Medicare Member Health Record

PERSONAL INFORMATION

NAME:___________________ ______ ______ ________________________
(LEGAL FIRST) (Mi) (LEGAL Last)

ADDRESS:	APT NO./SUITE
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	(CIRCLE ONE) MALE FEMALE
MARITAL STATUS: M D/S S W	NUMBER OF CHILDREN:
EMPLOYER NAME:	
WORK PHONE:	TYPE OF WORK: (I.E. PROFESSIONAL,SECRETARIAL, TRADESPERSON, LABORER, HOMEMAKER, STUDENT, RETIRED)

INSURANCE INFORMATION

HEALTH INSURANCE COMPANY NAME (IF APPLICABLE)	
NAME OF INSURED:	
INSURED DOB	INSURED SSN#

HEALTH HABITS

DO YOU SMOKE?	❑ YES	❑ NO
DO YOU DRINK ALCOHOL?	❑ YES	❑ NO
DO YOU DRINK COFFEE, TEA OR SODA?	❑ YES	❑ NO
DO YOU EXERCISE REGULARLY?	❑ YES	❑ NO

DO YOU WEAR:

❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

SUPPLEMENTS YOU TAKE

❑ ESSENTIAL FATTY ACIDS/FISH OIL	❑ PROBIOTIC
❑ MULTIVITAMIN WHICH :______________________	❑ OTHER______________________
❑ CALCIUM / MAGNESIUM	❑ OTHER ______________________
❑ VITAMIN D	❑ OTHER ______________________

Mouw Family Chiropractic: A Creating Wellness Center, P.C.
20 Power Drive, #1, Council Bluffs, IA 51501

CHIROPRACTIC EXPERIENCE

IS THERE SOMEONE WE MAY THANK FOR REFERRING YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY):
❑ NEWSPAPER ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ MAILING

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
❑ YES ❑ NO

DOCTOR'S NAME: DATE OF LAST VISIT

PAST HEALTH INFORMATION

MAJOR ACCIDENTS OR FALLS CONTRIBUTING TO CURRENT PROBLEM:
____

APPROXIMATE DATE: ______________________
MRI STUDIES FOR CURRENT PROBLEM? **YES** **NO**

DESCRIBE THE REASON FOR YOUR VISIT TODAY:

WHEN DID THIS CONCERN BEGIN?

HAS THIS CONCERN:
❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONCERN INTERFERE WITH:
❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES
PLEASE EXPLAIN:

HAS THIS CONCERN OCCURRED BEFORE? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? ❑ YES ❑ NO

DOCTOR/THERAPIST NAME:

TYPE OF TREATMENT:

RESULTS: ❑ GOOD ❑ BAD ❑ INDIFFERENT

TYPE OF DISCOMFORT: DULL/ SHARP/ ACHY/ THROBBING/ NUMB/ DEEP

SEVERITY (CIRCLE RANGE) 1 2 3 4 5 6 7 8 9 10= EMERGENCY ROOM

HOW WOULD YOU DESCRIBE THE AMOUNT OF TIME THAT YOU EXPERIENCE THIS CONCERN:
CONSTANT (75-100%) FREQUENT (50-75%)
OCCASIONAL (25-50%) INFREQUENT (0-25%)

PRODUCTIVE FACTORS:____
____

PALLIATIVE FACTORS:____
____

NOTES:
____
____
____
____
____
____

"The doors we open and close each day decide the lives we live."

ARE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?

❑ YES ❑ NO

THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?

❑ YES ❑ NO

CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?

