Mountain Island Chiropractic

WELCOME

Patient Information

Patient name _____

Today's date _____ Date of birth _____

Social Security # _____

Address _____

City _____

State _____ Zip _____

Gender: ❑ Male ❑ Female Height _____ Weight ___

❑ Single ❑ Married ❑ Partnered ❑ Engaged

❑ Separated ❑ Divorced ❑ Widowed ❑ Minor

How many children do you have? _____

Please list any family members being treated here _____

_____

Occupation _____

Employer/School _____

Employer/School address _____

_____

Employer/School phone number (_____) _____

Spouse's/Partner's name _____

Spouse's/Partner's employer _____

Who referred you? _____

Insurance

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co_____

Member ID:_____ Group #_____

Is patient covered by additional insurance? _____

Subscriber's Name:_____

Birthdate:_____ SS#:_____

Relationship to Patient_____

Insurance Co._____

Member ID#_____ Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the sue of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

Contact Information

Home phone (_____) _____

Cell phone (_____) _____

Email address _____

May we contact you via (please check for all applicable):

❑ Home phone ❑ Cell ❑ Work phone ❑ Email

In case of emergency please contact:

Name _____

Relationship _____

Home phone (_____) _____

Work/Other phone (_____) _____

Mission Statement

Our Passion is to share and celebrate in the healing journey of every family and individual who chooses to be lovingly served by us in a relaxed atmosphere.

We recognize health is an inherent state of well-being in mind, body and spirit. Our role is to remove any interference to health expression through optimal chiropractic and nutritional care supported by wellness education.

Our goal is to help create a world of maximized health and optimum human potential.

Patient Condition

What is your major complaint *(be as specific as possible)* _____

_____

When did your condition/symptoms/pain first appear? *(specific date, days ago, weeks ago, etc)* _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Since the onset of your problem is it: ❑ Getting worse ❑ Staying the same ❑ Slow to improve

When is it worse? ❑ Morning ❑ Afternoon ❑ Evening

Does it interfere with: ❑ Work ❑ Sleep ❑ Daily routines Other _____

Other doctors seen for this condition: ❑ MD ❑ DC ❑ DO ❑ DDS ❑ Other_____

Patient Condition

Does the condition/symptom/pain radiate? ❑ Yes ❑ No

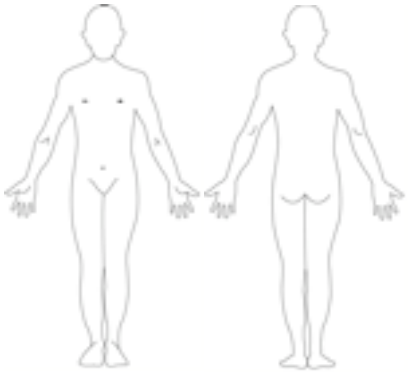
If yes, where and how frequently _____

How long/often does the radiation occur/last? _____

Do you have: ❑ Numbness ❑ Tingling ❑ Weakness

Describe _____

Mark all areas on the picture where your condition, symptoms, and/or pain occur.



List and mark the severity of your condition/symptoms/pain on the scales below:

Body part _____ _____

0 (None) 5 (Severe) 10

Body part _____ _____

0 (None) 5 (Severe) 10

Type of Pain: ❑ sharp ❑ dull ❑ aching ❑ throbbing ❑ numbness ❑ shooting ❑ burning ❑ tingling ❑ Other _____

What activities or positions aggravate your condition?

❑ bending ❑ coughing ❑ getting up/down ❑ driving ❑ lifting ❑ lying down ❑ reaching ❑ sitting ❑ sneezing ❑ standing ❑ straining at stool ❑ turning head ❑ twisting ❑ walking Other _____

What activities or positions relieve your condition?

❑ heat ❑ ice ❑ lying down ❑ medication ❑ sitting ❑ standing ❑ stretching Other _____

Have you ever had this condition before? ❑ Yes ❑ No If yes, when? _____

Were you treated for this condition or a similar one before? ❑ Yes ❑ No If yes, when/by whom? _____

_____

Health History

Do you have any allergies? (food, contact, environment) _____

List any prescribed medications, over the counter medications, vitamins, herbs, and supplements _____

_____

When was your last: Physical examination? _____ Blood/lab work? _____ X-ray study? _____

Injuries/Surgeries you've had and when? _____

_____

Have you had or do you have any of the following conditions or diseases? ***Please check yes or no for each one below.***

