

Welcome To Milonas Chiropractic

Name: _____ Birth Date: ____-____-____ Today's Date: ____/____/____ Age ____
 Address: _____ City: _____ State: _____ Zip: _____
 E-mail Address: _____ Add to E-mail list Yes No Social Security # ____/____/____
 # of Children _____ Single Married Significant Other Widowed Separated Divorced
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Your Employer: _____ Your Occupation: _____
 Name of Spouse: _____ Spouse's Employer: _____ Birth date of Spouse: ____/____/____
 WOMEN ONLY: Are you pregnant or nursing? Yes No
 Who may we thank you for referring to our office? _____ Method of payment for 1st Visit: _____

Your Health Profile

Check any of the following that you have ever experienced; present or past

<input type="checkbox"/> Numbness/Tingling/Pain in (Arms / hands/ fingers) R / L Both	<input type="checkbox"/> Hip Pain R / L	<input type="checkbox"/> Neck Stiffness/ Pain	<input type="checkbox"/> Back Stiffness/Pain
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Frequent Colds / Flu	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Fractured Bones	<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Swollen Painful Joints	<input type="checkbox"/> Tremors	<input type="checkbox"/> Blurred Vision R / L	<input type="checkbox"/> Double Vision R / L
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Pain w/ Cough / Sneeze	<input type="checkbox"/> Stroke	<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Buzzing/Ringing in ears	<input type="checkbox"/> Sinus Problems/Allergies	<input type="checkbox"/> Nervousness/Anxiety
<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Depression	<input type="checkbox"/> Irritability/Mood Swings	<input type="checkbox"/> Tension/Stress
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Stomach Upset
<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Recurring Infection	<input type="checkbox"/> Diarrhea/Constip./Gas
<input type="checkbox"/> Cold feet	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Jaw/TMJ Problems
<input type="checkbox"/> Foot Problems	<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Problems Urinating	<input type="checkbox"/> Heartburn/Reflux
<input type="checkbox"/> Cold Sweats	<input type="checkbox"/> PMS	<input type="checkbox"/> Menopause	<input type="checkbox"/> Ulcers
<input type="checkbox"/> High Blood pressure			<input type="checkbox"/> Cancer (Type) _____
<input type="checkbox"/> Other _____			

Have you ever been to a chiropractor before? Y / N When was your last adjustment? _____

Current Health Condition

Chief Complaint (why you are here today): _____

When did this condition begin? _____ Has it ever occurred before: Yes No
 Was this due to an accident/Trauma? Yes No
 If Yes, explain.(ex. fall, auto, sports) _____

Symptoms: When this problem is at its worst, can you explain exactly how it feels? _____

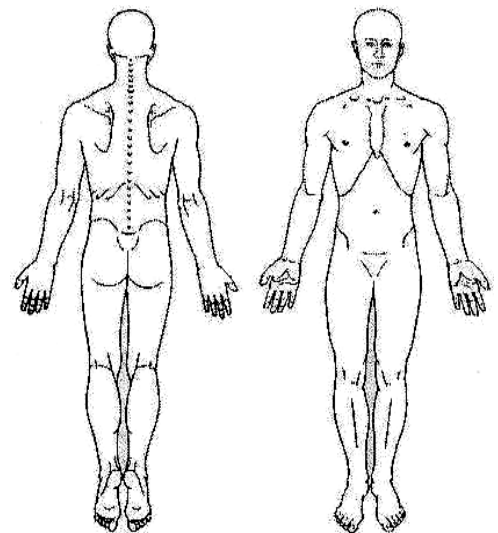
Severity of the pain Mild Moderate Severe
Does this pain travel or radiate? If so, where? _____

Quality: (mark all that apply)
 Burning Diffuse Dull/Aching Localized
 Sharp Shooting Stabbing Tingling
 Radiating Other _____

Is there anything that makes this better? _____
 Is there anything that makes this worse? _____

On a scale of 1 to 10 with 10 being the worst pain and 0 being no pain, rate how you feel today
 (Circle the number): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Please mark on the diagram below the area of discomfort. ↓



TIMING (circle all that apply)

Worse AM Worse PM Worse Sleeping

Pain is (please circle one).....

Constant (100% of time) Frequent (75-100%) Intermittent (50-75%) Occasional (25-50%) Infrequent (0-25%)

How long does the problem usually last? _____

What solutions have you attempted to solve this problem? _____

DAILY ACTIVITIES DISCOMFORT: Effects of Current Condition on Performance

Bending	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Carrying	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Climbing	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Concentrating	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Dancing	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Doing Computer Work	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Dressing	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Driving	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Gardening/Yard work	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Household chores	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Lifting	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Performing sexual activity	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Pushing/ Pulling	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Reading	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Recreating	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Rolling Over	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Running/ Jogging	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Shoveling	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Sitting	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Sitting to Standing	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Sleeping	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Sports	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Standing	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Walking	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Watching TV	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable
Working	<input type="checkbox"/> No Pain	<input type="checkbox"/> Little Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Almost Unbearable	<input type="checkbox"/> Unbearable

Please List any effects that this may have on any Work/ Recreational Activities _____

Are there any other complaints/conditions that you think are contributing to the present problem that the doctor should address? If so, list and describe: _____

Medications: What medications are you currently taking and for what conditions? _____

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? No Yes

If yes whom: Grandmother Grandfather Mother Father Sister(s) Brother(s) Son(s) Daughter(s)

2. Have they been treated for their condition? No Yes I don't know

3. Any other hereditary conditions the doctor should be aware of? No Yes

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation. I authorize payment to be made directly to Milonas Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible of HFW for any and all services I receive at this office.

Signature

____/____/____
Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

(Signature)

(Date)

Milonas Chiropractic
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**For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations**

I _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice’s Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (“PHI”) necessary for the Milonas Chiropractic to provide treatment to me, and also necessary for the Milonas Chiropractic to obtain payment for that treatment and to carry out is health care operations. Milonas Chiropractic explained to me that the Privacy Notice would be available to me in the future at my request. The Milonas Chiropractic has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. Milonas Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. Milonas Chiropractic’s “Notice of Privacy Practices” is also provided **behind the front desk**. I may also request a copy from this office at any time via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed) Date Signed Signature of Individual

Signature of Legal Representative Date Signed Relationship

Witness