

Kapeikis Chiropractic & Massage, P.S.

"Active Care for Active Lifestyles"

630 N. Chelan Ave. Ste. B-2, Wenatchee, WA 98801, phone: 509-665-8363, fax: 509-662-7274

Thank you for choosing Kapeikis Chiropractic & Massage, P.S.

You have opened the intake packet indicating you have recently been involved in a

MOTOR VEHICLE COLLISION/CAR ACCIDENT

This packet assumes the symptoms we will be evaluating are related to this automobile accident.

If your symptoms are not related to a motor vehicle collision, please go back and find a more appropriate "intake packet".

Our pre-exam question forms are designed to help us provide you with the best care possible. Please print the following pages, fill out what is relevant to your current symptoms and bring the completed forms with you to your 1st appointment.

Thank you for taking the time to help us provide appropriate and efficient care for you.

Sincerely,

Paul Kapeikis, D.C.

Kapeikis Chiropractic & Massage, P.S.

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ABOUT YOU

Name: _____ Birth Date: ____/____/____
Social Security Number _____ - _____ - _____ Married Partner Single Female Male
Home Address: _____ City: _____
State: _____ Zip: _____ Telephone Number: _____ Cell: _____
Email: _____
Parent or Spouse: _____
Emergency Contact _____ Phone # _____
Were you referred to our office? NO YES by: _____

ACCOUNT INFORMATION

I authorize the release of my records to my insurance company and to **relevant** health care providers for the purposes of collecting insurance payments and continuity of care.

I authorize assignment of my insurance benefits directly to Kapeikis Chiropractic & Massage, PS. I agree that my account is due within 90 days of the date of service, and that I am ultimately responsible for full payment regardless of insurance coverage. I agree that I will be responsible for all expenses incurred in collecting a past due account.

Patient Signature: _____ Date: _____

Parent Signature (for patients under age 18): _____

CONSENT TO PARTICIPATE

Therapeutic procedures conducted in this office are considered safe and effective methods of care. As with any procedure intended to help, complications may arise. These complications include increased pain, swelling, bruising, muscle strain and discomfort, burns, lightheadedness, fainting or a temporary worsening of symptoms. More serious complications are extremely rare. Additional information concerning side-effects and complications is always available upon request.

Your participation is voluntary.

I have read and understand the above statements regarding treatment side effects. I also guarantee that this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in the above information

Patient Signature: _____ Date: _____

Parent Signature (for patients under age 18): _____

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NAME: _____

DATE: _____

Motor Vehicle Collision Insurance Questionnaire

Date of accident: _____

Location of accident: _____
(City/County) (State)

Police Report: **Yes** (please provide a copy) **No** (police were not called to accident scene)

Your Insurance Information:

Driver of the vehicle you were riding in: _____ License #: _____

Insurance Corporation: _____

Address: _____ Phone: _____

Claim Number: _____ Claim Manager: _____

Your Legal Representation:

Name: _____ Law Firm: _____

Phone: _____ Address: _____

At Fault Party Insurance Information:

Driver of the Vehicle: _____ License #: _____

Insurance Corporation: _____

Address: _____ Phone: _____

Claim Number: _____ Claim Manager: _____

Do you have any other, Motor Vehicle Collision, Personal Injury, Workers Compensation, Labor & Industries, or Medical-Legal claims currently open or for which you are receiving ongoing compensation? Yes No

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NAME: _____ DATE: _____

Description of Accident

1. How much warning time did you have prior to the actual impact? _____

2. Your vehicle type: _____

Other vehicles involved: _____

3. Briefly describe the accident: _____

4. Was there any secondary impact? _____

5. Estimated damage to your vehicle: _____

Estimated damage to other vehicles/property: _____

6. Were you: Driver Front Passenger Rear Passenger Other: _____

7. Were you wearing a seatbelt? Yes No Seatbelt Type: 3 Point Lap Only Other: _____

8. Was your seat in the vehicle equipped with a headrest positioned at or above the height of your ears and less than 2 inches behind your head? Yes No

9. At the moment of initial impact, Your Head Was Positioned: _____

Your Torso was Positioned: _____

Your Hands Were Positioned: _____

Your Legs Were Positioned: _____

10. Did you strike any part of your body against any part of the vehicle? Describe: _____

11. Were you struck by any flying debris within the vehicle? Describe: _____

12. Did you lose consciousness during or following the accident? Yes No

13. Were paramedics or EMTs called to the scene of the accident? Yes No

14. Did you go to a hospital, emergency or walk-in clinic after the accident? Yes No

How did you get there? Ambulance Driven by Relative/Friend Drove Myself Other: _____

