

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 # days you eat junk food per wk _____

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

Ounces of water per day _____ Cups coffee per day _____ Soda _____ Tea _____ Nicotine _____

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 ^{great} 10

Comment _____

Have you been diagnosed with any health conditions _____

Doctor's notes _____

MURRY
CHIROPRACTIC
& Associates, PS

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System Review

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	vomiting blood	hemorrhoids	poor digestion
rectal bleeding	vomiting	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	tonsillitis	hearing loss	hay fever	hoarseness
ear ache	nose bleeds	sinus congestion	vertigo	thyroid

Respiratory

chest pain	chronic cough	spitting blood	spitting phlegm	difficulty breathing
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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	eczema
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Women

cramps	excessive flow	hot flashes	irregular cycle	painful periods
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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 Dr. Murry 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

 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

 Date

Name: _____ Date: _____

Patient ID#: _____

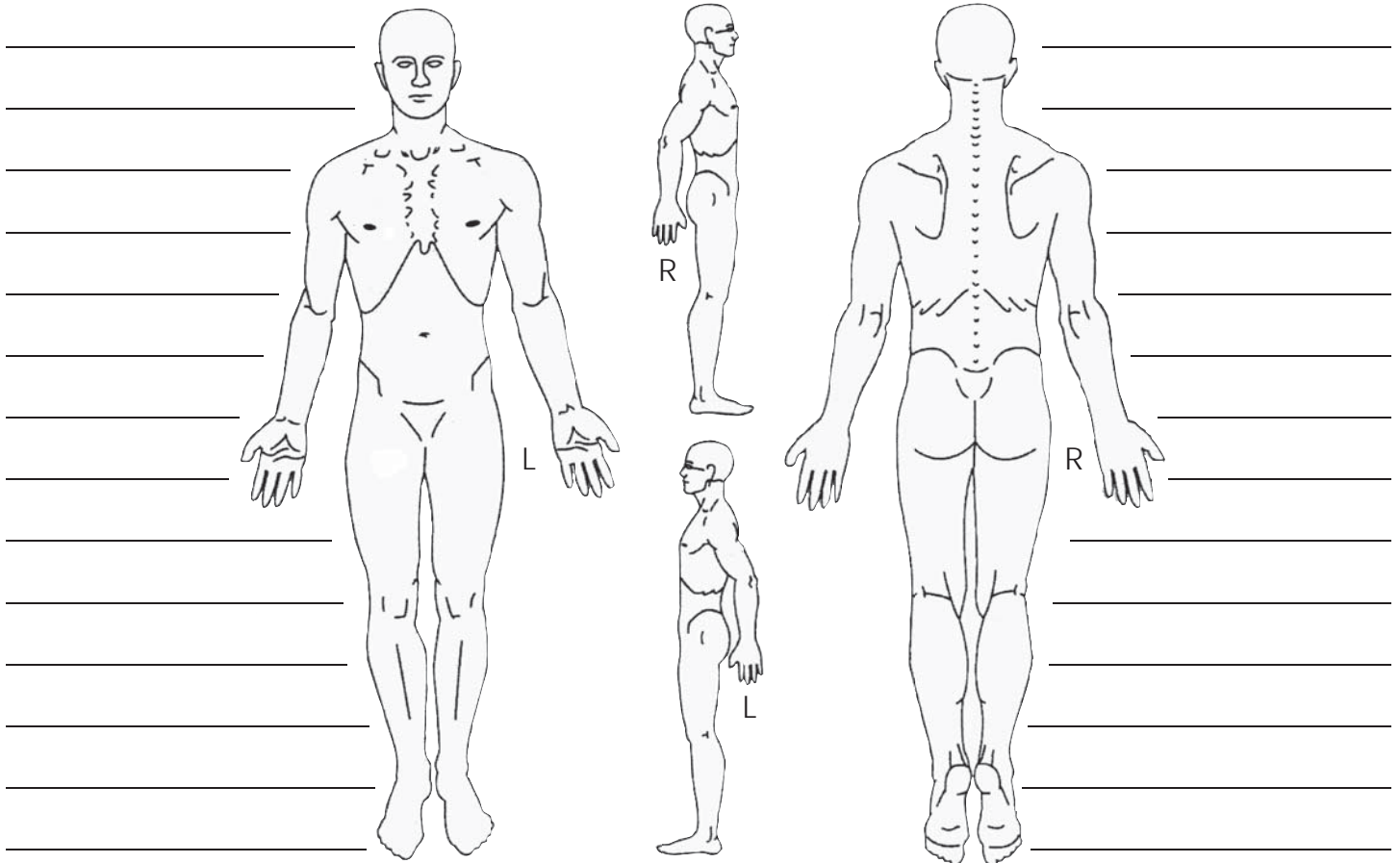
Please indicate the location of your pain or dysfunction on the imaged below.
Use the symbols shown to represent the type(s) of dysfunction or pain.

BBB = Burning
CCC = Cramping
DDD = Dull
SSS = Stabbing/Sharp

TTT = Tingling (pins & needles)
NNN = 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

Low Back Pain & Disability Index (Revised Oswestry)

Patient Name: _____ File #: _____ 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 your 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 with 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 definitely 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 _____

Date _____

Neck Pain & Disability Index (Vernon-Mior)

Patient Name: _____ File #: _____ 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 _____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal; to restore balance and function to the nervous system. It is important that each patient understands both the objective and the method that will be used to attain this objective.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of nervous system interference. Our chiropractic method of correction is by specific adjustments to joints in the body.

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

Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column or other joints in the body which causes aberrant nerve function and interference to the transmission of nerve impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than nerve interference. If during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, a diagnosis or treatment for these findings, we will recommend that you seek the services of a health care provider who specialized in that area.

I, (print name) _____ have read and fully understand the above statements. I certify that I have read and understand the above financial policy. 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

Witness

Date

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 and 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., P.O. Box 1215, 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
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(360) 734-9525



Payment, Cancellation & No Show Policy

Payment

All payments including co-pays and deductibles are due at the time of service. For your convenience we accept MasterCard & Visa, cash or checks. 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 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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chiropractic • massage • acupuncture 