MALINA CHIROPRACTIC

Application for Health

PRACTICE MEMBER INFORMATION

______________________ ______________________ ________
LAST NAME FIRST NAME M.I.

____
STREET ADDRESS

______________________ ______________________ ________
CITY STATE ZIP CODE

______________________ ______________________
BEST PHONE NUMBER TO REACH YOU E-MAIL (FOR COMMUNICATING IMPORTANT HEALTH INFORMATION)

______________________ ______________________
YOUR EMPLOYER YOUR OCCUPATION

__________ ____ ______________ _M_F_ __________
DATE OF BIRTH AGE SOCIAL SECURITY # (FOR INSURANCE) SEX MARITAL STATUS

____
NAMES AND AGES OF CHILDREN

Scoliosis can be prevented or minimized if detected early enough. Would you like to receive complimentary scoliosis examinations for your children? □ Yes □ No

Will you be using health insurance to supplement payment to our office? □ Yes □ No
If yes, please provide us with your insurance card and we'll make a copy. We will also verify your coverage.
Are you covered under someone else's insurance? □ Yes □ No □ Spouse □ Parent
Enter their information below:

______________________ ______________________ ________
LAST NAME FIRST NAME M.I.

______________________ ______________________
SOCIAL SECURITY # (FOR INSURANCE) DATE OF BIRTH (FOR INSURANCE)

Are you filing a worker's compensation claim? □ No □ Yes Date reported to employer: ______

Are you filing a personal injury claim? □ No □ Yes Attorney name: _______________________

We provide the following healthcare services. Check ALL the types of care that you are interested in receiving.
□ **Wellness Care:** I currently have no symptoms. My goal is to maintain the health of my spine and nervous system while preventing degenerative disease.
□ **Corrective Care:** My goal is to achieve natural symptom relief and to maximally improve my posture, spinal alignment, mobility, strength, nerve function and health.
□ **Rehabilitation Care:** My goal is to achieve natural symptoms relief and maximum healing of my injuries/tissue damage.
□ **Relief Care:** My goal is to achieve natural symptom relief without the dangerous side-effects of medications.

How did you find out about Malina Chiropractic? ______________________________________
Who may I thank for referring you to Malina Chiropractic? __________________________________

When was your last chiropractic visit? □ First time □ ___weeks □ ___months □ ___years
What type of care? □ Corrective/Rehabilitative □ Symptom relief □ Wellness/Maintenance

Name: ____ Date: ____________________

√ Check each of your health problems.	√ Check which side of your body it is located.	At its worst, how severe is your health problem? (10 is the most severe) *Circle the number.*	What percentage of your waking day do you feel your health problems? (100% is constant)
HEAD PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 1. Headaches or Migraines	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 2. TMJ (jaw) Pain/Clicking	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
SPINAL PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 3. Neck □ Pain □ Stiffness	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 4. Upper Shoulder (trapezius) Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 5. Upper Back (Shoulder blades) Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 6. Middle Back □ Pain □ Stiffness	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 7. Low Back □ Pain □ Stiffness	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 8. Pelvis/Buttock Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
UPPER EXTREMITY (ARM) PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 9. Shoulder Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 10. Elbow Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 11. Wrist Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 12. Hand □Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 13. Arm □ Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
LOWER EXTREMITY (LEG) PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 14. Hip Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 15. Knee Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 16. Ankle Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 17. Foot □ Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 18. Leg □ Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
CHEST, ABDOMINAL OR PELVIC PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 19. Chest Pain/ Symptoms	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 20. Abdominal Pain/ Symptoms	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 21. Pelvic Pain/ Symptoms	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%

Answer the following questions regarding your health problems:

Which health problem concerns you the most? ____

Describe your health problem: □ sharp □ dull ache □ burning □ radiating/spreading □ throbbing □ pinching □ twinge

Explain: ____

How many days out of the week do you experience you health problem? □ daily □ 6 □ 5 □ 4 □ 3 □ 2 □ 1 day (s)

What time of the day is your health problem the worst? □ morning □ afternoon □ evening □ sleeping □ all day □ varies

How long have you been experiencing your health problem? □ ___ day(s) □ ___ week(s) □ ___ month(s) □ ___year(s)

Have you experienced your current health problem in the past? □ No □ Yes, the last time was _________________ ago.

