Confidential Patient Health Record   Today's Date: ___/____/_______

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 (Circle)? ***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: ____

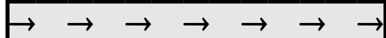
Occupation/Job Title and Description: ____

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.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



Key: A=Ache B=Burning N = Numbness P=Pins & Needles S=Stabbing

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

When did this Condition BEGIN? _______/_______/__________

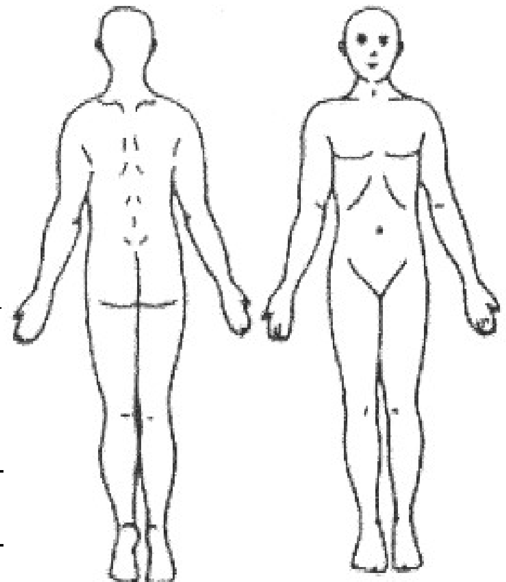
Has it ever occurred before? ☐**Yes** ☐**No When?** _________________

Is the Condition: ☐**Auto-Related** ☐**Job-Related** ☐ **Home Injury**

☐ **Slip or Fall** ☐ **Lifting** ☐ **Slept Wrong** ☐ **Unknown Cause**

Other: ____
____

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.***

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

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

Medication	For What Condition?	How long have you taken?

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

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

Surgery (ies): **Circle or List All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

angioplasty	**cosmetic**	**hysterectomy**	**pacemaker insertion**
appendectomy	**D & C**	**joint reconstruction**	**rotator cuff**
caesarian section	**dental surgery**	**joint replacement**	**spinal fusion**
cardiac catheterization	**gall bladder**	**knee repair**	**tonsillectomy**
carpal tunnel repair	**hemorrhoidectomy**	**laminectomy**	**other:**
coronary artery bypass	**hernia repair**	**mastectomy**	**other:**

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

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

Clinic's Name and Location ____

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

Doctor: ____________________________________

Clinic's Name and Location ____

Financial Policy:

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 collections 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. 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 (if keeping one on file).

Informed Consent:

I hereby request and consent to the performance of diagnostic tests, chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, 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.

I understand that the treatment I receive at this clinic will either be performed by a licensed Doctor of Chiropractic or an advanced chiropractic intern under the supervision of a licensed chiropractor.

I understand that chiropractic care is a practice that involves body parts being physically examined, touched & treated. I acknowledge that if, at any time, I am uncomfortable or if there is a place that I am uncomfortable with being touched, I am responsible for informing the provider and/or intern so they can appropriately respond to my concerns.

I understand that chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation, often involving muscle or soft tissue work as well. Like most health care procedures, the adjustment has risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. The following are known risks of chiropractic adjustments: temporary soreness, increased symptoms and bruising. Less likely symptoms include dizziness, nausea and flushing. Rare side effects include fractures, disc herniation, stroke and burns from physiotherapy devices that produce heat.

I understand that the practice of chiropractic, like other healing arts, is not an exact science. I acknowledge that no guarantee can be given as to the results or outcome of my care.

I have read the above financial policy & consent to treat. I understand I have the opportunity to ask questions about their content, and by signing below I agree to the above-named policies & procedures. I intend this treatment consent to cover the entire course of care for my present condition and for any future condition(s) for which I seek treatment. I also understand the MFC/BFC HIPAA policy for my protected health information.

Print Patient Name: ______________________________ Patient's Signature: ________________________ Date: ___________

I, _____________________________, the parent/guardian having legal custody/legal guardianship of the above named child, a minor, do hereby authorize MFC/BFC chiropractic providers to evaluate and treat as deemed advisable by a licensed chiropractic doctor.

Signature of Adult Authorizing Care: ___________________________________ Date: ____________