Masula Chiropractic
Neurology and Family Wellness

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Demographics (PLEASE PRINT)

Today's Date: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F

Cell Phone: _____ Email Address: _____

Cell Carrier for text reminders: _____ Social Security #: _____

Circle **ALL** that apply: Married Single Widowed Divorced Employed Retired Homemaker Student

Referred to this office by: _____

Employment Information

Employer: _____ Job Title: _____ City, State: _____

Name of Spouse: _____Spouse's Occupation:_____ Employer:_____

Health Insurance **Name/Policy Number**_____

Emergency Contact Information

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State:_____ ZIP: _____

Phone: _____ Relationship: _____

Is this visit related to worker's compensation? Y N
Is this visit related to any legal actions? Y N
Is this visit related to any sort of motor vehicle accident? Y N

Patient Condition Please Describe the Major Problem That Brings You in Today to See a Chiropractic Neurologist:

_____
_____
_____
_____

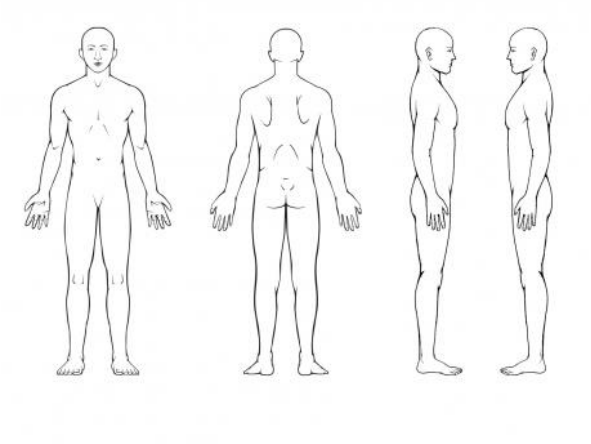
When did this condition begin**?**_____
_____

Have you ever experienced a similar problem in the past? □ Y □ N When: _____
How long has it been since your last medical/chiropractic evaluation? _____
If you follow a specific diet, please describe: _____

Please circle if you have the pain or difficulty performing the following:

Bending	Extended computer use	Lifting children	Sexual activities
Carrying Groceries	Feeding	Pet care	Sleeping
Change position (sit-stand)	Household chores	Reading (concentration)	Static Sitting
Climbing stairs	Kneeling	Self-care (bathing)	Walking
Driving	Lifting	Self-care (dressing)	Yard work

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing? 0 = no pain and 10= the worst pain imaginable?

Please circle:

0 1 2 3 4 5 6 7 8 9 10

How are your symptoms changing?
Please circle:

Getting better Not changing Getting worse

Other: _____

Family History Do you have a family member affected with: (please circle)

Condition Relative Condition Relative

Alcoholism, Diabetes, Depression, Heart Disease, Hypertension, Migraines, Neuromuscular junction disease, Multiple Sclerosis, Neuropathy, Neurological Disorder, Osteoporosis, Parkinson's disease, Seizures or Epilepsy, Stroke, Thyroid Disease, Any Other Condition

Please list all medications and supplements you take routinely, prescribed or over the counter, along with the dosages:

_____

_____

Review of Symptoms Do you currently, or have you had a problem with (please circle):

