Malina CHIROPRACTIC and Wellness Center

# 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:** _____ _____ _____ _____
Street City State Zip Code

**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:** _____

| | | AGE |
|---|---|---|
| **Children** | ☐ 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?**

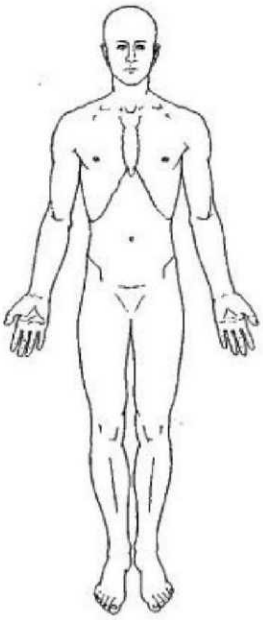
_____

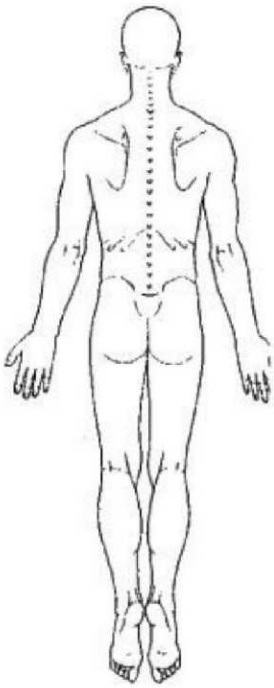
**HAS THIS CONDITION:**

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. Whitney Malina 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: _____