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?):_____

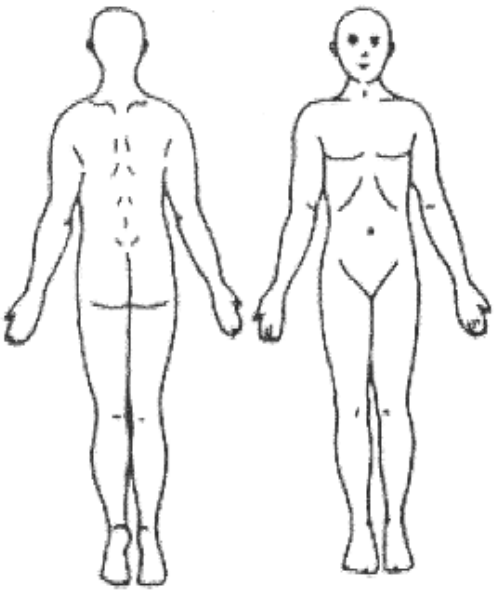
_____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

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



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.**

□ ADD/ADHD	□ ear infections	□ high / low blood pressure	□ psychiatric problems
□ allergy:_____	□ depression	□ influenzal pneumonia	□ scoliosis
□ Alzheimer's	□ diabetes (insulin dep)	□ liver disease	□ seizures
□ anemia	□ diabetes (non-insulin)	□ lung disease	□ 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 or vertigo
□ 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): **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): **Mark 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** □ **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 opt to get text reminders. Number where to send reminder_____ 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.

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.

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

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

Signature of Other Parent Authorizing Care: _____