



Welcome to 24 Bones

Our mission at 24 Bones Chiropractic is to help you achieve all your health goals and needs. Whether your main reason for seeing us is to get out of pain, increase your energy, lose weight, or simply take your health to the next level, we are here to provide you with the tools and knowledge to help you on your journey to optimal health.

The first step in the process is to establish your current state of health and the overall function of your body. In order for us to assess this and understand the root cause of your symptoms, we will take you through a series of non-invasive examinations on your initial visit. This includes a full case history, nerve and muscle tests, postural analysis, functional movement assessment, bio impedance analysis, and blood pressure tests.

There are a few simple steps we recommend for you to follow prior to your examination:

- No alcohol within 24 hours
- No exercise for 4 hours
- Avoid caffeine or food for 4 hours
- Consume 2-4 glasses of water within 2 hours

On the day of your visit, we ask that you wear comfortable clothing you can easily move in. We will take a postural photo of you, so please avoid multiple layers or bulky clothing.

At your initial visit, please bring all completed paperwork (4 pages total) and any previous x-ray or MRI reports, or recent blood work with you so we may refer to these during our case history.

Your initial assessment will take between 45-60 minutes. Please allow sufficient time for your appointment. If you have time constraints, contact our front desk prior to your visit.

Please Note:

We have a 24-hour cancellation policy where the agreed upon fee will be charged if prior notice has not been given. If you are running late, please contact front desk at 509-948-5119. Late arrivals do run the risk of requiring a rescheduled appointment. We do our best to make sure patients aren't having to wait too long and we will try to work with you as best we can to accommodate the appointment times you need.



Your Life Review

Date: _____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birthdate: ____/____/____

Phone: _____

Okay to email our specials? Yes No

Age: ____ Male Female

Email: _____

Married: Y N Children: Y N

Name of Spouse: _____

Occupation: _____ Employer: _____ City/State: _____

Emergency Contact: _____ Phone: _____

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Insurance Information

Please complete this section regardless of your referral source (including non-referral external workshops). We are happy to verify your insurance coverage and provide your benefits information to you. We will NEVER bill your insurance without your permission.

Who is responsible for this account? _____ Relationship to patient: _____

Name of insurance company: _____ ID#: _____

Subscriber Name: _____ Birthdate: _____

Secondary Insurance: _____ ID#: _____

Assignment and Release:

I certify that I, and / or my dependent(s), have insurance coverage with _____ and assign directly to Dr Corey Nay, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of above signature

Relationship to Patient

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Financial Responsibility

Dear Patient,

24 Bones Chiropractic provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.

Signature: _____ Date: _____

10121 W. Clearwater Ave #112, Kennewick, WA 99336

☎ : 509-783-5255 ✉ : DrNay@24bones.com 🌐 : www.24bones.com

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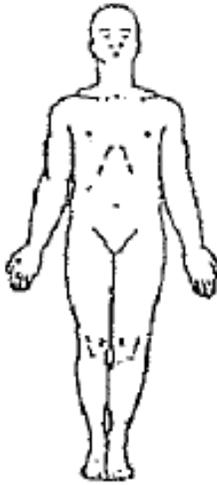
3 Your Visit

We appreciate you choosing our office. Is there anyone we can thank for referring you?

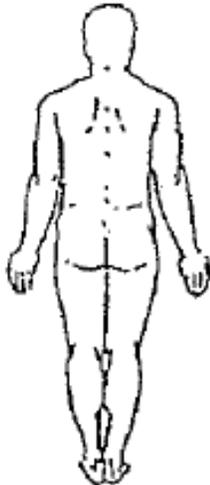
Please indicate the main reason you are seeing us today: _____

Is your condition the result of an accident? Yes ___ No ___ Date: _____

If you are seeing us for a pain-related issue, USE THE SYMBOLS on the image below to show the type of pain you feel in each location
 [XXXX = Dull/Achy] [///// = Sharp/Stabbing] [oooo = Numbness/Tingling] [ssss = Stiff/Tight] [---- = Burning]



Front



Back



Right



Left

- 0 = No Pain.** No Discomfort
- 1 = Minimal Discomfort.** Minor stiffness or tightness
- 2 = Discomfort.** Stiff, tight, sore. Muscle fatigue.
- 3 = Minimal Pain.** More than just sore. Uncomfortable.
- 4 = Mild Pain.** Noticeable pain but tolerable.
- 5 = Moderate Pain.** Aggravating. Still allows movement.
- 6 = Strong Pain.** Quite aggravating. Movement slightly limited
- 7 = Very Strong Pain.** Very aggravating. Movement definitely limited
- 8 = Very, Very Strong Pain.** Extremely aggravating. Movement very limited.
- 9 = Severe Pain.** Brings tears. Almost impossible to move.
- 10 = Excruciating Pain.** Agony. Unbearable. Cannot move. ER.

Using the pain scale to the right, CIRCLE the pain level you experience when your problem is at its very worst.

Is there any radiating pain into the arms or legs? Yes ___ No ___ Is there any numbness or tingling? Yes ___ No ___

How often do you experience your problem? (Please indicate for each of the body locations, if applicable)

Constant (75-100% of the time): _____ Frequent (50-75% of the time): _____

Occasional (25-50% of the time): _____ Intermittent (0-25% of the time): _____

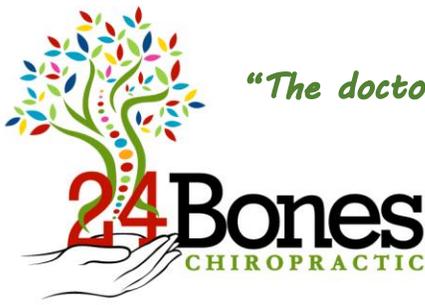
Have you seen anyone about this problem: _____

What tests have you already had for this problem? X-rays ___ MRI ___ Myelogram ___ EMG/NCV ___ None ___

Other (please describe) _____

What makes your problem **worse**?

