Bellevue Spine

Aaron Ilk, DC
Chiropractic Physician

1750 112th Ave NE
Suite E-165
Bellevue, WA 98004

425-827-2302 voice
425-454-2579 fax
FrontDesk@BellevueSpine.com

CONFIDENTIAL PERSONAL INFORMATION

Full Legal Name:_____ Name you prefer:_____

Address:_____

City / State / Zip:_____

Phone: (home) ___ - ___ - _____ (work) ___ - ___ - _____ (cell) ___ - ___ - _____
Which number is the best to reach you? Circle one: Home Work Cell

Birth date:___/___/_____ Age:_____ Sex:_____ Marital Status: S M W D Sep DP

Spouse / Partner Name_____ # Children_____ Education _____

Email: _____ How did you hear about us? _____

Driver's License #:_____ Emergency Contact:_____

Relation to Emergency Contact:_____ Phone: ___ - ___ - _____

Your Employer:_____ Phone: ___ - ___ - _____

Employer's Address:_____

City / State / Zip:_____

Job Title:_____ Supervisor's Name:_____

Insurance Company:_____ Phone: ___ - ___ - _____

Claims Address: _____

Effective Date:_____ Member ID:_____ Group #: _____

Are you the subscriber of the policy? Yes – skip remainder of this section No – please complete section

Subscriber's Name:_____ Subscriber's Date of Birth: _____

Subscriber's Address: _____

City / State / Zip:_____

I understand that payment for services rendered is due in full at the end of each visit and if for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. I understand it is my responsibility to verify insurance eligibility, to familiarize myself with my insurance coverage and to update Bellevue Spine immediately if/when changes are made to my insurance policy. I understand that I am ultimately financially responsible for any and all services performed. I authorize Bellevue Spine to utilize and release appropriate and necessary information from my medical records to assist in collecting sums due for services rendered, including but not limited to, billing first party insurance providers (eg: personal injury insurance, group medical insurance, Labor and Industries).

Patient Signature:_____ Date: _____

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CONFIDENTIAL CASE HISTORY FILE

MEDICAL HISTORY (please be complete)

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any Motor Vehicle Collision injuries (include dates): _____

List any On The Job injuries (include dates): _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):

_____

_____

List all over-the-counter and prescription medications used (include reason used): _____

_____

_____

_____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.):

_____

_____

When was your last physical examination? _____ **Dr:** _____

Is this your PCP? □ Yes □ No – Name of PCP: _____

Have you ever been under chiropractic care? □ No □ Yes (describe): _____

If female, is there any possibility that you are pregnant? □ No □ Yes

Do you smoke / use tobacco? □ No □ Yes **Exercise habits:** □ Never □ Occasional □ Frequent

Check any of the following symptoms you have noticed: (○ = Previously, □ = Now)

- ○ □ Headaches
- ○ □ Dizziness or light-headed
- ○ □ Jaw pain, clicking or locking
- ○ □ Pain or difficulty swallowing
- ○ □ Neck pain or stiffness
- ○ □ Shoulder pain
- ○ □ Mid-back pain
- ○ □ Chest pain or cough
- ○ □ Pain/trouble breathing
- ○ □ Arm/hand numbness/tingling
- ○ □ Arm/hand fatigue/weakness
- ○ □ Low back pain
- ○ □ Leg/foot numbness/tingling
- ○ □ Leg/foot fatigue/weakness
- ○ □ Leg pain with walking
- ○ □ Abdominal pain
- ○ □ Nausea or vomiting
- ○ □ Diarrhea or constipation
- ○ □ Blood in urine or stool
- ○ □ Difficulty or pain w/urination
- ○ □ Difficulty w/sexual function
- ○ □ Abnormal menstrual periods
- ○ □ Sensitivity to light or sound
- ○ □ Visual or hearing disturbances
- ○ □ Memory loss/problems
- ○ □ Irritability or depression
- ○ □ Fatigue or loss of energy
- ○ □ Fainting or convulsions
- ○ □ Trouble w/balance or coordination
- ○ □ Sleep disturbances/problems
- ○ □ Rashes (face, body, limbs)
- ○ □ Joint pain or swelling
- ○ □ Pain w/exertion (activity, climbing stairs, etc.)

