

Personal Information

Last: _____ First: _____ Middle: _____

Preferred Name: _____ Birth Date: ___/___/___ Age: _____ Sex: Male / Female

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ Primary Phone: (_____) _____ - _____

Email Address: _____ Spouses Name: _____

In the event we need to contact you, what is the best method of communication? *Phone E-Mail*

Children (Names and Ages): _____

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Internet/website Drove by Physician Insurance Plan

Emergency Contact

Name: _____

Phone # (____) _____ - _____ Relationship: Spouse Relative Friend Other _____

Employment Information

Business Name: _____

Occupation/Job Title and Description: _____

Current Health Condition: Addressing what brought you to this office: If no symptoms, skip to Review of Systems (p.2)

Unwanted Condition (Why you are here today?): _____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

Key: A=Ache B=Burning N = Numbness

P=Pins & Needles S=Stabbing

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



How would you rate your pain? 0 1 2 3 4 5 6 7 8 9 10 (worst)

When did this Condition BEGIN? ___/___/___

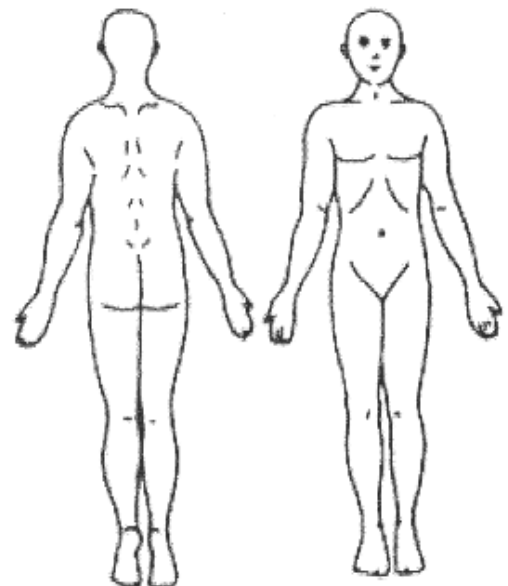
Has it ever occurred before? Yes No. When? _____

Is the Condition: Auto Related Job Related Home Injury

Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Accident: _____ Do you SUFFER with ANY OTHER condition than which you are now consulting us?



Previous Care for this Same Condition:

NO, I have not previously seen a doctor for this condition OR Fill in the information BELOW

Other doctors seen for this condition: [] Chiropractor [] MD or DO [] Other _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

Review of Systems: CIRCLE all CURRENT and PAST conditions. List any health conditions that are not shown below. Even if a condition seems unrelated to care, please check. These may affect your overall care.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> ear infections | <input type="checkbox"/> high / low blood pressure | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> allergy: _____ | <input type="checkbox"/> depression | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> Alzheimers | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (non-insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoid) | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> asthma | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> cancer | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> heart disease | <input type="checkbox"/> pleural effusion | <input type="checkbox"/> tinnitus or vertigo |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | <input type="checkbox"/> diarrhea/ constipation: |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> heartburn | <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> high cholesterol |
| <input type="checkbox"/> anxiety / stress | <input type="checkbox"/> numbness | <input type="checkbox"/> fatigue | <input type="checkbox"/> frequent colds |
| <input type="checkbox"/> jaw pain | <input type="checkbox"/> headaches | <input type="checkbox"/> currently pregnant | <input type="checkbox"/> osteopenia |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> traumatic birth -your own | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you taken?

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

Name	Dosage	For What Condition, if any?	How long have you taken?

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental surgery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsillectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | <input type="checkbox"/> other: |

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- back injury
- broken bones
- disability (ies)
- fall (severe)
- fracture
- head injury (loss of consciousness)
- head injury (no loss of consciousness)
- industrial accident
- joint injury
- laceration (severe)
- motor vehicle accident
- soft tissue injury (mild)
- soft tissue injury (severe)
- other:
- other:

Family History:

We know that many health problems can be genetic and run in families. Does anyone in your immediate family have/had health problems that concern them? Diabetes Heart Disease Cancer Fibromyalgia Stroke Back Pain
Other: _____

Social History: Mark all that apply below.

- Alcohol: do not drink alcohol social consumption only drink regularly, quantity of ___ glasses per _____
- Caffeine: pop diet pop coffee other _____ Amount: _____
- My diet – rate: (Poor) 1 2 3 4 5 6 7 8 9 10 (Perfect) Average daily water intake _____
- Never Smoker Former Smoker, years quit: _____ Someday smoker Every day smoker, packs/day _____
- Sleep Amount: _____ hours per night

With which physician(s) do you want us to coordinate care?

(Circle one) Primary Physician, Pediatrician, Ob/Gyn, Asthmatic specialist, Orthopedic Surgeon, Internist, Other

Doctor: _____ Doctor: _____

Clinic's Name and Location _____

Financial Policies:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Mitchellville/Bondurant Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Mitchellville/Bondurant Family Chiropractic will be credited to my account upon receipt. I understand that insurance companies do not pay for services that they determine to be not "medically necessary" and therefore, may deny payment for the services provided to me by Dr. Jason or Dr. Laura. However, I clearly understand and agree that all services rendered to me are my personal responsibility and I am securing my account with the credit card listed below. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. If payment hasn't been received in 10 days from terminating care, I authorize deduction from my credit card.

MasterCard/Visa/Discover Account # : **Please have available when checking in at front desk.**

Text Reminder Option:

- No thanks, I'd rather not receive text reminders
- I'd like to receive text reminders. Send to number: _____ Carrier _____

Informed Consent:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Jason, Dr. Laura and/or other licensed doctors of chiropractic who now or in the future work at Mitchellville/Bondurant Family Chiropractic, PC.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.

I have read the above consent. I understand I have the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have received MFC/BFC's 2018 HIPAA notice and understand the policy for my protected health information.

Patient Print Name: _____ Patient's Signature: _____ Date: _____

Consent to treat a Minor - Guardian or Parent's Signature of Authorizing Care: _____

Signature of Other Parent Authorizing Care: _____