Confidential patient information

Name:_____ Age:_____ Birth date:_____

Address_____ Phone_____

City:_____ State:_____ Zip:_____Email:_____

Job Type:_____ SS#:_____

Marital Status_____ # of children_____

How were you referred to this office?_____

Reason For Visit : ❑ Musculo-Skeletal Evaluation ❑ Laser Treatment

❑ Biocleanse Footbath ❑ Allergy Evaluation ❑ Nutritional Consult

❑ Hormone Balancing ❑ Therapeutic Massage

Patient History

Important! Please fill out completely! If you need help, Please ask.

Primary Complaint:_____

Date of Onset: _____Is this visit accident related: ❑ Yes ❑ No

What has been done previously to solve this problem_____

_____

Have you ever been to a chiropractor before? ❑ Yes ❑ No Who?_____

When? _____Same Complaint? ❑ Yes ❑ No Results?_____

List Dates of Auto Accidents:_____

List all other accidents: (sports, work, recreation…)_____

Any other Health Problems/Illnesses/Hospitalizations/Surgeries_____

_____

Is there any possibility of current pregnancy? ❑ Yes ❑ No (Please Initial)_____

Health Lifestyle

Medications	Allergies	Vitamins/ Herbs / Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever suffered a life threatening allergic reaction? Yes No Allergen_____

Exercise	Work Activity	Habits	
❑ None	❑ Sitting	❑ Smoking	Packs/day_____
❑ Minimal	❑ Standing	❑ Alcohol	Drinks/week_____
❑ Moderate	❑ Light Labor	❑ Coffee	Cups/day_____
❑ Heavy	❑ Heavy labor	❑ High Stress	Reason_____

Health Conditions

Cervical Spine (Neck):
Postural distortions from subluxations in your neck will weaken the nerves into your arms, hands and head and affect these parts of your body. Do you experience…?

- ❑ Neck Pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Hearing disturbances
- ❑ Weakness in grip
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Thyroid conditions
- ❑ Sinusitis
- ❑ Allergies/Hay fever
- ❑ Recurrent Colds/Flu
- ❑ Low Energy/Fatigue
- ❑ TMJ/Pain/Clicking

Thoracic Spine (Upper Back):
Postural distortions from subluxations in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

- ❑ Heart Palpitations
- ❑ Heart murmurs
- ❑ Tachycardia
- ❑ Heart attacks/Angina
- ❑ Recurrent lung infections/bronchitis
- ❑ Asthma/wheezing
- ❑ Shortness of breath
- ❑ Pain on deep inspiration/expiration

Thoracic Spine (Mid Back):
Postural distortions from subluxations in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience…?

- ❑ Mid back pain
- ❑ Pain into ribs/chest
- ❑ Indigestion/Heartburn
- ❑ Reflux
- ❑ Nausea
- ❑ Ulcers/Gastritis
- ❑ Hypoglycemia
- ❑ Tired/irritable after eating

Lumbar Spine (Low Back):
Postural distortions from subluxations in the low back will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Constipation/Diarrhea
- ❑ Menstrual irregularities/cramping (females)
- ❑ Sexual dysfunction
- ❑ Low Back Pain

We are dedicated to helping you reach your health goals, so we ask that you take a moment and check your present health goals:

- ❑ Get out of pain
- ❑ Get out of pain, but I am interested in learning about wellness care and how it can improve my health
- ❑ Reaching optimum health and wellness

AUTHORIZATION OF CARE

I authorize and agree to allow the Doctor to work with my spine through the use of spinal adjustment and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Mountain View Chiropractic will assist me in making collection from the insurance company by assisting me with forms and reports, however, I understand that the submittal to the insurance company is performed at the discretion of Mountain View Chiropractic. I understand that any amount authorized to be paid to Mountain View Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. In the event of nonpayment I understand that all fees associated with the collection of this account to include attorney fees, collection costs, court fees and court cost, should be added to the base amount owed.

The Doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from these programs. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered.

_____ _____

Patient's signature Date Parent/Guardian

IN CASE OF EMERGENCY CALL:

Name_____

Relationship_____

Work Phone_____

Home Phone_____

Cell Phone_____

INSURANCE INFORMATION

If you do not have your insurance card avaliable, please fill out the information below:

Name of Insurance Co._____ Policy#_____

Address_____ Phone#_____

Insured's Name_____ Insured's SS#_____

Relationship to Insured_____ Birth date_____

Employer_____

WHO SHOULD RECEIVE THE CHARGES ON YOUR ACCOUNT?

❑ Patient ❑ Spouse ❑ Parent/Guardian ❑ Workers Comp ❑ Auto Insurance

❑ Medicare ❑ Personal Health Insurance