Work-Related: _____
      ☐ Personal: _____
      ☐ Sports Injury: _____
      ☐ Other: _____

f. Are You Currently Taking Any Vitamins, Minerals or Herbs? (List Supplements) ☐ Yes ☐ No

_____

_____

g. Are You Currently Taking Any Medications? ☐ Yes ☐ No

For What Condition(s) Are You Taking Medications?

☐ Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.):

_____

☐ Pain/Analgesics: _____

☐ Anti-Depressants: _____

☐ Muscle Relaxants: _____

☐ Blood Pressure Pills: _____

☐ Antibiotics: _____

☐ Birth Control Pills: _____

☐ Corticosteroids: _____

☐ Other: _____

In The Past Have You Used Any Of The Following?

☐ Birth Control Pills ☐ Corticosteroids

h. Are You Currently Allergic To Any Medications? ☐Yes ☐No

List Medications:

_____

_____

i. <u>WOMEN ONLY</u>:

	Yes	No
To Your Knowledge, **<u>Are You Pregnant?</u>**	☐	☐
If Pregnant In Past, Were Pregnancies Normal?	☐	☐
Are You Seeing An OB-GYN Regularly?	☐	☐

Number of Births: ☐1 ☐2 ☐3 ☐4 ☐5 ☐Other: _____

Date of Last Exam: ____/____/_____

Physician's Name: _____

2. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	Hypertension	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Genetic Disease	Other	Deceased
Father																		
Mother																		
Brother																		
Sister																		
Children																		

Describe Others: _____

_____

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3. CONDITIONS OR ILLNESSES
Please Indicate If You <u>Now Have</u> Or Have <u>Had In The Past</u> Any Of The Following Illnesses:

☐ No Current or Previous Conditions/Illnesses

Now Have	In Past		Now Have	In Past	
☐	☐	**Sinus Trouble**	☐	☐	**Kidney Trouble**
☐	☐	**Hay Fever**	☐	☐	**Urinary Retention**
☐	☐	**Allergies**	☐	☐	**Frequent Urination**
☐	☐	**Emphysema**	☐	☐	**Prostate Trouble**
☐	☐	**Tuberculosis**	☐	☐	**Arthritis**
☐	☐	**History Of Infection**	☐	☐	**Osteoporosis**
☐	☐	**Fever (Continuous)**	☐	☐	**Scoliosis**
☐	☐	**Cancer/Tumor**	☐	☐	**Dislocated Joints**
☐	☐	**Diabetes**	☐	☐	**Spinal Disc Disease**
☐	☐	**Visual Disturbances**	☐	☐	**Bone Fractures (list/dates):**
☐	☐	**Dizziness/Fainting**			**_____**
☐	☐	**Epilepsy/Seizures**			**_____**
☐	☐	**Thyroid Trouble**	☐	☐	**Mental/Emotional Difficulty**
☐	☐	**High Blood Pressure**	☐	☐	**Sex. Trans. Disease**
☐	☐	**Low Blood Pressure**	☐	☐	**HIV**
☐	☐	**Heart Trouble**	☐	☐	**AIDS/ARC**
☐	☐	**Pacemaker**	☐	☐	**Abnormal Weight Gain**
☐	☐	**Stroke (date): ___/___/_____**	☐	☐	**Abnormal Weight Loss**
☐	☐	**Aortic Aneurism**	☐	☐	**Numbness Groin/Buttocks**
☐	☐	**Anemia**	☐	☐	**Other: _____**
☐	☐	**Rheumatic Fever**			**_____**
☐	☐	**Polio**			**_____**
☐	☐	**Multiple Sclerosis**	☐	☐	**Other: _____**
☐	☐	**Ulcer**			**_____**
☐	☐	**Liver Trouble**			**_____**

H. OCCUPATIONAL INFORMATION/ACTIVITIES OF DAILY LIVING

1. **Are You Right Or Left Handed?** ☐ Right ☐ Left
2. **Occupation**: _____
3. **Hours Per Week: _____**
4. **How Long Have You Been In This Occupation?**
   Years ☐ 10 ☐20 ☐ 30 ☐ 40 ☐ 50
   ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9
5. **Do Your Present Complaints Affect The Number Of Hours You Work Per Day?** ☐ Yes ☐ No

