MIDDENDORF CHIROPRACTIC

2021 Southeast Sedgwick Road, Suite 1 Port Orchard, WA 98366

Phone: (360) 871-5200 Fax: (360) 871-5350

Eric E Middendorf, DC

WELCOME

You deserve to be healthy. You were given all of life's blueprints, intelligence, tools, and systems to lead a healthy and active life. Life is a miracle and so are you. Unfortunately, things like accidents, stress, and poor habits can compromise your health. With your participation in the restoration and maintenance of your spinal and nervous system health through chiropractic care you can have the quality of life you so deserve.

Here at Middendorf Chiropractic we are committed to providing you and your family with corrective and wellness chiropractic care in the most stress free and welcoming environment we can possibly provide. To further benefit your chiropractic care, and to make your experience at our office as convenient as possible we do offer on site massage therapy as well as an assortment of wellness products.

Thank you for choosing our office for your chiropractic needs.

PERSONAL DATA INFORMATION

Today's Date: _____

Full Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: M F Marital Status: Single Married Divorced

Home#: _____ Cell#: _____ Work#: _____

Email: _____ Referred By: _____

Preferred Method(s) of Communication: □ Mail □ Phone □ Text □ Email

Have you had chiropractic care previously? If yes, with whom and when?: _____

_____

INSURANCE INFORMATION

Occupation: _____ Employer: _____

Primary Insurance Carrier: _____ Phone#: _____

Policy/Claim#: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Secondary Insurance Carrier: _____ Phone#: _____

Policy/Claim#: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Other than you is anyone responsible for the bill?:

__ Spouse __ Parent __ Personal Health Ins. __ Personal Injury Ins. __ Workers Comp Ins. __ 3rd Party Auto Ins.

PAST HISTORY

If any of the following apply please indicate when, where, how, etc.:

Injuries including broken bones, falls, sport injuries, accident related injuries, etc.: _____

_____

_____

_____

Major Surgeries: _____

_____

Major Illnesses: _____

_____

Been knocked unconscious? Y / N Had X-rays taken? Y / N

_____

_____

_____

CURRENT HEALTH PROBLEMS OR COMPLAINTS: (CIRCLE ALL THAT APPLY)

NECK PAIN	TENSION HEADACHES	MIGRAIN HEADACHES	NECK STIFNESS
UPPER BACK PAIN	UPPER BACK STIFFNESS	MID BACK PAIN	SHOULDER PAIN
LOW BACK PAIN	LOW BACK STIFFNESS	HIP/BUTTOCK PAIN	LEG PAIN
ARM PAIN	WRIST/HAND NUMBNESS	WRIST/HAND PAIN	ELBOW PROBLEMS
ANKLE/FOOT PAIN	LEG/FOOT NUMBNESS	KNEE PROBLEMS	ARTHRITIS
EARACHES	DIFFICULT TO BEND/TWIST	BREATHING PROBLEMS	ALERGIES
NERVOUSNESS	LOSS OF BALANCE	EARS RINGING	FAINTING
BLURRED VISION	HIGH BLOOD PRESSURE	FATIGUE	COLD HANDS
COLD FEET	HIGH CHOLESTOROL	LIVER PROBLEMS	CHEST PAIN
LOSS OF TASTE	LOSS OF SMELL	LOSS OF MEMORY	INSOMNIA
BEDWETTING	LOSS OF BLADDER CONTROL	DIFFICULTY URINATING	IRRITABLE BOWEL
CONSTIPATION	LOSS OF BOWEL CONTROL	DIARRHEA	IRRITABLE
DIZZINESS	ACID REFLUX/HEARTBURN	KIDNEY TROUBLE	CANCER
HEART ATTACK	MENSTRUAL IRREGULARITY	MENSTRUAL CRAMPS	FATIGUE
FIBROMYALGIA	GALL BLADDER PROBLEMS	PROSTATE PROBLEMS	DIABETES
HERNIA	DIFFICULTY W/ PROLONGED:	STANDING SITTING	WALKING

CURRENT & PAST HABITS: (CIRCLE ALL THAT APPLY)

Did you or do you:

Smoke Packs/Day _____

Drink Alcohol Drinks/Day _____

Drink Soda Cans/Day _____

Drink Coffee Cups/Day _____

Drink Water Cups/Day _____

Exercise Times per week _____ Duration ___ 30 MIN ___ 1 HR ___ OTHER

Type of exercise: _____ Are you a member of a gym?: Y / N

Do you purchase any of the following?: □ Bottled Water □ Vitamins □ Organic Health Food

X-rays are beneficial in viewing the status of your spine and spinal joints. It also provides a blueprint to better design your treatment. X-rays, however, should not be done in the area of the lower back and/or abdomen of pregnant women.