Have you had ANY of the following:

Now

- □ Pain worse at night
- □ Constant pain unrelated to motion
- □ Unexplained weight loss
- □ Recent (30 days) fever or chills
- □ Recent (30 days) bacterial infection
- □ Loss of bowel or bladder control
- □ Urinary discharge
- □ Recent (30 days) surgery

Ever

- □ History of cancer
- □ History of IV drug use
- □ History of blood transfusion

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INFORMATION ABOUT YOUR CURRENT CONDITION / COMPLAINTS

What is your primary complaint/problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

How did your symptoms first begin? _____

Pain is: □ Constant □ Intermittent **Is you condition getting worse?** □ No □ Yes

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

_____

Have you had?

□ X-rays	Date: _____	□ EMG	Date: _____
□ MRI	Date: _____	□ Bone Scan	Date: _____
□ CATScan	Date: _____	□ Blood work	Date: _____

List all home remedies tried for this problem: _____

Is your condition worse in the morning or evening? Explain: _____

Does your condition interfere with: **work:** □ no □ yes **sleep:** □ no □ yes **normal daily routine:** □ no □ yes

Have you had symptoms like this before? □ no □ yes **(describe)** _____

Draw the area of your symptoms using these symbols: (mark on the figures)

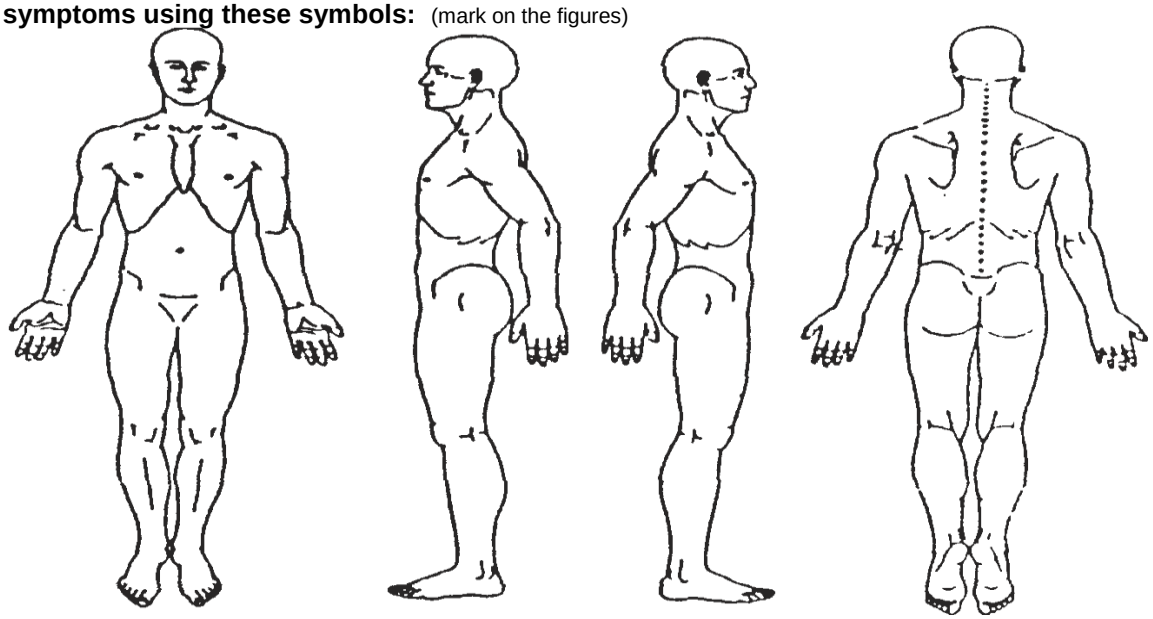
XXX = ache

*** = sharp/stab

○○○ = numb/tingle

→→→ = shooting

/// = stiff/tight



Regarding your main complaint

How bad is your pain?

(mark on all 3 scales)

1. Right now: 0 ——— 10

2. Average: 0 ——— 10

3. At worst: 0 ——— 10

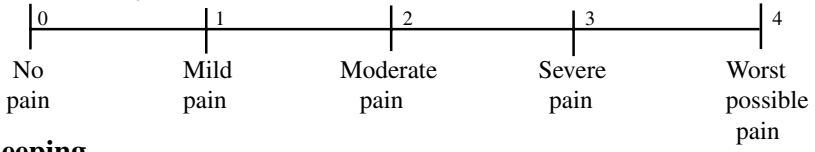
0 = no pain 10 = worst pain imaginable

Functional Rating Index

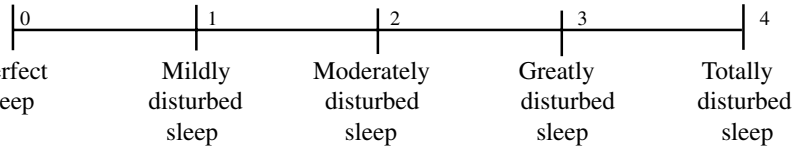
For use with **Neck and/or Back Problems** only.

