Meridian Medicine Registration Form

Today's date: / /

PATIENT INFORMATION

Patient's last name:	First Name:	Preferred Name:	MI:	Gender at Birth: ☐M ☐F Current/Preferred Gender:

Is patient a minor? ❑ Yes ❑ No	If Yes, who is legal guardian/parent responsible for him/her?	Date of Birth / /	Age:	Preferred Pronoun

Emergency Contact Name:	Relationship:	Phone:
Preferred Pharmacy	Address:	Phone:

CONTACT INFORMATION

Address:		Home Phone: ☐ Leave messages/test results here ( )
City:	State:	Mobile Phone: ☐ Leave messages/test results here ( )
Occupation:	Employer/School:	Work Phone: ( )
Email:	May we add you to our QUARTERLY newsletter? ☐ Yes ☐ No	

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr.

☐Family	☐Event (Name):	☐Sign/location	☐Yellow Pages	☐Internet (Which Site?):

☐Family/Friend/Co-Worker/Other (Name):

INSURANCE INFORMATION

(Skip if we copy your card)

Insurance Carrier Name (i.e., Allstate, Geico, etc.)
Policy Number:
Insurance Policy Holder Name:
Address:
Phone:

ACCIDENT INFORMATION

Type of Accident ☐ Automobile ☐ Work-Related ☐ Home ☐ Other (please indicate):

Have you reported this incident? ☐ Yes ☐ No	If **Yes**, to whom have you reported:

If **automobile accident related**, please complete **Personal Injury Questionnaire**

If **work related**, please complete the following:

Employer:	Date of injury: / /	Claim # (if claim is open):

INJURIES / SURGERIES

PLEASE COMPLETE THE FOLLOWING WITH AN APPROXIMATE DATE AND A BRIEF DESCRIPTION.

Falls / Head Injuries: _____

Broken Bones / Dislocations: _____

Surgeries: _____

Work Injuries: _____

Auto Accidents: _____

_____

_____

(Please See Reverse Side)

Meridian Medicine Registration Form

HEALTH HISTORY

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other: _____

Name of doctor(s) who have treated you for your current condition:

For best results, we like to communicate with your Health Care Providers. May we send them periodic reports of your progress?

☐ Yes ☐ No

Date of Last:

Physical Exam:_____

Spinal Adjustment:_____

Spinal X-Ray/MRI:_____

PLEASE CHECK ALL THAT APPLY

☐	Alcoholism	☐	Glaucoma	☐	Numbness	☐	Tremors
☐	AIDS/HIV	☐	Goiter	☐	Osteoarthritis	☐	Tuberculosis
☐	Allergy Shots	☐	Gout	☐	Osteoporosis	☐	Tumors, Growths
☐	Anemia	☐	Headaches	☐	Pacemaker	☐	Typhoid Fever
☐	Anorexia / Bulimia	☐	Hearing Loss	☐	Parkinson's Disease	☐	Ulcers
☐	Appendicitis	☐	Heart Attack	☐	Pinched Nerve	☐	Whooping Cough
☐	Arthritis	☐	Hemorrhoids	☐	Pneumonia	☐	Vision Problems
☐	Asthma	☐	Hepatitis	☐	Polio	☐	Fever (prolonged)
☐	Bed Wetting	☐	Hernia	☐	Prostate Problem	☐	Mumps
☐	Bleeding Disorders	☐	Herniated Disc	☐	Prosthesis	☐	TMJ (Jaw)
☐	Bronchitis	☐	High Blood Pressure	☐	Psychiatric Care	**Women Only:**	
☐	Cancer	☐	High Cholesterol	☐	Rheumatic Fever	☐	Hysterectomy
☐	Chemical Dependency	☐	Infertility	☐	Rheumatoid Arthritis	☐	Miscarriage
☐	Chicken Pox	☐	Kidney Disease	☐	Ringing in Ears	☐	Menopause
☐	Diabetes	☐	Liver Disease	☐	Scarlet Fever	☐	PMS
☐	Difficulty Breathing	☐	Low Back Pain	☐	Sinus Infections	☐	Irregular Menses
☐	Dizziness	☐	Measles	☐	STDs	☐	Cramps
☐	Emphysema	☐	Migraines	☐	Stroke	☐	Breast Problems
☐	Epilepsy	☐	Mononucleosis	☐	Thyroid Problems	☐	Pregnant
☐	Fatigue	☐	Multiple Sclerosis	☐			Due Date: _____
☐	Frequent Colds						