Ankylosing spondylitis	❑ Yes	❑ No	Cushing's disease	❑ Yes	❑ No	Knee surgery	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Cystic medial necrosis	❑ Yes	❑ No	Liver disease	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Depression	❑ Yes	❑ No	Marfan syndrome	❑ Yes	❑ No
Bleeding disorder	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Multiple sclerosis	❑ Yes	❑ No
Blurred vision	❑ Yes	❑ No	Digestive/Bowel problems	❑ Yes	❑ No	Osteoporosis /penia	❑ Yes	❑ No
Bowel/Bladder problems	❑ Yes	❑ No	Dizziness or vertigo	❑ Yes	❑ No	Parkinson's disease	❑ Yes	❑ No
Buzzing in ears	❑ Yes	❑ No	Fibromuscular dysplasia	❑ Yes	❑ No	Prosthesis	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Fibromyalgia	❑ Yes	❑ No	Rotator cuff problem	❑ Yes	❑ No
Carpal tunnel	❑ Yes	❑ No	Fusions (spinal, joint, etc)	❑ Yes	❑ No	STI/STD	❑ Yes	❑ No
Celiac disease (gluten)	❑ Yes	❑ No	Gout	❑ Yes	❑ No	Shoulder surgery	❑ Yes	❑ No
Chest pains	❑ Yes	❑ No	Heart disease	❑ Yes	❑ No	Spinal surgery	❑ Yes	❑ No
Chronic fatigue	❑ Yes	❑ No	Hepatitis (A, B, C, etc)	❑ Yes	❑ No	Stroke/TIA	❑ Yes	❑ No
Cold hands or feet	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Thyroid problems	❑ Yes	❑ No
Colitis/Diverticulitis	❑ Yes	❑ No	High blood pressure	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Compression fractures	❑ Yes	❑ No	Hip replacement	❑ Yes	❑ No	Other _____		
Connective tissue issues	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No	Other _____		
COPD (bronchitis/emphy)	❑ Yes	❑ No	Kidney disease	❑ Yes	❑ No	Other _____		

Are there any conditions that run in your family? ❑ Yes ❑ No If yes, what condition(s) and which family members? ____

For Women Only

Do you currently or have you ever used birth control? ❑ Yes ❑ No If yes, what brand(s), dosage, when, and for how long?

Do you currently or have you ever taken hormone replacement medication? ❑ Yes ❑ No If yes, what brand(s), dosage, when, and for how long? _____

Are you currently pregnant, or do you think you may be pregnant? ❑ Yes ❑ No If yes, for how many weeks? _____

Personal and Social Health History

How many hours per week do you typically work/attend school? ❑ <20 hrs ❑ 20 hrs ❑ 30 hrs ❑ 40 hrs ❑ 40+ hrs

What are your typical duties and postures (sitting, standing, lifting, etc)? _____

Do you exercise? ❑ Yes ❑ No If yes, how often and what type? _____

Do you or does anyone else ever "crack" your neck/back/joints? ❑ Yes ❑ No If yes, how often and what body part(s)? ____

How would you rate your eating habits? ❑ Excellent ❑ Pretty good ❑ Could be better ❑ Needs improvement

Do you follow a specific nutritional program? ❑ Yes ❑ No If yes, what type? _____

Would you like help with your diet or have a nutritional program developed for you? ❑ Yes ❑ No

Habits? ❑ Tobacco : Packs/Day _____ ❑ Alcohol: Drinks/Week _____ ❑ Caffeine: Cups/Ounces/Day _____

Other habits? _____

How well do you sleep? ❑ Excellent ❑ Pretty good ❑ Restless ❑ Can't Sleep

How many hours of sleep do you get daily? _____ *and* Do you feel well rested in the morning? ❑ Yes ❑ No

How is your energy overall? ❑ Full power ❑ Ok ❑ Low ❑ Sporadic/Generally fatigued

How do you feel your immune system is? ❑ Strong ❑ Ok ❑ Low

In your own words, what do you think chiropractors do? _____

What do you hope to receive from our program? _____

Other than the current condition(s) for which you are here today, are there any other conditions that you have that you would like to have checked by the doctor? ❑ Yes ❑ No If yes, describe? _____

Please add any comments here _____

Permission to Test and Treat

I hereby request and consent to the administration of diagnostic procedures, chiropractic adjustments and other chiropractic procedures including, but not limited to, various modes of physical therapy and diagnostic x-rays administered by the staff at Mountain Island Chiropractic, PLLC. I have been informed of the benefits and risks of chiropractic care and understand it is my responsibility to ask questions. I attest that the information completed by me on this form is correct and true to the best of my knowledge and agree to notify this office in the event of any change. Payment is expected for all office visits, services, treatments, procedures, and products purchased at the time of each visit unless other arrangements have been made with the business office personnel.

_____	_____	_____
Signature of Patient or Guardian	Printed Name of Patient or Guardian	Date