Indicate all procedures performed:

MRI Resuscitation Exam X-Rays CT (CAT) Scan
Sutures/Stitches Physical Therapy Surgery Casting Broken Bones Medications Prescribed

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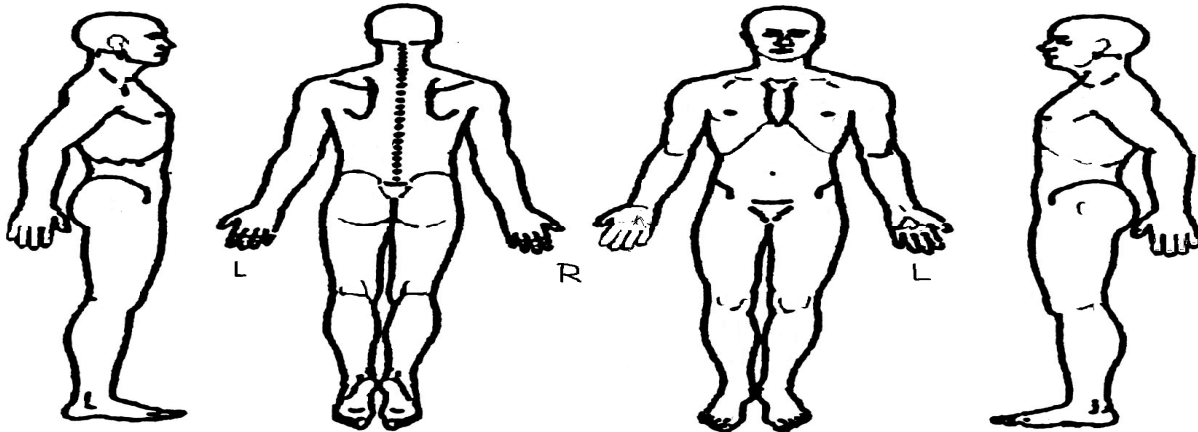
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NAME: _____ DATE: _____

COMPLAINT #1

Please fill out a **SEPARATE FORM FOR EACH COMPLAINT**

- My Complaint is:** Headaches Jaw Neck Upper Back L Shoulder R L Elbow R L Wrist R L Hand R
Mid Back Low Back L hip R L Knee R L Ankle R L Foot R Other: _____
- Please indicate on the drawings where you notice your symptoms. Please indicate the quality of these symptoms:** SS=sharp stabbing, DD= dull diffuse, A= aching, B=burning, St= stiffness, Nb= numbness, T= tingling, CR= cramping, El= electrical "zingers". Please feel free to add your own description including radiation or referral of your symptoms.



(0 is no pain/symptoms -10 is unbearable pain/symptoms)

- Please indicate the severity of symptom right now:** 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
- How often do you experience these symptoms?**
Constant (76-100% of the time) Frequent (51-75% of the time) Occasional (26-50% of the time) Intermittent (1-25% of the time)
- What aggravates these symptoms?** _____
- What is the worst these symptoms have been?** 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
- What alleviates these symptoms?** _____
- What is the best these symptoms have been?** 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
- How are these symptoms interfering with your normal activities?** _____
- Have these symptoms changed with time?** Getting Worse Staying the Same Getting Better

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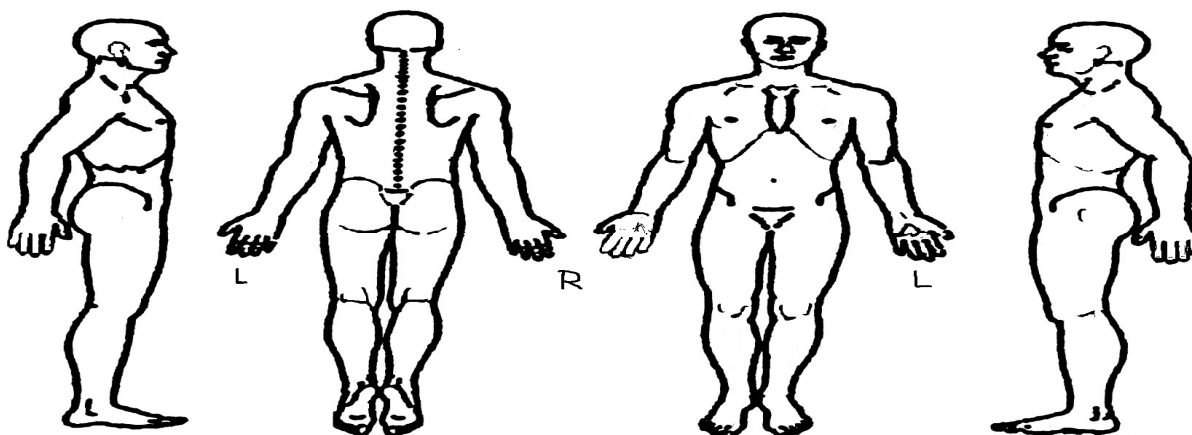
NAME: _____ DATE: _____