IS THERE A CHANCE YOU ARE PREGNANT? YES NO

The previous statements regarding my condition are true.

Signature: _____ Date: _____

If you will not be having X-rays at Middendorf Chiropractic today please fill out the following X-ray release:

Let it be known that I, _____, have requested a chiropractic adjustment without the benefit of X-rays. I understand that there may be consequences arising from the lack of said X-ray.

Signature: _____ Date: _____

TERMS OF ACCEPTANCE OF CARE AT MIDDENDORF CHIROPRACTIC

When a patient seeks chiropractic health care it is essential for both the patient and doctor to work towards the same objective. The chiropractor's objective is to detect and correct or reduce the vertebral subluxation complex. It is important that each person understands both the objective and the method that will be used to attain it preventing any confusion or disappointment.

VERTEBRAL SUBLUXATION: A dysfunction of one or more of the 24 vertebrae and their articulations with the skull, sacrum, and pelvis relating to misalignment which interferes with the transmission of impulses of the nerves that pass from the brain to the spinal canal and out to each and every part of the body. This results in decreasing the body's innate ability to function at its full potential.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. We utilize several techniques to restore motion, improve alignment, and remove nerve interference to improve structure and restore function to its full potential.

HEALTH: A state of optimal physical, mental, and social well being. Health is not merely the absence of infirmity or pain.

***** We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a Chiropractic examination, we encounter non chiropractic or unusual findings, we will recommend the services of a healthcare provider who can provide you with diagnoses and treatment. Regardless of what the disease is called we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only objective is to eliminate the interference to the expression of the body's ability to heal itself and perform at its optimal level of health.

I, _____, have read and fully understand the above statements.

PRIVACY STATEMENT

I have read the information regarding privacy of my healthcare records according to the HIPPA regulations. I understand that this facility will adhere to those requirements.

CONSENT FOR CARE

I understand and agree that if I have health and or accident insurance, these policies are an arrangement between the carrier and me. This healthcare provider will prepare reports and forms to assist in reimbursement from the insurance company for a fee if over that deemed usual and customary. Any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand that all services rendered are my personal responsibility for payment.

I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of chiropractic healthcare, and I give authority for these procedures to be performed. It is understood and agreed that the amount paid to the doctor for imaging (X-rays) is for examination only.

I, _____, have read and fully understand the above statements. Questions regarding the privacy of my records, the doctor's objectives pertaining to my care in this office, and my financial responsibilities have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Thank you for visiting our office today.

Signature: _____ Date: _____

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SYMPTOM FORM

Patient Name _____ Date _____

Symptom/Pain Site(s) (please circle or list): Headache Neck Upper to Mid Back Lower back Hips Other _____

- On a scale of 0-10, with 0 being no pain and 10 being the worst, please circle the number that describes your symptom: 0 1 2 3 4 5 6 7 8 9 10
- What % of the time you are awake do you experience your symptom(s) at that intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptoms begin? _____
- How/what caused the symptom? _____

  _____
- Did the symptom begin suddenly or gradually? (circle one)
- What causes you to notice your symptoms? (Circle one or more) Almost any movement
  Bending neck forward Bending neck backward Tilting head to left
  Tilting head to right Twisting head to left Twisting head to right
  Bending forward at waist Bending torso backwards Tilting torso to left
  Tilting torso to right Twisting torso to left Twisting torso to right
  Getting up from sitting Sitting down from standing Getting into a car/truck
  Going up or down stairs Using arms at or above shoulders
  Lifting Reaching Pushing Pulling Walking Running Standing Sitting
  Crouching Kneeling Other _____
  Doing repetitive movements (describe) _____
  Holding prolonged stance (describe) _____

- What makes the pain/symptom better? (circle all that apply) Chiropractic Rest
  Heat Ice Pack Massage Stretching Pain Medication Muscle Relaxants
  Nothing Other _____
- Describe the quality of pain/symptoms: (circle all that apply) Dull Aching Sharp
  Burning Tingling Numb Shooting Other _____
- Does the symptom/pain move/radiate to another part of the body? (example: neck pain goes down the arm) Yes No If yes, describe _____
- Is the symptom/pain worse at certain times of day? (circle one or more) Morning
  Afternoon Evening Night Affects Sleep Unaffected by Time

Patient Signature _____