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

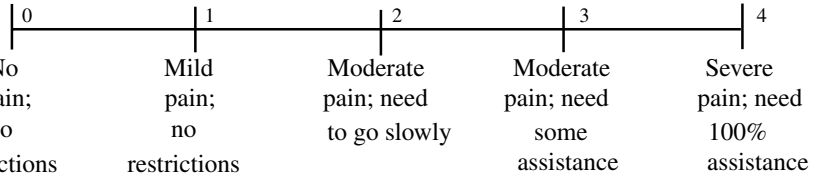
1. Pain Intensity



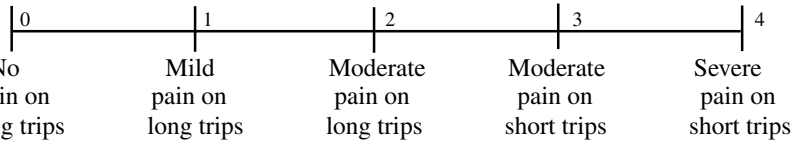
2. Sleeping



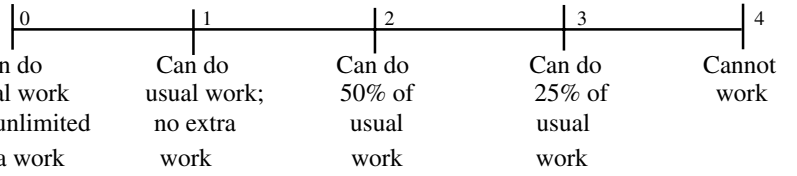
3. Personal Care (washing, dressing, etc.)



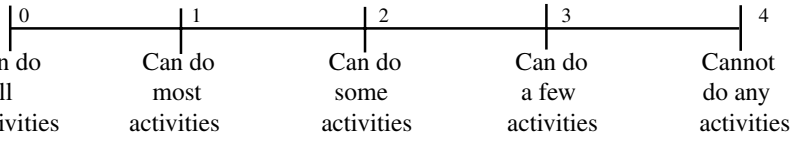
4. Travel (driving, etc.)



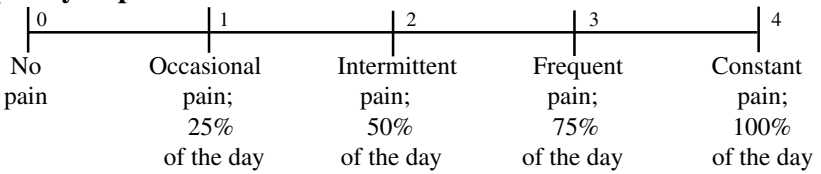
5. Work



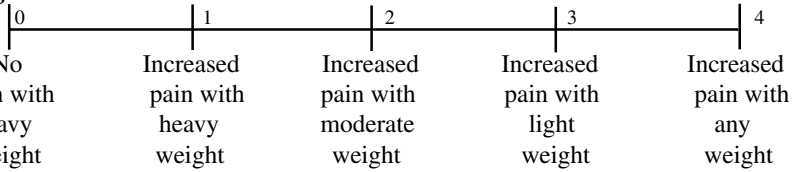
6. Recreation



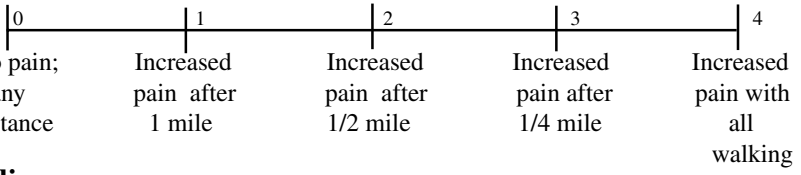
7. Frequency of pain



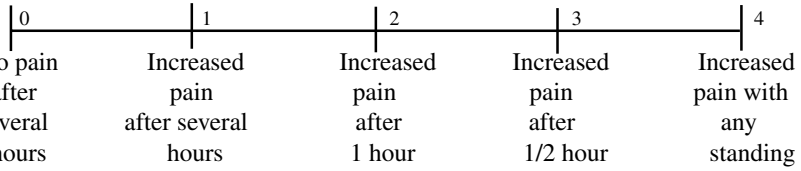
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date