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6. **What Is Your Primary Work Position And Location?**
   Work Position: Work Location:
   □ Seated □ Standing □ Desk □ Counter □ Workbench
   □ Other: _____ □ Other: _____
7. **What Movements Does Your Job Require?**
   □ Bending □ Turning □ Stooping □ Twisting
   □ Walking □ Repetitive Hand Use □ Carrying
   □ Other: _____
8. **Does Your Job Involve Lifting?**
   □ Never □ Occasionally □ Intermittently □ Frequently □ Constantly
   How Many Pounds? □<10 □10-25 □26-50 □51-75 □76-100 □100+
9. **What Best Describes Your Stress Level At Work?**
   □ None □ Minimal □ Moderate □ Extreme
10. **How Do You Rate Your Physical Activity At Work?**
    □ Light □ Moderate □ Heavy
11. **Do Your Work Activities Aggravate Your Current Complaint(s)?**
    □ Yes □ No If Yes, Explain: _____
    _____
    _____
    _____

_____ _____/_____/_____
Patient's Signature Date

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Today's Date: ____/____/_____

Name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Home Phone: (____) ____-_____ Cell/Work Phone: (____) ____-_____

Social Security Number: _____-____-_____ Date of Birth: ____/____/_____

Marital Status:
- □ Married
- □ Single
- □ Widowed
- □ Divorced
- □ Separated

Employer: _____ Occupation: _____

Employer Address: _____
_____

Name of Spouse: _____

Spouse Employer: _____ Occupation: _____

Number of Children: ____ Name(s)/Age(s): _____

Referred to our office by: _____

Insurance Information:
(Please present your insurance card when returning this form and we'll do the rest for you!)

Assignment of Benefits: hereby assign and grant the benefits that I am eligible to receive for professional services rendered in this office to McCracken Chiropractic. I authorize the release of any medical information necessary to process any insurance claims for payment. I understand that I am financially responsible for those charges not paid by my insurance.

_____ _____/_____/_____
Patient's Signature (Guardian if minor) Date

Accident/Injury Questionnaire
M^{c}Cracken Chiropractic & Wellness Center
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Patient: _____ **#:** _____
Today's Date: ____/____/_____

A. DATE AND TIME OF ACCIDENT/INJURY

Date: ____/____/_____ Time: ____:____ am/pm

B. DESCRIPTION OF ACCIDENT/INJURY

☐Automobile Crash ☐Workmen's Compensation
Other: ☐Accident ☐Injury _____

C. DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED

_____
_____
_____
_____
_____
_____
_____

D. DETAILS OF AUTOMOBILE ACCIDENT

1. Your Vehicle

a) Type: _____

b) Vehicle Size
☐Compact ☐Mid-Size ☐Full-Size ☐Other: _____

c) What Was Your Location In The Vehicle?
☐Driver ☐Front Passenger **Rear**: ☐Left ☐Middle ☐Right

d) What Damage Did The Vehicle You Were In Sustain?
☐Minimal ☐Moderate ☐Extensive ☐Totaled ☐Unsure

2. Other Vehicle

a) Type: _____

b) Vehicle Size
☐Compact ☐Mid-Size ☐Full-Size ☐Other: _____

c) How Did This Vehicle Strike The Vehicle You Were In?
☐Heads On ☐From Right ☐From Left ☐Rear Ended
☐Sideswiped On Left ☐Sideswiped On Right ☐Other: _____

d) **What Damage Did The Other Vehicle Sustain?**
☐Minimal ☐Moderate ☐Extensive ☐Totaled ☐Unsure

3. Describe Any Other Vehicle(s) To Strike The Vehicle You Were In

_____
_____
_____
_____

4. Were Traffic Citations Issued As A Result Of The Accident?
☐No ☐Driver Of Your Vehicle ☐Driver Of Other Vehicle ☐You ☐Unsure