COMPLAINT #2

Please fill out a SEPARATE FORM FOR EACH COMPLAINT

1. **My Complaint is:** Headaches Jaw Neck Upper Back L Shoulder R L Elbow R L Wrist R L Hand R
Mid Back Low Back L hip R L Knee R L Ankle R L Foot R Other: _____

2. **Please indicate on the drawings where you notice your symptoms. Please indicate the quality of these symptoms:** SS=sharp stabbing, DD= dull diffuse, A= aching, B=burning, St= stiffness, Nb= numbness, T= tingling, CR= cramping, El= electrical "zingers". Please feel free to add your own description including radiation or referral of your symptoms.



(0 is no pain/symptoms -10 is unbearable pain/symptoms)

3. **Please indicate the severity of symptom right now:** 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

4. **How often do you experience these symptoms?**

Constant (76-100% of the time) Frequent (51-75% of the time) Occasional (26-50% of the time) Intermittent (1-25% of the time)

5. **What aggravates these symptoms?** _____

6. **What is the worst these symptoms have been?** 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

7. **What alleviates these symptoms?** _____

8. **What is the best these symptoms have been?** 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

9. **How are these symptoms interfering with your normal activities?** _____

10. **Have these symptoms changed with time?** Getting Worse Staying the Same Getting Better

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Neck Disability Index

Name: _____ **Date:** _____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

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.

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.

Personal Care (Washing, Dressing, etc.)

- 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 self-care.
- I do not get dressed, I wash with difficulty and stay in bed.

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 not do any work at all.

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.
- 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.

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.

Reading

- I can read as much as I want with no pain in my neck.
- I can read as much as I want 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 due to pain.

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).

Headaches

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score: _____

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Back Disability Index

Name: _____ **Date:** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

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 very severe and does not vary much.

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 sleep is reduced by less than 25%.
- Pain prevents me from sleeping at all.
- Because of pain my normal sleep is reduced by less than 50%.
- Because of pain my normal sleep is reduced by less than 75%.

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 1 hour.
- I avoid sitting because it increases pain immediately.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more than 10 minutes.

Standing

- I can stand as long as I want without pain.
- I have some pain while standing but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I avoid standing because it increases pain immediately.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.

Walking

- I have no pain while walking.
- I have some pain while walking but it doesn't increase with distance.
- I cannot walk more than 1 mile without increasing pain.
- I cannot walk at all 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.

Personal Care

- I do 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.

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.
- I can only lift very light weights.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.

Traveling

- I get no pain while traveling.
- I get some pain while traveling but none of my usual forms of travel make it worse.
- I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Pain restricts all forms of travel.
- I get extra pain while traveling which causes me to seek alternate forms of travel.
- Pain restricts all forms of travel except that done while lying down.

Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- I have hardly any social life because of the pain.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).

Changing degree of pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow.
- My pain is rapidly worsening.
- My pain is neither getting better or worse.
- My pain is gradually worsening.

Form BI100

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score: _____

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NAME: _____ DATE: _____

HEALTH HISTORY

1. Who is your Primary Care provider? _____
2. Please list ALL previous significant physical injuries, severe sprains, strains or broken bones?

(Approximate Dates) _____

3. Please list ALL Surgeries? (Approximate Dates) _____
- _____
- _____
- _____

4. Please indicate any history of the following conditions not part of today's complaint:

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> MS |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Angina | <input type="checkbox"/> ALS |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Drug/Alcohol Dependence |
| <input type="checkbox"/> Elbow/Upper Arm Pain | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Dermatitis/Eczema/Rash |
| <input type="checkbox"/> Upper Leg Pain | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Abnormal Weight Gain/Loss | <input type="checkbox"/> Physical/Emotional Abuse |
| <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Abdominal Pain | |
| <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disorders | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> General Fatigue | |
| <input type="checkbox"/> Tumor | <input type="checkbox"/> Muscular dis-coordination | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Visual Disturbances | |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Dizziness | |

5. Have you recently experienced any of the following:
- | | | | |
|---|--|--|---------------------------------|
| <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fever | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Rapid or Skipping Heart Beat | <input type="checkbox"/> Severe Constipation or Diarrhea | <input type="checkbox"/> Unexplained Extreme Fatigue | |
| <input type="checkbox"/> Bloody, Black or Consistently Narrowed Stool | <input type="checkbox"/> Cloudy, Bloody, Sweet or Unusual Smelling Urine | | |
| <input type="checkbox"/> Unexplained Weight Loss or Gain. | | | |

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NAME: _____ DATE: _____

HEALTH HISTORY (cont.)