MEDICATIONS

Medications:

Allergies (if any):

Vitamins/Herbs/Mineral/Supplements:

PERSONAL LIFESTYLE

Exercise	Work Activity	Stress Level	Habits	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs/day:
☐ 1-2 x week	☐ Standing	☐ Medium	☐ Alcohol	Drinks/week:
☐ 3-4 x week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups/day:
☐ 5+ x week	☐ Heavy Labor	☐ Causes:		

Type of Exercise: _____

Eating Habits

In the last 24 hours, how many servings of fruits and vegetables have you consumed: _____

Is this typical? ☐ Yes ☐ No

Average fast food you eat per week: ☐ 0 (None) ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 4+

ASSIGNMENT

I, the undersigned, certify that I (or my dependent) have insurance with _____ and I authorize direct payment to Meridian Medicine for any insurance benefits otherwise payable to me for the services rendered. I understand that I am responsible for all charges if not paid by insurance. I authorize the doctor to release all information necessary to secure benefits. I authorize the use of this signature on all insurance claims. I understand that a copy of my insurance card is to be kept on file for the purposes of billing for all services rendered herein. The above information is true and correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges incurred in this office. All fees are payable at the time of service, unless other arrangements are made in advance.

_____ _____

Patient/Guardian signature *Date*

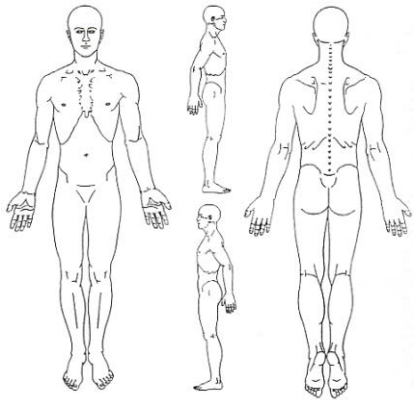
Pain Diagram

Name:_____ Date: _____

My Chief Complaint is:_____

Other Complaints:_____

Please draw the location and type of pain on the body diagrams:



Ache	**Burning**	**Numbness**
MMMMM	-----	O O O O O
Pins/Needles	**Stabbing**	**Other**
ooooo	/////	xxxxx

FUNCTIONAL RATING INDEX

To properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage every day activities. For each item below, please **circle the number which most closely describes your condition right now.**

1. Intensity of problem

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

4. Traveling (driving, etc.)

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

5. Work

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of Pain

0	1	2	3	4
No pain	Pain 25% of the day	Pain 50% of the day	Pain 75% of the day	Constant pain

8. Lifting

0	1	2	3	4
No pain lifting heavy weight	Increased pain lifting heavy weight	Increased pain lifting moderate weight	Increased pain lifting light weight	Increased pain lifting any weight

9. Walking

0	1	2	3	4
No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Meridian Medical
Notice of Privacy Practices

ACKNOWLEDGEMENT

Our ***Notice of Privacy Practices*** describes in more detail how your health information may be used and disclosed, and how you can access your information. An additional copy of our ***Notice of Privacy Practices*** can be obtained at our office.

By my signature below I acknowledge having been given the opportunity to review Meridian Medical's ***Notice of Privacy Practices***.

_____ _____

Patient/Legally Authorized Signature Date

_____

Printed Name

Meridian Medical
Informed Consent for Chiropractic Adjustments

Chiropractic treatment consists of manipulations of joints and soft tissues, using the hand and/or a mechanical instrument. You may feel joint movement, and you may hear joint clicks or other noises. Some patients will feel some stiffness and soreness following the first few days of treatment, these are normal and not a cause for concern. There are different techniques used in chiropractic spinal adjustments. There are also alternatives to chiropractic care, including but not limited to: Physical therapy, massage therapy, osteopathic manipulations, and medical care. There are also material risks inherent in the above listed alternatives, which should be discussed between you and the specialty care provider. You also have the option of not seeking any care. The risk of remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are certain risks which may arise during the exam and treatment. Those complications include: strokes or stroke-like conditions, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, pathological fracture, cervical disc protrusions, cervical dislocations, costovertebral strains, rib fractures, costochondral separations, compression of the cauda equina. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. The risks of massage are bruising, local tenderness, and the release of toxins in the body. I have read or have had read to me the above explanation of the nature and purpose of chiropractic adjustments, other alternatives/procedures for care, massage, and possible risks. I have also had the opportunity to ask questions about its content and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have, myself, decided that it is in my best interest to undergo the treatment recommended, and listed below. Having been informed of the risks, I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures, and diagnostic x-rays-if warranted, massage, and the use of natural substances such as vitamins, minerals, or other natural substances on me or on the patient named below, for whom I am legally responsible, by the doctor of chiropractic named below and/or licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or servicing as backup for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient/Legally Authorized Signature Date