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5. **Conditions At The Time Of Accident?**
   a) **Timing:** ☐Daylight ☐Night ☐Dawn ☐Dusk ☐Other: _____
   b) **Road:** ☐Dry ☐Wet ☐Snow Covered ☐Icy ☐Other: _____
   c) **Visibility:** ☐Good ☐Fair ☐Poor ☐Other: _____
6. **At Moment Of Impact**
   a) **Were You Prepared For The Accident?**
      ☐No ☐Yes
   b) **Were You Wearing A Seatbelt?**
      ☐No ☐Yes If Yes: ☐Shoulder Belt ☐Shoulder-Lap Belt ☐Lap Belt
   c) **Was The Vehicle Equipped With Headrests?**
      ☐No ☐Yes If Yes, Location: ☐Low ☐Middle ☐High ☐Unknown
   d) **Did Airbags Deploy?**
      ☐No ☐Yes
7. **Your Body Positioning**
   a) **What Was Your Body Position At Impact?**
      ☐Straight ☐Slouched Forward **Rotated**: ☐Left ☐Right
      ☐Don't Recall ☐Other: _____
   b) **What Direction Was Your Body Thrown?**
      ☐Forward/Backwards ☐Sideways ☐Across Vehicle
      ☐Outside Vehicle ☐Don't Recall ☐Other: _____
8. **Your Head/Neck Positioning**
   a) **What Was Your Head/Neck Position At Impact?**
      ☐Straight ☐Tilted Forward **Rotated**: ☐Left ☐Right
      ☐Don't Recall ☐Other: _____
   b) **Through What Motion Were Your Head/Neck Thrown?**
      ☐Forward/Backwards ☐Sideways ☐Don't Recall
      ☐Other: _____
9. **Result Of Impact**
   a) **Did The Force Of Impact Cause Your Head/Neck To Strike Anything?**
      ☐No ☐Yes If Yes, Then What: _____
   b) **Did The Force Of Impact Cause Any Other Part OF Your Body To Strike Anything?**
      ☐No ☐Yes If Yes, Then What: _____

E. IMMEDIATELY AFTER THE ACCIDENT

1. **Did You Lose Consciousness?**
   ☐Yes ☐No ☐Don't Know
2. **How Did You Feel?**
   ☐Confused ☐Dazed ☐Dizzy ☐Nervous ☐Weak ☐Other: _____
3. **Where Did You Immediately Feel Pain?**
   ☐Head ☐Neck ☐Upper Back ☐Mid Back ☐Low Back ☐Arms ☐Legs
   ☐Other: _____

4. **Did You Receive Emergency Care?**
   ☐No ☐Yes If Yes, Then Describe Care: _____
5. **Destination After Accident/Injury**
   ☐Hospital ☐Home ☐Work ☐School ☐Other: _____

F. HOSPITAL VISIT AFTER THE ACCIDENT/INJURY

1. **When Did You Go?**
   ☐Immediately ☐Later That Day ☐Next Day ☐Days Later
   ☐Other: _____
2. **Were X-rays Taken?**
   ☐Yes ☐No
3. **Was A CAT Scan Performed?**
   ☐Yes ☐No
4. **Was An MRI Performed?**
   ☐Yes ☐No
5. **What Was The Diagnosis(es) Given At The Hospital?**

_____
_____
_____
_____

6. **What Treatment(s) Was/Were Given At The Hospital?**

_____
_____
_____

7. **What Recommendations Were Made?**

_____
_____
_____

G. FOLLOWING THE ACCIDENT/INJURY

1. **What, If Any, Additional Symptoms Developed?**

_____
_____
_____
_____

2. **How Much Later Did Additional Symptoms Develop?**
   ☐Immediately ☐Hours ☐That Evening ☐Next Morning ☐Days ☐Week
   ☐Month ☐Other: _____

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3. Since Your Accident/Injury Have You Suffered From?

☐Blurred Vision ☐Double Vision ☐Reduced Vision ☐Impaired Hearing
☐Ringing In Ears ☐Chest Pain ☐Difficulty Breathing ☐Palpitations
☐Constipation ☐Diarrhea ☐Nausea ☐Vomiting ☐Frequent Urination
☐Inability To Hold Urine ☐Painful Urination ☐Anxiety ☐Depression
☐Mood Swings ☐Nervousness ☐Poor Memory ☐Tension ☐Convulsions
☐Dizziness ☐Headaches ☐Fainting ☐Loss Of Balance ☐Fatigue
☐Restlessness ☐Insomnia ☐Light Sensitivity ☐Reduced Appetite
☐Weakness ☐Weight Gain ☐Weight Loss ☐Other: _____

4. Has The Accident/Injury Restricted Your Activities?

☐No ☐Yes If Yes, Describe: _____
_____
_____
_____

5. Have You Missed Work Due To This Accident/Injury?

☐Missed No Work ☐Limited Work Activity
☐Missed Work From: ____/____/_____ to ____/____/_____

6. Did You Self Treat Your Symptoms?

☐No ☐Yes If Yes, Then How Or With What: _____
_____
_____

H. INSURANCE/ATTORNEY INFORMATION

1. Have You Contacted An Insurance Adjuster Or Representative Regarding This Claim?

☐No ☐Yes If Yes, Company: _____
Adjuster: _____ Claim #: _____

2. Have You Engaged Services Of An Attorney?

☐No ☐Yes If Yes, Attorney: _____
Address: _____
City: _____ State: ____ ZIP: _____
Phone: (____) _____-_____

3. Have You Filed An Accident/Injury Report?

☐No ☐Yes

4. Have You Filed For Insurance Benefits?

☐No ☐Yes

_____ ____/____/_____
Patient Or Guardian's Signature Date

Financial Policy
McCracken Chiropractic & Wellness Center
284 Central Way
Kirkland, WA 98033

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment. If at any time you have questions regarding any treatment, fee, or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding or rectify an injustice.