What do you feel caused your health problem? □ I don't know □ injury □ auto accident □ stress □ developed over time

Explain: ____

What aggravates or makes you health problem worse? ____________________________________

What relieves or makes your health problems better? ____________________________________

Who have you seen previously for this health problem? □ No one □ Chiropractor □ Medical □ Physical Therapist

What treatment did you receive? ____

Which of the following activities of daily life are being adversely affected by your current health problem?

□ Sitting	□ Walking	□ Climbing stairs	□ Housework	□ Job/Work
□ Standing up	□ Running	□ Bending over	□ Cooking	□ Computer work
□ Standing	□ Exercising	□ Sleeping	□ Laundry	□ Social life
□ Laying on side L R	□ Sports activities	□ Lifting children	□ Yard work	□ Relationships
□ Laying on back	□ Relaxation	□ Playing with kids	□ Driving	□ Finances

Other activities not listed: ____

Name: ____ Date: ____________________

PHYSICAL TRAUMA: List any significant physical traumas from birth to the present– include current (accidents, injuries, etc.): ____
____

EMOTIONAL TRAUMA: List any significant emotional traumas form birth to the present (deaths, divorce, etc.):
____
____

HOSPITAL: List any illnesses or conditions that required hospitalization or surgery:
____
____

DISEASE OR ILLNESS: List any diagnosed diseases or conditions (such as diabetes, allergies, asthma, etc):
____
____

FAMILY HEALTH HISTORY: List any significant health problems involving parents or siblings (cancer, heart disease, etc.):
____
____

MEDICATION: Are you currently taking any prescription or over the counter drugs? Yes No
List the medication and the condition you are taking it for: ____
____
Have you experienced side effects?: No Yes ____
STRESS: How would you rate your stress level? □ none □ mild □ moderate □ severe □ very severe
HABITS: Do you smoke? No Yes How many years? _______ How many per day? ______________________
Do you drink more than two servings of alcohol per day on a regular basis? No Yes
Do you drink caffeinated drinks? (coffee, tea, soda, etc.) No Yes How many cups per day? __________________
Do you eat white sugar foods? (cookies, cakes, candy, etc.) No Yes How many servings per day? ____________
PREGNANCY: Are you pregnant? Yes No Unsure If yes, how many weeks? ____ Due Date: ________________
EXERCISE: Do you exercise? No Yes How many days per week? 1 2 3 4 5 6 7
Type of exercise? □ Cardio/Aerobics □ Weights □ Stretching □ Yoga □ Other: _________________________
NUTRITION: How would you describe your diet? □ poor □ fair □ good □ excellent
How many servings of fruits and vegetables do you consume on a daily basis? __________
List any nutritional supplements you are taking? ____
____

HEALTH: On a scale from 1 to 10, how would you rate your current state of health?

1	2	3	4	5	6	7	8	9	10

FAILING POOR FAIR GOOD EXCELLENT

FITNESS: On a scale from 1 to 10, how would you grade your level of fitness (strength, endurance, etc.)?

1	2	3	4	5	6	7	8	9	10

VERY POOR POOR FAIR GOOD EXCELLENT

COMMITMENT: On a scale from 1 to 10, how committed are you to regaining your health and fitness?

1	2	3	4	5	6	7	8	9	10

NOT A PRIORITY SLIGHTLY MODERATELY VERY EXTREMELY

In the last 5 years has your health been: □ getting worse □ getting better □ staying the same

Do you base your health on how you feel (presence or absence of pain or symptoms) or do you base your health on scientific measurements of function such as lab and diagnostic tests? □ How I feel □ How I function

____ ____________________
Patient Signature Date

Name: ____ Date: ___________________

Below are lists of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

□ Pneumonia
□ Rheumatic Fever
□ Polio
□ Tuberculosis
□ Whooping Cough
□ Anemia
□ Measles
□ Mumps
□ Small Pox
□ Chicken Pox
□ Diabetes
□ Cancer
□ Heart Disease
□ Thyroid
□ Influenza
□ Pleurisy
□ Arthritis
□ Epilepsy
□ Mental Disorders
□ Low back pain
□ Eczema

Have you been tested HIV positive? □ Yes □ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULOSKELETAL CODE