ALLERGIC Autoimmune disease (i.e., lupus), Food, Inhalant (nasal) allergies, Skin Rash	ENDOCRINE: Breast lumps/ discharge, Bleeding/Bruising, Cancer, Change in hair or skin, Cold extremities, Diabetes, Excessive thirst/urination, Hypoglycemia, Irregular Menses, PMS, Sexual Dysfunction, Symptoms of menopause, Thyroid disease	MUSCULOSKELETAL: Arm or leg Pain/Weakness/Numbness Arthritis, Back pain, Broken bones, Joint pain or swelling, Neck Pain, Padgett's disease, Restless Legs, TMJ pain
CONSTITUTIONAL: Fatigue, Fever, History of falls, Weight loss >5 lbs.	EYES: Cataracts, Glaucoma, Vision problems, Wear glasses/contacts	NEUROLOGICAL: Daytime sleepiness, Difficulty with balance, Difficulty with memory, Difficulty with speech, Disorientation, Dizziness, Double or Blurred vision, Fainting spells / black outs, Headaches / migraines, Inability to concentrate, Loss of consciousness, Loss of sensation, Seizures, Stroke, Teeth grinding/clenching
CARDIOVASCULAR: Chest pain or angina, Circulation problems, Heart Murmur, High blood pressure, High cholesterol, Irregular pulse, Low blood pressure, Pacemaker, Swelling in hands or feet, Palpitations	GASTROINTESTINAL: Abdominal pain, Blood in vomit, Change in bowel habits, Constipation, Diarrhea, Heartburn, Jaundice / liver disease Nausea / vomiting, Ulcers or gastritis	PSYCHIATRIC: Anxiety / Depression Panic Attacks Insomnia
EAR, NOSE, THROAT & MOUTH: Balance (vertigo, spinning, etc.) Dental problems, Ear Pain/Infections, Hearing loss, Hoarseness, Inability to smell, Nasal congestion/Drainage, Nose bleeds, Ringing in ears, Sinus problems, Wear hearing aid(s)	GENITOURINARY: Bladder control / incontinence, Blood in your urine, Difficult starting/stopping stream, Kidney stones, Painful urination, Urinary tract infections	RESPIRATORY: Asthma, Breathing difficulty, Chronic Cough, Emphysema / lung disease, Sleep Apnea, Snoring, Wheezing
	HEMATOLOGIC/LYMPHATIC: Anemia, Blood transfusion, Bruising, Fainting spells / blacking out,	OTHER:

	Hemophilia	

ALLERGIES/SENSITIVITIES: Please (E.g., medications, foods, latex, iodine, etc.)

_____

Are you taking any **blood thinning** medications including aspirin?

Surgical History Please list all operations you have had:

_____

Social History

Hobbies: _____

Tobacco? Y / N How many a day? _____ At what age did you start? _____ At what age did you stop? _____
Do you drink alcohol? Y N If yes, how much daily? _____

Do you use recreational drugs? Y N Type? _____

Do you exercise regularly? Y N How frequently? _____

Female Medical History:
Are you pregnant? ____Y ____ N If yes, how many weeks? _____ Age at first menstrual period? _____ Age at last? ____
Have you ever used oral contraceptives? _____Have you ever used hormone replacement therapy? ____Y___N

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ Relief Care is the care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, not fixing the leak, or cause of the symptom.

□ Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time but is longer lasting.

□ Check here if you want the Doctor to select the type of care appropriate for your condition.

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

Financial Agreement
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. **If** you have Health Insurance; we will bill them as a courtesy and assist you in receiving the maximum reimbursement benefits possible. Furthermore, I understand that Dr. Masulas' Office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. The patient also agrees that he/she is responsible for all bills incurred at this office.

Please Initial at Each Line Below:

PERSONAL INJURY / WORKERS COMPENSATION

____ **Assignment of Benefits** (Personal Injury case or Worker's Comp case)
I hereby authorize payment directly to the physician of all benefits otherwise payable to me, but not to exceed the total charges for the services rendered.

My signature below indicates that I have read, understand, and agree to all of the above listed information.

_____ **Date:** _____/_____/_____
Responsible Party/Guardian Signature

AUTHORIATION TO RELEASE INFORMATION

I authorize the physician and/or his or her representatives to release any and all information contained in my complete medical and billing record to:

- My insurance company or its representatives.
- Other persons or entities financially responsible for my care or treatment.
- The Medicare program and its fiscal intermediaries, if applicable or otherwise required/permitted/regulated by law.
- Federal and state agencies, as required or permitted by laws and regulations.

_____ **Date:** _____/_____/_____
Responsible Party/Guardian Signature

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition, there are reported cases of stroke associated with visits to Medical Doctors, Osteopaths, Chiropractors, Physical Therapists, and Occupational Therapists.

Would you like a copy of our Informed Consent Form?

_____ **Yes** (Patient *needs to sign Consent form*)

_____ **No –** I decline a copy of the (ICF) form

X _____ Signature

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Masula Chiropractic Neurology and Family Wellness Center is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Would you like a copy of our Notice of Privacy Act Form?

____ **Yes** (Patient *needs to sign NPP form*)

____ **No –** I decline a copy of the NPP form

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAS BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE MASULA FAMILY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

X _____ **Date:** _____/_____/_____
Patient Signature

_____
Doctor's Signature

Parental Consent for Minor Patient:

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Patient Name: _____
Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for.
Name: _____
Relationship to Patient: _____

X Signature: _____ **Date:** _____/_____/_____