☐ INSURANCE
As a courtesy to you, we will bill your insurance carrier for you. All co-payments, deductibles, and payments for supplements, supports, and other "non-covered" services are due at time of service unless prior arrangements have been made. Payments may be made by cash or check. No Visa, MasterCard, or any other credit/debit cards are accepted. If you are unable to pay in full, it is your responsibility to contact our billing department to set up an agreeable payment plan. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

☐ UCR (USUAL AND CUSTOMARY RATES)
Our practice is committed to providing the best treatment possible for our patients, and we charge what is usual and customary for our area. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary rates.

☐ INJURIES/ACCIDENTS INVOLVING LITIGATION
We will make every effort to recover our fees from all available sources, including your health insurance and any med-pay benefits that are available on your auto insurance policy. We will then wait to collect any unpaid balances until after a settlement is reached. It must be understood, however, that the payment of the balance is ultimately your responsibility.

☐ WORKER'S COMPENSATION
Our office will file worker's compensation claims. It is your responsibility to contact your employer to establish a worker's compensation claim. If the claim is denied, we will bill your personal health insurance carrier. If the claim is unsettled or unpaid within 90 days, you will receive a statement from our office.

☐ MINOR PATIENTS
An adult must accompany the minor at the time of the first visit. The adult accompanying the minor is responsible for payment of the account.

☐ MEDICARE
We accept Medicare assignment. We will also file the claim to any secondary insurance that you may have.

☐ MISSED APPOINTMENTS
Missed appointments are not something we will ever bill you for! We understand that things come up and that some of us "forget" occasionally. All that we ask is a common courtesy phone call to reschedule your appointment.

PATIENT STATEMENT
I have read and understand the Financial Policy of McCracken Chiropractic & Wellness Center. I understand that I am ultimately responsible for the payment of any services or products received at this office. I also understand that I will be responsible for any fees related to collecting my unpaid balance, including reasonable attorney fees.

Signed _____ Date ____/_____/_____
(Patient or Guardian if patient is under 18 years of age)

McCracken Chiropractic & Wellness Center

284 Central Way
Kirkland, WA 98033

Notice of Privacy Practices: This Notice of Privacy Practices describes how we may collect, use and disclose your personal information, and your rights regarding that information. Under the Health Insurance Portability and Accountability Act of 1996, health care providers must take measures to protect the privacy of your personal information. We are required by law to:

- Protect the privacy of personal information.
- Provide this Notice explaining our duties and privacy practices.
- Abide by the terms of this notice.

Ways We Protect Your Personal Information: We allow only McCracken Chiropractic & Wellness Center staff access to the records and use personal information only to the extent necessary to conduct the practice of healthcare services. We secure the building, patient charts and computer records each day after work. We train our staff on our written confidentiality policy and procedures and employees are subject to discipline if they violate them. We will protect your privacy even if you no longer are a patient here. We shred old documents prior to discarding them.

How We Collect Your Personal Information: We collect the information from you in our initial Patient Information and Health History forms. We may also collect information regarding previous chiropractic treatment and medical conditions from health care providers you have seen in the past.

How We Use Your Personal Information: We use your information to determine appropriate care during your treatment here. We use personal information we collect here (i.e., X-ray records, charting information) to determine what chiropractic treatment we will provide. We may share this information with other chiropractic specialists to help determine your treatment. We use Social Security numbers, birth date and employer information to identify you with health care insurance groups. We use phone numbers and addresses to communicate with you regarding appointments and billing for services. Unless you request us not to, we may discuss your information with immediate family, i.e., with a spouse, also we discuss dependent's treatment with parents. We may be ordered by the Court in some unusual situations to release information and do so if it is required.

Your Rights: You may inspect records we retain regarding personal information and amend them if you feel they are in error. You may request we restrict the sharing of your information except on a case-by-case basis. You may request we only contact you at specific locations, i.e. only at work. You may also request records; we may charge a reasonable fee for this service. You may ask questions regarding your Personal information here.

Patient acknowledgement of Privacy Practices: I have seen the Privacy Practices notice as required by HIPAA, have read it and been given the opportunity to ask questions.

Patient Signature: _____ Date: ___/___/_____