



**Confidential Patient Data**

The following information is needed in order to better serve you. Please complete all questions. If you need any assistance completing this form, please ask the receptionist  
*(Fill out forms in Blue or Black ink only)*

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_      Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_      City: \_\_\_\_\_      State: \_\_\_\_\_      Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_      Work Phone#: \_\_\_\_\_      Cell #: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Age: \_\_\_\_\_      Sex:    Female    Male

Email Address: \_\_\_\_\_      Driver's License #: \_\_\_\_\_

Preferred method of contact (circle one):      Home    Work    Cell    Email

Marital Status (circle one):      Married    Single    Divorced    Separated    Partnered

Number of Children: \_\_\_\_\_

#1. Name: \_\_\_\_\_      Age: \_\_\_\_\_      #2. Name: \_\_\_\_\_      Age: \_\_\_\_\_

#3. Name: \_\_\_\_\_      Age: \_\_\_\_\_      #4. Name: \_\_\_\_\_      Age: \_\_\_\_\_

Occupation: \_\_\_\_\_      Employer: \_\_\_\_\_

Name of Spouse or Nearest Relative: \_\_\_\_\_      Phone #: \_\_\_\_\_

Referred to this Office by (circle one): Friend/Family Member- Name? \_\_\_\_\_

Clinic Location      Insurance Company      Google      Event      Website      Other

Have you been adjusted by a Chiropractor before?      Yes      No

Reason for those visits? \_\_\_\_\_

Approximate date of last visit? \_\_\_\_\_

Whom may we contact in case of emergency?

Name: \_\_\_\_\_      Phone Number: \_\_\_\_\_      Relationship: \_\_\_\_\_

Patients Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:**

Mark the areas of pain on the figures below and then circle on the pain scale from 0-10 the pain you feel with this condition.

**Area of  
Complaint**

**(Rate 1-10)**

**Please mark an X  
where you have pain**

1. \_\_\_\_\_

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

**When did this condition begin  
and how?**

\_\_\_\_\_

**Has this condition:**

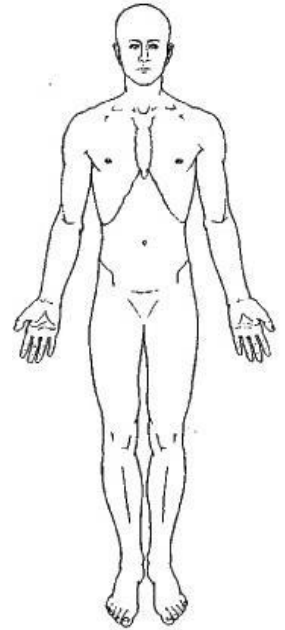
Gotten worse      Gotten better

Stayed constant      Comes and goes

**Type of pain:** Stiffness, Burning,  
Numb/Tingling, Sharp,  
Soreness/Achy

**Please state the following activities that aggravate  
your condition:** \_\_\_\_\_

**Please state the following activities that relieve your  
condition:** \_\_\_\_\_



2. \_\_\_\_\_

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

**When did this condition begin  
and how?**

\_\_\_\_\_

**Has this condition:**

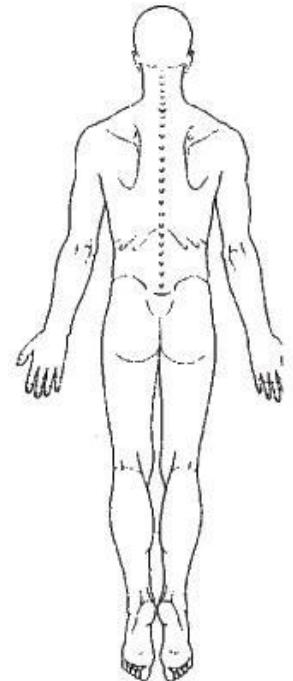
Gotten worse      Gotten better

Stayed constant      Comes and goes

**Type of pain:** Stiffness, Burning,  
Numb/Tingling, Sharp, Soreness/Achy

**Please state the following activities that aggravate  
your condition:** \_\_\_\_\_

**Please state the following activities that relieve your  
condition:** \_\_\_\_\_



3. \_\_\_\_\_

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

**When did this condition begin and how?**

\_\_\_\_\_

**Has this condition:**

Gotten worse      Gotten better

Stayed constant      Comes and goes

**Type of pain:** Stiffness, Burning,  
Numb/Tingling, Sharp, Soreness/Achy

**Please state the following activities that aggravate  
your condition:** \_\_\_\_\_

**Please state the following activities that relieve your  
condition:** \_\_\_\_\_

**Name and location of doctors previously seen for present  
condition:** \_\_\_\_\_

Patients Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEDICATIONS & SOCIAL HISTORY (circle which apply)**

Are you taking any herbs/supplements? No Yes, what kind? \_\_\_\_\_  
 Are you... Right handed Left handed

Tobacco use: No Yes \_\_\_\_\_ Cigarettes/ Day

Alcohol use: No Yes \_\_\_\_\_ Drinks/ Day

Recreational drug use: No Yes

Do you spend time on the computer? No Yes

Is your computer station ergonomically correct? No Yes

Do you exercise regularly? No Moderate Daily

Do you wear: Heel lifts Sole lifts Insoles Arch Supports

How is your diet? Balanced Not balanced

How is your sleep schedule? <8 hours/night >=8 hours/night Insomnia

How many ounces of water do you drink daily <64 oz/day >64 oz/day Never

What position do you sleep in (i.e. side, back, stomach)? \_\_\_\_\_

Are you aware of any poor postural habits? \_\_\_\_\_

<b>MEDICATION HISTORY (Please write 'N/A' if this question does not apply)</b>			
<b>Medication Name</b>	<b>For What Medical Condition</b>	<b>Start Date</b>	<b>Dosage</b>

Do you have any seasonal, medication, systemic allergies or intolerances? No

<b>Type of Allergy</b>	<b>Reaction</b>	<b>Onset date</b>	<b>Additional comments</b>

Patients Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEDICAL HISTORY**

**SURGICAL HISTORY (Please write 'none' or 'N/A' if this question does not apply)**

Surgery	Date	Surgery	Date
1.		3.	
2.		4.	

Have you ever had any type of implant? No Yes, what kind? \_\_\_\_\_

Have you ever sustained a gunshot wound? No Yes, where? \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_

**Women Only:**

Are you pregnant? No Yes, due date? \_\_\_\_\_

Date of last menstrual cycle: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her associates have permission to perform an X-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Today's date

**Accident History (circle which apply)**

(Please write 'none' or 'n/a' if this question does not apply):

Job	Auto	Other: _____	Date: / /
Job	Auto	Other: _____	Date: / /
Job	Auto	Other: _____	Date: / /

**Family History: (Circle all that apply)**

	Mother	Father	Brother	Sister
Arthritis				
Cancer				
Diabetes				
Heart Disease				
Hypertension				
Stroke				
Thyroid				
Other: _____				

Patients Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Review of Systems** – (Check box if you have had trouble with any of the following)

<b>Cardiovascular</b>			No	<b>Respiratory</b>			No	<b>Allergic/Immunologic</b>			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								<b>Ear, Nose and Throat</b>			No
Jaw Pain				<b>Eyes</b>			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
<b>Genitourinary</b>			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				<b>Psychiatric</b>			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				<b>Gastrointestinal</b>			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				<b>Endocrine</b>			No	Bowel Problems			
<b>Neurologic</b>			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				<b>Hematologic</b>			No				
Pinched Nerves					Past	Present		<b>Musculoskeletal</b>			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
<b>Constitutional</b>			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

# MALINA CHIROPRACTIC

## INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below.

As a part of the analysis, examination and treatment, you are consenting to the following procedures: Spinal manipulative therapy, palpitation, range of motion testing, orthopedic testing, basic neurological muscle strength testing, postural analysis testing, hold/cold therapy, spinal decompression, cervical traction, radiographic studies, vital signs and low level laser light therapy. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of these chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. 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, is in my best interest.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

**I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.**

**I also acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read and understand the Notice.**

PATIENT NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

PATIENT SIGNATURE (Or Guardian's signature if Patient is a minor): \_\_\_\_\_

(If applicable) NAME OF GUARDIAN/RELATIONSHIP TO PATIENT: \_\_\_\_\_

NAME OF TREATING D.C. _____	SIGNATURE _____	DATE _____
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### **OFFICE FINANCIAL POLICY**

1. **If you DO NOT have insurance (Self-Pay):** All payments are due at the time of treatment or by an authorized payment plan. With the exception of authorized payment plans, your personal balance may not exceed \$100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. **If you DO have insurance:** Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care. All deductibles, co-insurance and co-payments are the patient's responsibility and are due at the time of treatment or by an authorized payment plan. With the exception of an authorized payment plan, your patient responsibility balance may not exceed \$100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a self-pay patient until you bring in your completed insurance forms and we qualify and accept your insurance coverage.

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Not all services provided in our office are a covered benefit with all insurance contracts. Some insurance companies arbitrarily select certain services that they will not cover or which they have deemed not necessary. Your doctor will determine the best route of care for you based on your individual circumstances, not based on insurance coverage. If a treatment is not covered by your insurance, you will be responsible for the amount due for that treatment. We will make every effort to verify your coverage before treatment is rendered and will make you aware of your coverage. Please know this does not guarantee payment from your insurance carrier. If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid a claim within ninety (90) days of submission, you accept financial responsibility for payment in full of any outstanding balance. When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for treatment(s) will be due as it/they are rendered.

### **3. Personal Injury/Third Party Claims:**

**A. If You Have Medical Payments (MedPay or PIP) Coverage on Your Auto Policy:** Whether or not you are the responsible (at fault) party involved in the accident, you are entitled to use your MedPay benefits to pay for your care. It is our policy that we will file on your MedPay coverage if you have it and may decline services if you refuse to use your MedPay coverage.

**B. If You Have Health Insurance:** We may be able to file your health insurance to assist in payment of your Personal Injury claim with the following conditions: a) MedPay benefits have been exhausted, and b) it is our policy that we will not file to carriers that do not allow us to balance bill for Usual and Customary Rates.

**C. Liens:** If you do not have MedPay coverage, we will consider taking your case on a lien basis at the discretion of the doctor. In most cases, you will need a lawyer representing you before we will agree to work on a lien.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim(s) submitted or any authorized payment plans. Returned checks are subject to a \$35 handling fee. We will send a statement of your account with any thirty (30) day balances due. At sixty (60) days, you will receive a statement with late charges applied. At ninety (90) days, if we have not received payment on your past due balance, we will send the account to collections. If it becomes necessary to turn your account over for collection, you accept responsibility for any fees involved in that process.

By signing below, I acknowledge that I have fully read and understand the Office Financial Policy for Malina Chiropractic.

Patient's Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_