6. Please list all prescription medications you are currently taking:

7. Please list all of the over-the-counter medications/vitamins you are currently taking:

8. Are you currently taking any blood thinners or garlic supplements? Yes No

9. Please list all known allergies: _____

10. Is there anything else pertinent to today's visit? _____

Females

Have not started menstrual cycle. Circle and skip this section

1. Is there ANY possibility you may be pregnant now? No Yes

2. Number of Past Pregnancies: _____ Number of Children: _____

Ages of Children: _____ Cesarean Section(s): _____

Complications of Pregnancy? Diabetes Preeclampsia Pelvic Damage Nerve Damage

other: _____

3. Birth Control? No Yes What Type & How Long? _____

4. Menstrual Problems? Irregular PMS Endometriosis Other: _____

5. Hysterectomy? No Yes Date: _____ Reason? _____

6. Menopause? No Yes Age: _____ Hormone Replacement? No Yes Yes - Bio-identical

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NAME: _____ DATE: _____

HEALTH HABITS

1. **Exercise Activities:** _____
2. **Exercise Frequency:** Daily 2-4 times weekly 1 time weekly Seldom Never
3. **My Exercise Activity Duration is usually:** 90 min or more 30-90 min. Less than 30 min.
4. **Sleep:** 0-6 hours/night 6-8 hours/night 8 or more hours per night
5. **Sleeping is:** frustrating & not rejuvenating 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 easy and rejuvenating
6. **Water intake:** Never 0-32 oz daily 32-64 oz daily 64 oz or more daily
7. **Nutrition:** I eat whatever I like and don't worry 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 I nutritionally evaluate everything I eat and stick to a healthy diet.
8. **Fast food:** Never 1-12 times/year 2-3 times/month 1-3 times/week 4+ times per week
9. **Packaged food:** Never 0-4 meals/month 1-7 meals/week 2+ meals/day
10. **Alcohol:** Never 1-3 drinks at special occasions only More than 3 drinks at special occasions only
1-2 drinks per day routinely More than 2 drinks per day routinely Intoxicated frequently
11. **Caffeine (including soft drinks):** Never Just occasional 1-2 cups per day 3 or more cups per day
12. **Past or current Tobacco use:** Never Occasional Weekly Daily Light Daily Heavy Quit
13. **Recreational Drug use?** Yes No

SOCIAL STRESS

All information gathered in this section is voluntary and completely confidential

PERSONAL RELATIONSHIPS:

1. **I am:** Single Dating Married Life Partner Widow/Widower Divorced **How Long?** _____
2. **Spouse/Partner's Employment:** _____ Retired Unemployed Disabled
3. **My current relationship is:** Very Stressful 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Fantastic
4. **My relations with extended family are:** Very Stressful 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Fantastic
5. **I am responsible for the welfare of children/elderly:** Yes (How many children? _____) No
6. **My social network is:** not satisfying 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 very supportive and satisfying

SECURITY:

1. **My housing situation is:** Homeless Shared Rental Renting Homeowner Other: _____
2. **My living arrangements are:** stressful 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 not stressful
3. **In the past 10 years I have changed communities/moved:** 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 times
4. **My financial security is:** very low 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 very high

OCCUPATION:

1. **Highest Education:** Did not Graduate High School /GED College/Trade School Post-Graduate Degree
2. **Occupation:** _____ **How Long?** _____
3. **My usual work hours are:** reliable not reliable on-call days nights swing shift
4. **My usual work hours are:** 0-20hr/wk 20-40hr/wk 40-60hr/wk 60+hr/wk
5. **My job security is:** not secure 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 very secure
6. **My overall job satisfaction is:** very low 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 very high

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NAME: _____ DATE: _____

FAMILY/GENETIC HISTORY

Within your genetic family, please list any major illnesses, approximate age of onset, age of mortality, cause of death if from disease as best you can. Of particular interest are any known genetic conditions.

Or: I was Adopted, My Genetic History is Unknown