_____

Printed Name

MERIDIAN | MEDICINE

2111 N Northgate Way Ste 201
Seattle, WA 98133
P: 206.525.8015
F: 206.525.8014
www.theuhc.com
info@theuhc.com

Patient Name:_____ Date:_____

Date of the collision:_____ Time of the collision:_____

Description of Collision and Injuries

Describe in your own words what happened in the collision:_____

_____

_____

_____

Where did the collision take place? (road, intersection, etc.) _____

What direction were you traveling in at the time of collision?_____

What direction was the other car traveling?_____

What state did the collision happen in?_____

What city did the collision happen in?_____

How many cars were involved in the collision?_____What was the estimated damage to the car you were in? $_____

Where did the impact take place on the car? ☐ Front Rear ☐ Driver's Side ☐ Passenger's Side ☐ Other

What was the size of the car you were in? ☐ Sub compact ☐ Compact ☐ Mid-size ☐ Full size

What was the size of the other car? ☐ Sub compact ☐ Compact ☐ Mid-size ☐ Full size

What type of car were you in? _____ What type of car was the other car?_____

What was the visibility at the time of the collision? ☐Clear ☐Sunny ☐Dawn ☐Dusk ☐Night/Dark _____Other

What were the road conditions? ☐ Dry ☐ Wet ☐ Damp ☐ Snow ☐ Icy ☐ Clear _____ Other

Where were you sitting in the car?_____

Were you aware the collision was coming? ☐ Yes ☐ No

Where you wearing a seatbelt? Lap belt: ☐ Yes ☐ No Shoulder Strap: ☐ Yes ☐ No

Where you ejected from the car? ☐ Yes ☐ No Did the airbags deploy? ☐ Yes ☐ No

Did you have a headrest? ☐ Yes ☐ No Where was the headrest positioned on your head (even, below 1", above 1" etc)? _____

What is the last thing you remember before the collision_____ and the first thing you remember after the collision_____?

Did you lose consciousness? ☐ Yes ☐ No

Continue on other side

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Did your body hit anything in the car? ☐ No If yes please explain:_____

_____

What body parts were injured during or after the collision?_____

_____

Are there any or were there any cuts, bruising or bleeding after the collision on your body? ☐No If yes please explain:_____

_____

Hospital Treatment

Did you go to the hospital?☐ No If Yes, where_____

Date Treated at Hospital?_____

Were you taken by ambulance? ☐ Yes If No, how did you get there?_____

Was an examination performed on you? ☐ Yes ☐ No

What Treatment was rendered at the hospital (medication, braces, etc.)?_____

_____

Did you have any imaging done (CT, MRI, X-rays, Etc.)?☐No Yes (explain)_____

_____

Other Treatments

Have you seen any other doctor in relation to this collision outside of the ER? ☐No If Yes (Who/Where?)_

_____

If yes, when was this medical treatment received?_____

Were any imaging studies taken (x-rays, CT scans, MRI, etc.)? ☐No Yes (explain)_____

_____

What type of treatment did you receive (medication, collars, braces, etc.)?_____

_____

By signing below, I verify that all of the information provided above is true to the best of my knowledge. I, understand that by signing below I take full responsibility for the information provided in relation to the auto collision in which I was involved in. I also understand that ultimately, I am responsible for any charges for the treatments rendered in relation to this collision.

Patient Name:_____

Patient Signature:_____

Date:_____

The Rivermead Post-Concussion Symptoms Questionnaire*

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0 = Not experienced at all
1 = No more of a problem
2 = A mild problem
3 = A moderate problem
4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches.....	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance.....	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful.....	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light.....	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1._____	0	1	2	3	4
2._____	0	1	2	3	4

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592