Welcome to Peninsula Chiropractic!
Dr. Michael Dam, D.C.
231 W. Patison Street
Port Hadlock, WA 98339

Patient Name:_____ **Birth date:**_____

Male **Female** **Other** **Height:** _____ **Weight:**_____

Mailing Address: _____ **City:** _____

State:_____ **Zip:**_____ **Home Phone:**_____ **Cell Phone:**_____

Email Address:_____

Marital Status: **Single** **Married** **Divorced** **Widowed** **Domestic Partner**

Primary language:_____

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Unknown/Unavailable

Ethnicity Designation:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unavailable/Unknown

Who Referred You to Our Office?_____

Primary reason for your visit: **Headache** **Neck Pain** **Back Pain** **Other Pain**

Primary Care Physician:_____

Current Work Status: **Employed** **Retired** **Not Working** **Light Duty**

Your Occupation:_____

Are you: **Right handed** **Left handed** **Both**

Have You Seen a Doctor in the Past for These Injuries/Conditions?

Doctor: _____ **Date:**_____ **Treatment:**_____

Doctor:_____ **Date:**_____ **Treatment:**_____

MEDICATIONS

MEDICATIONS	DOSE

ALLERGIES

ALLERGY	SEVERITY (MILD, MODERATE, SEVERE)

PAST SURGERIES

SURGERY	DATE

BACK PAIN

Location:

_____ No back pain
_____ Centrally located low back pain
_____ Right sided low back pain
_____ Left sided low back pain
_____ Both sides into the hips
_____ Between the shoulder blades

Describe Your Pain:

_____ Deep dull
_____ Sharp
_____ Burning
_____ Electric
_____ Hot/tingling
_____ Stiff and sore

When did your back pain begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago *(Please Circle)*
_____ Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Duration:

_____ Constant
_____ Intermittent

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for low back pain?

_____ Yes _____ No

Does your pain radiate? *Please circle*

_____ Does not radiate to legs/feet/toes
_____ Radiates into the leg left/ right
_____ Radiates into the foot/toes left/right
_____ Radiates into the arms left/right
_____ Radiates into the hands/fingers left/rt.

How well do you function with your pain?

_____ I have 100% function with usual activities
_____ I have 75% function with usual activities
_____ I have 50% function with usual activities
_____ I have 25% function with usual activities
_____ I cannot function

Do you have numbness/ tingling?

_____ No numbness or tingling
_____ into the right leg
_____ into the left leg
_____ into the right foot/toes
_____ into the left foot/toes
_____ Into hands/ arms
Left/ Right (Please circle)

What makes your pain worse?

_____ Bending forward
_____ Bending backward
_____ Rotating left / right
_____ Laying on back
_____ Coughing / sneezing
_____ Laying on side
_____ Motion

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Exercise and stretching
_____ Rest
_____ Laying on side
_____ Laying on back

NECK PAIN

Location:

_____ No neck pain
_____ Centrally located low neck pain
_____ Right sided low neck pain
_____ Left sided low neck pain
_____ Both sides into the shoulders
_____ At the base of the skull

Describe Your Pain:

_____ Deep dull
_____ Sharp
_____ Burning
_____ Electric
_____ Hot/tingling
_____ Stiff and sore

When did your neck pain begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ *(Please circle)*
Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Duration:

_____ Constant
_____ Intermittent

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for neck pain?

_____ Yes _____ No

Does your pain radiate?

_____ Does not radiate to arms/hands/fingers
_____ Radiates into the right arm
_____ Radiates into the left arm
_____ Radiates into the right fingers
_____ Radiates into the left fingers

How well do you function with your pain?

_____ I have 100% function with usual activities
_____ I have 75% function with usual activities
_____ I have 50% function with usual activities
_____ I have 25% function with usual activities
_____ I cannot function

What makes your pain worse?

_____ Moving head up
_____ Moving head down
_____ Rotating left / right
_____ Motion
_____ Coughing / sneezing

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Rest
_____ Medication

HEADACHES

Location:

_____ No headaches
_____ Forehead
_____ Right side of head
_____ Left side of head
_____ Behind the eyes
_____ Back of head

Describe Your Pain:

_____ Deep pressure
_____ Dull ache
_____ Burning
_____ Throbbing
_____ Hot/tingling
_____ Stiff and sore

When did your headaches begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ *(Please circle)*
Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Frequency:

_____ per week

History:

_____ History of headaches?
_____ Ever suffered a concussion?
_____ Prior epilepsy treatment?
_____ Prior history of seizures?

What makes your pain worse?

_____ Noise
_____ Light
_____ Food
_____ Motion
_____ Coughing / sneezing

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Rest
_____ Medication

OTHER PAIN

Location: _____

Describe Your Pain: _____

Intensity:

_____ Mild (1-3)

_____ Moderate (4-7)

_____ Severe (8-10)

Duration:

_____ Constant

_____ Intermittent

When did your pain begin?

_____ After my accident

_____ Years ago (Date) _____

_____ A few days/weeks/months ago

_____ *(Please circle)*

_____ Always had some pain/stiffness

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for this pain?

_____ Yes _____ No

Does your pain radiate? _____

How well do you function with your pain? _____

What makes your pain worse? _____

What makes your pain better? _____

REVIEW OF SYSTEMS

Have you noticed any of the following?

_____ Unexpected weight loss or gain

_____ Blurred / double vision

_____ Headache

_____ Chest pain

_____ Shortness of breath

_____ Nausea

_____ Painful urination

_____ Joint pains

_____ Skin rash

_____ Dizziness

_____ Depression

_____ Easy bruising

_____ Excessive thirst or urination

_____ Reaction to foods / environment

PAST MEDICAL HISTORY

Have you had any of the following?

_____ Hypertension

_____ Coronary Artery Disease

_____ Arthritis

_____ Cancer

_____ Stroke

_____ Overweight

_____ Osteoporosis

_____ Immune Disorder

_____ Other: _____

Do you consume alcohol?

_____ I do not drink _____ I am a recovering alcoholic _____ I drink occasionally _____ I drink frequently

Do you smoke?

_____ Yes _____ No _____ I used to smoke

Do you use recreational drugs?

_____ No _____ I have previously used _____ I currently use

FAMILY HISTORY

Has anyone in your immediate family ever had the following?

_____ Cancer

_____ Stroke

_____ Hypertension

_____ Alcoholism

_____ Bleeding tendency

_____ Other: _____

Everything I have answered is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Authorization For Treatment

1. Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that I may refuse treatment at any time.
Initial _____

2. Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.
Initial _____

3. Privacy Rights

I certify that I have reviewed/had the opportunity to review the notice posted in the reception area describing how medical information about me may be used and disclosed under HIPAA law and how I may access this information.
Initial _____

4. Financial Obligation

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In most cases, exact insurance benefits cannot be determined until the insurance company receives the claim. **I understand that any quote of benefits given to me as a courtesy by this office does not guarantee insurance payment. I accept full responsibility for understanding my insurance benefits.**

Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initial _____

Signature_____Date_____