❑ YES ❑ NO

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ❑ **Relief care:** Symptomatic relief of pain or discomfort.
- ❑ **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.
- ❑ **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- ❑ ***I want the Doctor to select the type of care for my condition.***

MEDICATIONS / SUPPLEMENTS

❑ CHOLESTEROL MEDICATIONS	❑ BLOOD PRESSURE MEDICINE
❑ STIMULANTS	❑ BLOOD THINNERS
❑ TRANQUILIZERS	❑ PAIN KILLERS (INCLUDING ASPIRIN)
❑ MUSCLE RELAXERS	❑ VITAMINS:
❑ INSULIN	❑ SUPPLEMENTS:

MAJOR SURGERIES / OPERATIONS

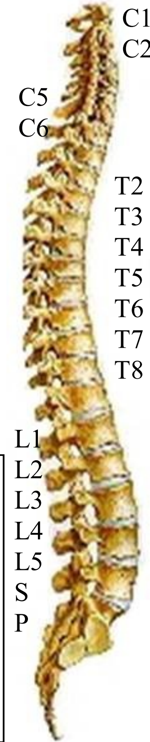
APPENDECTOMY / TONSILLECTOMY / GALL BLADDER / HERNIA / BACK SURGERY
BROKEN BONES
OTHER:________________________________

YOUR CONCERNS

INSTRUCTIONS: *Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

__Headaches
__Migraines
__Dizziness
__Sinus Problems
__Allergies
__Fatigue
__Head Colds
__Vision Problems
__Difficulty Concentrating

__Thyroid problems
__Sore Throat
__Stiff Neck
__Radiating Arm Pain
__Hand/Finger Numbness
__Asthma
__Allergies
__High Blood Pressure
__Low Blood Pressure
__Heart Murmur
__Pacemaker
__Acid Reflux
__Ulcers



__Middle Back Pain
__Congestion
__Difficulty Breathing
__Bronchitis
__Pneumonia
__Gallbladder Conditions
__Stomach Problems
__Diabetes
__Gastritis
__Hepatitis
__Kidney Problems

__Constipation
__Colitis
__Diarrhea
__Gas Pain
__Irritable Bowel
__Bladder Problems
__Menstrual Problems
__Low Back Pain
__Pain or Numbness in legs

OTHER:
____
____

FAMILY HISTORY

	MOTHER	FATHER	MGP	FGP
❑ DIABETES				
❑ CANCER				
❑ HEART DISEASE				
❑ MENTAL ILLNESS				
❑ STROKE				

❑ OTHER________________________________

CONTRAINDICATIONS FOR ADJUSTMENT

ACUTE ARTHROPATHIES **Y / N** *ACUTE FRACTURE/DISLOCATION WITH INSTABILITY* **Y / N**

UNSTABLE OS ODONTOIDEUM **Y / N** *MALIGNANCIES IN VERTEBRAL COLUMN* **Y / N**

INFECTION OF BONE OF VERTEBRAL COLUMN **Y / N**

SIGNIFICANT MAJOR ARTERY ANEURYSM NEAR AREA OF MANIPULATION **Y / N**

"Don't go through life, grow through life."

Rate your health

Place an '**X**' ON THE DOTTED LINE where you believe your level of health to be AT THE CURRENT MOMENT.

Place an '**O**' on the dotted line indicating where you would like your health to be if conditions were to improve.

AUTHORIZATION FOR CARE AND INFORMED CONSENT

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

As with any health care problem there are certain complications that may arise during chiropractic adjustments and therapy. Soreness as in that experienced following exercise is most common. Dizziness, fractures/joint injury may occur but are extremely rare. Nerve damage or stroke is reported to occur once in one million to once in ten million adjustments. This is comparable to your chance of getting hit by lightening. Your chiropractor will make every reasonable effort to screen for complications of care; but if you have a condition that would not otherwise come to his/her attention, it is your responsibility to inform me. Other treatment options may include; self-administered over-the-counter analgesics, rest, medical care, prescription drugs, hospitilizations and surgery. If you choose one of these options listed you should be aware that there are risks and benefits of such options. The risks of remaining untreated: Remaining untreated may complicate treatment making it more difficult and less effective the longer it is postponed.

Ownership of X-ray Films: *It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

Do you have any questions regarding the above authorization statement and /or informed consent? ( )NO ( )YES, Please explain: ______________________________

SIGN IF READ ABOVE ____ DATE____________ DOCTOR/CA INITIALS: ________

SIGNATURE OF PARENT OR GUARDIAN IF MINOR CHILD ______________________________________ PRINT NAME:______________________

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE: