

Name: _____ Patient #: _____ Age: _____ Date: _____

Address: _____
Residence and mailing City State Zip/Postal Code

Home Telephone () _____ Work Phone () _____ Male _____ Female _____

Social Security # _____ Driver's Lic.# _____ Birthdate _____

Occupation/Employer's Name and address _____

Single _____ Married _____ Divorced _____ Widowed _____ Spouse's Occupation/Employer _____

No. of children: _____ (In Canada) Health Card# _____ Version Code: _____

Reason for consulting our office? _____

Who may we "Thank" for referring you to our office? _____

YOUR HEALTH PROFILE

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS

YES NO UNSURE

YES NO UNSURE

Did you have any childhood illnesses?

Did you have any serious falls as a child?

Did you play youth sports?

Did you take/use any drugs?

Did you have any surgery?

Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)

Were you involved in any car accidents as a child?

Was there any prolonged use of medicine such as antibiotics or an inhaler?

Did you suffer any other traumas? (physical or emotional)

Were you vaccinated?

As a child, were you under regular Chiropractic care?

COMMENTS: _____

ADULT - (18 TO PRESENT)

YES NO

YES NO

Do/did you smoke?

Do/did you drink alcohol?

Have you been in any accidents?

Have you had any surgery?

Do/did you play any adult sports?

Do/did you participate in extreme sports?

On a scale of 1-10 describe your stress level: (1=none/10=Extreme)

Occupational _____
Personal _____

On a scale of Poor, Good or Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here _____ **“Wish to have Chiropractic Wellness Services”** and skip to **“Family Health Profile.”** Others need to briefly describe the chief area of complaint, including the affect it has had on your life.

If you are experiencing pain, is it...

Sharp Dull Comes & Goes Travels Constant

Since the problem started, it is... About the same Getting better Getting worse

What makes it worse: _____

Yes, it interferes with: Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem (please list)

- Chiropractor _____
 Medical Doctor _____
 Other _____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

- | | | | |
|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Sensitive Eyes | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers |

List any medications you are taking _____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____
Spouse _____
Mother _____
Father _____
Brother(s) _____
Sister(s) _____
Others _____

Have you ever:

- Bought bottled water: YES NO
Belonged to a health club: YES NO
Consumed vitamins or supplements: YES NO

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Signature

Date



Pain Update Index

Name _____ Date _____

Please draw the location of your pain or discomfort on the image below. Use the symbols shown to represent the type(s) of pain:

P = Pain

N = Numbness

T = Tingle

B = Burn

S = Stiff

D = Dull

Extreme Pain

10
9
8
7
6
5
4
3
2
1
0

No Pain

Comments:

ACTIVITES DISCOMFORT SCALE

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't hurt at all	Hurts a little	Hurts very much	Almost unbearable	Unbearable pain prevents activity
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or jogging					
8. Climbing stairs					
9. Carrying					
10. Pushing and pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					
TOTAL					

COMMENTS: _____

Patient Authorization for open adjusting area and contact regarding chiropractic care, related health services and/or related health products

It is our desire for our staff to use your name, address, email and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products. In addition this information may be used to remind you about scheduled appointments, re-evaluations or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care.

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

It is the desire of this office to utilize any picture or written testimonial offered for the promotion of chiropractic and our office. We use these in the office in testimonial books as well as on open display boards for other patients and visitors to view. From time to time we utilize these in our office advertising as well.

You understand that in using our sign in sheets other chiropractic patients may see your name.

If you choose not to authorize this use your decision will have no adverse effect on your care from this office or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name (printed)

Signature

Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Mercado Chiropractic
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Ph: 480-661-7000 Fax: 480-661-0220
Email: mercadochiro@aol.com

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Mercado Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and any amount authorized to be paid directly to Mercado Chiropractic will be credited to my account by 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 my care, any fees for professional services rendered will be immediately due and payable. A service charge will be added after 30 days unless predetermined arrangements have been made.

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services. I offer limited Power of Attorney in the event a payment is made to doctors office on my behalf and requires my signature. You may endorse and apply payment to my account.
3. In the event of any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demanding by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.
4. This authorization and assignment shall be valid and effective for all charges and fees hereafter incurred unless retracted and revoked by me in writing.
5. I hereby authorize the doctors at the doctor's office to care for my condition as they deem medically necessary. It is understood and agreed that the amount paid for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen. The doctor's office will not be held responsible for any pre-existing medically diagnosed conditions. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

DATE _____ SIGNED _____

WITNESS _____

FEMALE PATIENTS: PREGNANCY STATUS

I verify that my last menstrual period was _____ and that I am not pregnant at this time. The doctors and staff at Mercado Chiropractic have been informed of my condition and are not responsible for any future condition as a result of diagnostic x-rays taken on _____

SIGNATURE _____ DATE _____