- | | | | | |
|--------------|-----------------------|--------------|--------------|-----------------------------|
| ___ Sitting | ___ Changing Position | ___ Twisting | ___ Lifting | ___ Telephone |
| ___ Standing | ___ Sneeze/Cough | ___ Reaching | ___ Bending | ___ Going from Sit to Stand |
| ___ Walking | ___ Computer Work | ___ Driving | ___ Sleeping | ___ Other |



"The doctor of the future will give no medicine, but will interest his patients in the care of the human frame, in a proper diet, and in the cause and prevention of disease"

Thomas Edison

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Medical History

List any medications, herbs or supplements you are taking and the reason for their use:

Please list any significant conditions you've been diagnosed with or have been treated for over the course of your life: _____

Please list any surgeries you have had over the course of your life: _____

Are you allergic to anything? Yes ___ No ___ If Yes, Please list: _____

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Family History

Mother: Living ___ Deceased ___ List any medical problems: _____

Father: Living ___ Deceased ___ List any medical problems: _____

List any problems common to your family: Cancer ___ Diabetes ___ Heart Disease ___ High Blood Pressure ___

Stroke ___ Arthritis ___ Scoliosis ___ Thyroid Disease ___ Osteoporosis ___ Other _____

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Social History

Are you: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Partnered for ___ years

Do you have any children? Yes ___ No ___ If yes, how many? _____

Do you drink alcohol? Yes ___ No ___ If yes, how much and how often? _____

Do you smoke? Yes ___ No ___ If yes, how much, how often, and how long? _____

What do you do most of the day in your job postures, positions and repetitive movements? _____

On a scale of 0-10 (0 = worst and 10 = Best) rate how well you think you are doing with the following:

Exercise _____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level _____

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Review of Systems

Please use the scale below (0 to 4) to rate each of the symptoms on the next page according to your health status over the past 30 days:

0 = Never have this symptom

1 = Occasionally have this symptom, effect not severe

2 = Occasionally have this symptom, effect is severe

3 = Frequently have this symptom, effect not severe

4 = Frequently have this symptom, effect is severe



Head: <input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Dizziness <input type="checkbox"/> Insomnia	Energy / Activity: <input type="checkbox"/> Fatigue / Sluggishness <input type="checkbox"/> Apathy / Lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness	Lungs: <input type="checkbox"/> Chest Congestion <input type="checkbox"/> Asthma, Bronchitis <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Difficulty Breathing
Eyes: <input type="checkbox"/> Watery or Itchy Eyes <input type="checkbox"/> Swollen, Red or Sticky Eyelids <input type="checkbox"/> Bags or Dark Circles Under Eyes <input type="checkbox"/> Blurred or Tunnel Vision (not including near or far sightedness)	Weight: <input type="checkbox"/> Binge Eating / Drinking <input type="checkbox"/> Craving Certain Foods <input type="checkbox"/> Excessive Weight <input type="checkbox"/> Compulsive Eating <input type="checkbox"/> Water Retention <input type="checkbox"/> Underweight	Heart: <input type="checkbox"/> Irregular or Skipped Heartbeat <input type="checkbox"/> Rapid or Pounding Heartbeat <input type="checkbox"/> Chest Pain
Ears: <input type="checkbox"/> Itchy Ears <input type="checkbox"/> Earaches, Ear Infections <input type="checkbox"/> Drainage from Ear <input type="checkbox"/> Ringing in Ears, Hearing Loss	Emotions: <input type="checkbox"/> Mood Swings <input type="checkbox"/> Anxiety / Fear / Nervousness <input type="checkbox"/> Anger / Irritability / Aggressiveness <input type="checkbox"/> Depression	Digestive Tract: <input type="checkbox"/> Nausea, Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating Feeling <input type="checkbox"/> Belching, Passing Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Intestinal / Stomach Pain
Nose: <input type="checkbox"/> Stuffy Nose <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Hay Fever <input type="checkbox"/> Sneezing Attacks <input type="checkbox"/> Excessive Mucus Formation	Mind: <input type="checkbox"/> Poor Memory <input type="checkbox"/> Confusion, Poor Comprehension <input type="checkbox"/> Poor Concentration <input type="checkbox"/> Poor Physical Condition <input type="checkbox"/> Difficulty Making Decisions <input type="checkbox"/> Stuttering or Stammering <input type="checkbox"/> Slurred Speech	Mouth and Throat: <input type="checkbox"/> Chronic Coughing <input type="checkbox"/> Frequent Need to Clear Throat <input type="checkbox"/> Sore Throat, Hoarseness <input type="checkbox"/> Swollen or Discolored Tongue <input type="checkbox"/> Canker Sores
Skin: <input type="checkbox"/> Acne <input type="checkbox"/> Hives, Rashes, Dry Skin <input type="checkbox"/> Hair Loss <input type="checkbox"/> Flushing, Hot Flashes <input type="checkbox"/> Excessive Sweating	Joints / Muscles: <input type="checkbox"/> Pain or Aches in Joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness or Limited Movement <input type="checkbox"/> Pain or Aches in Muscles <input type="checkbox"/> Weakness or Fatigued Muscles	Other: <input type="checkbox"/> Frequent Illness <input type="checkbox"/> Frequent or Urgent Urination <input type="checkbox"/> Genital Itch or Discharge
Grand Total:		