Chart

#_____

Mason Chiropractic and Rehabilitation Center

111 Reading Road, Mason, Ohio 45040
(513) 398-2020 (p) ~ (513) 398-9067 (f)

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Best time/place to contact you:	
Date of birth:	**Age:**
No. of children:	**Pregnant? ☐Yes ☐No**
Height:	**Weight:**
Driver's license number:	
Marital status: M S W D	**Spouse/guardian name:**
Your Occupation:	
Employer's Name & Address:	
Spouse's Occupation/Employer:	
Name of person responsible for account:	
Do you have insurance that covers Chiropractic care? ☐Yes ☐No	**Do you have Medicare coverage? ☐Yes ☐No**
Name of Insurance Company:	
Insurance Policy number:	**Insurance Company phone number:**
Insurance Company address:	

Who may we thank for referring you? _____

Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at the clinic's request, and convey directly to **Mason Chiropractic and Rehabilitation Center** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Name: _____ Date: _____

Signature: _____

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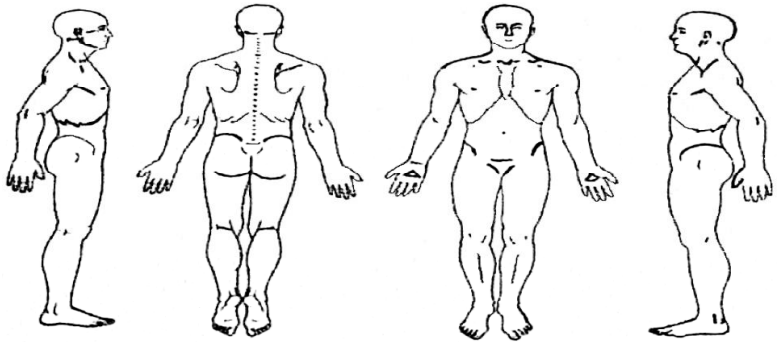
Addressing What Brought You Into This Office:
Health Concerns

Please list your health concerns according to their severity (worst to least)	Rate severity of pain (0-10) 0 = no pain 10 = worst pain	When did this episode start?	How did this condition start?	Did the condition begin with an injury?	What makes it better?
1.					
2.					
3.					
4.					

Please mark the areas on the figure below using the appropriate letters that correspond to the areas of your body. Also mark areas of radiation.

PLEASE DO NOT SIMPLY CIRCLE THE AREA OF INVOLVEMENT!

N=Numbness
P=Tingling/Pins & Needles
B=Burning
A=Aching
S=Sharp/Stabbing
O=Other



Have you had this condition before? When? _____

What have you done for this condition? _____

Which activities aggravate your condition or are difficult? _____

Since the problem started is it: ☐About the same? ☐Getting better? ☐Getting worse?

Is this condition interfering with any of the following:

☐Work ☐Sleep ☐Daily routine Sports/exercise☐ ☐Other (please explain):-

_____

Other doctors you have seen for this condition: (Please mark the boxes if they apply)

"Limited Scope" Chiropractor **(focuses mainly on neck and back pain)**	☐
"Wellness" Chiropractor **(focuses on health and well being as well as underlying cause of pain and health concerns)**	☐
Medical Doctor	☐
Other (please describe)	☐

Chiropractor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Doctor's details:

Name:	Address:
When did you see them?	

What did they say was wrong?	
Did it help?	What did they do?

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgeries)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? ☐Yes ☐No
2. Type:	When?	Hospitalized? ☐Yes ☐No
3. Type:	When?	Hospitalized? ☐Yes ☐No

Have you ever had any x-rays, MRI's, CT scans taken?

Area of body: _____ When? _____ Where? _____

Do you wear orthotics or heel lifts? ☐Yes ☐No

Do you have a pacemaker? ☐Yes ☐No

Have you ever had hip or knee replacement(s)? ☐Yes ☐No If yes (which body part)? _____

List any fractured or broken bone(s) and when they occurred _____

Female History: Are you pregnant at this time? ☐Yes ☐No ☐Unsure but could be

Date of last menstrual cycle _____ ☐Regular ☐Irregular

Current Medicines and Supplements

What medications or drugs are you currently taking? (check those that apply): Pain Killers ____ Insulin _____

Cholesterol Meds____ Blood Pressure Meds ____ Muscle Relaxers ____ Birth Control ____ Other: _____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why: _____

_____

Past Health History

Please mark the following conditions you have had or have now:

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder Problems
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)

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☐ Irregular Periods	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough

Any other conditions not listed above? _____

_____

Are you interested in knowing more about how your nutrition (foods you eat) affects your overall health and well-being?	☐Yes ☐No ☐Maybe
If dietary changes are indicated would you be willing to make changes in your diet?	☐Yes ☐No ☐Maybe
Would you take whole food supplements if indicated?	☐Yes ☐No ☐Maybe
If specific exercises or stretching would help would you consider adding them to your program?	☐Yes ☐No ☐Maybe
If reducing stress would help you would you like to know ways to reduce stress?	☐Yes ☐No ☐Maybe

What is your goal in this office? _____