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

Today's Date: ____________________

Name (print) (Last, First, M.I.): ___________________________________ ☐ M ☐ F **DOB:** _____________________

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: ____ ____

Best phone number: ___________________________________ **Email:** ____

Preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ Email

Payment/Insurance Information: ☐ Self ☐ Health Insurance

Health Insurance Carrier: __________________________________ **Insurance Card ID Number:**____________________

Children		**AGE**
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	

Occupation:______________________________ **Employer:** ____

Name of Spouse or Nearest Relative: ________________________________ **Phone number:** ________________________

Referred to this office by: ☐ Friend/Family 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? ______________________________________

Phone Number: _______________________ **Relationship:** ________________

Patient signature: ________________________________ **Date**: ____/______/____

PLEASE MAKE SURE TO SIGN AND DATE EACH PAGE. THANK YOU.

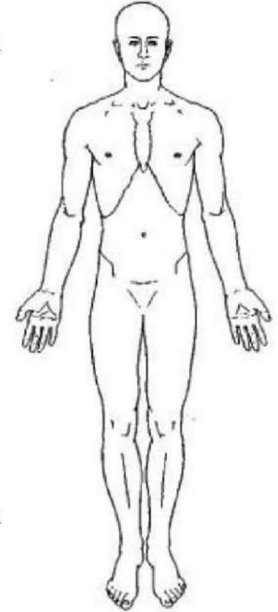
PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

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. 10 being the worst pain you have ever felt and 0 being no pain at all.

Area of complaint	(Rate 1-10)	Please mark an X where you have pain or other symptoms

1. ___________________________

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



WHEN DID THIS CONDITION BEGIN?

____

HAS THIS CONDITION:

Gotten worse Gotten better

Stayed constant Comes and goes

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

2. ___________________________

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

WHEN DID THIS CONDITION BEGIN?

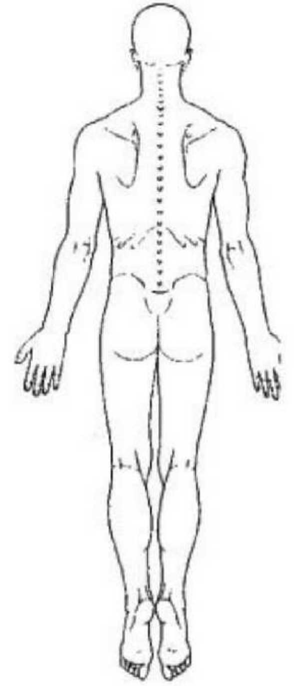
____

HAS THIS CONDITION:

Gotten worse Gotten better

Stayed constant Comes and goes

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



3. ___________________________

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

WHEN DID THIS CONDITION BEGIN?

____

HAS THIS CONDITION:

Gotten worse Gotten better

Stayed constant Comes and goes

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

Name of doctors previously seen for present condition:

1. ____

2. ____

Patient signature: ______________________________ **Date**: ____/______/____

PLEASE MAKE SURE TO SIGN AND DATE EACH PAGE. THANK YOU.

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:	☐ None	☐ Heel lifts	☐ Insoles
How is your diet?	☐ Balanced	☐ Not Balanced	
How is your sleep schedule?	☐ <8 hrs/night	☐ >=8 hrs/night	☐ Insomnia
How many ounces of water do you drink daily	☐ <64 oz/day	☐ >=64 oz/day	☐ Rarely

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

Medication Name	For What Medical Condition	Start Date	Dosage

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

Type of Allergy	Reaction	Onset date	Additional comments

Patient signature: ________________________________ **Date**: ____/______/____

PLEASE MAKE SURE TO SIGN AND DATE EACH PAGE. THANK YOU.

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 and Doctor: ____

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

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

Patient signature: ______________________________ **Date**: ____/______/____

PLEASE MAKE SURE TO SIGN AND DATE EACH PAGE. THANK YOU.

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

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			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								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			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				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			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			

Patient signature: _______________________________ **Date**: ____/______/____

PLEASE MAKE SURE TO SIGN AND DATE EACH PAGE. THANK YOU.

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__________________

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: ____________________________________