□ Low Back Pain
□ Pain Between Shoulders
□ Neck Pain
□ Arm Pain
□ Joint Pain/ Stiffness
□ Walking Problems
□ Difficult Chewing/ Clicking Jaw
□ General Stiffness

NERVOUS SYSTEM CODE

□ Nervous
□ Numbness
□ Paralysis
□ Dizziness
□ Forgetfulness
□ Confusion/ Depression
□ Fainting
□ Convulsions
□ Cold/ Tingling Extremities
□ Stress

GENERAL CODE

□ Fatigue
□ Allergies
□ Loss of Sleep
□ Fever
□ Headaches

GASTRO-INTESTINAL CODE

□ Poor/Excessive Appetite
□ Excessive Thirst
□ Frequent Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Hemorrhoids
□ Liver Problems
□ Gall Bladder Problems
□ Weight Trouble
□ Abdominal Cramps
□ Gas/ Bloating After Meals
□ Heartburn
□ Black/ Bloody Stool
□ Colitis

GENITO-URNIARY CODE

□ Bladder Trouble
□ Painful/ Excessive Urination
□ Discolored Urine

C-V-R CODE

□ Chest Pain
□ Short Breath
□ Blood Pressure Problems
□ Irregular Heartbeat
□ Heart Problems
□ Lung Problems/ Congestion
□ Varicose Veins
□ Ankle Swelling
□ Stroke

EENT CODE

□ Vision Problems
□ Dental Problems
□ Sore Throat
□ Ear Aches
□ Hearing Difficulty
□ Stuffed Nose

MALE/FEMALE CODE

□ Menstrual Irregularity
□ Menstrual Cramps
□ Vaginal Pain/ Infection
□ Breast Pain/ Lumps
□ Prostate/ Sexual Dysfunction
□ Other Problems
□ _________________________
□ _________________________
□ _________________________

FEMALES ONLY:

When was your last period?
____

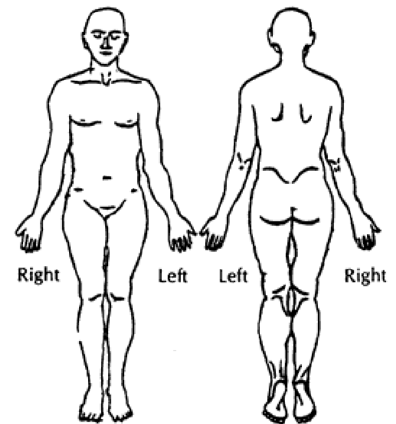
Are you pregnant? Yes No

FAMILY HISTORY

The following members have a same or similar problem as I do:

□ Mother
□ Father
□ Brother
□ Sister
□ Spouse
□ Child

With XXXs please mark the locations of ALL your health problems:



3826 N. Druid Hills Rd.
Decatur GA 30033
Fax: 404.325.8859

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:__________________________ **Last Name**:__________________________

Email address: _________________________@____________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ___________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Marital Status: ______________ **Do you have children?** Y / N **If so, how many?** _________

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: ____ Date:_________________

For office use only

Height: _________ Weight:____________ Blood Pressure:______ /______

OFFICE FINANCIAL POLICY

1. **If you DO NOT have insurance (Self-Pay):** All payments are due at the time of treatment or by an authorized payment plan. With the exception of authorized payment plans, your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. **If you DO have insurance:** Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care. All deductibles, co-insurance and co-payments are the patient's responsibility and are due at the time of treatment or by an authorized payment plan. With the exception of an authorized payment plan, your patient responsibility balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a self-pay patient until you bring in your completed insurance forms and we qualify and accept your insurance coverage.

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Not all services provided in our office are a covered benefit with all insurance contracts. Some insurance companies arbitrarily select certain services that they will not cover or which they have deemed not necessary. Your doctor will determine the best route of care for you based on your individual circumstances, not based on insurance coverage. If a treatment is not covered by your insurance, you will be responsible for the amount due for that treatment. We will make every effort to verify your coverage before treatment is rendered and will make you aware of your coverage. Please know this does not guarantee payment from your insurance carrier. If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid a claim within ninety (90) days of submission, you accept financial responsibility for payment in full of any outstanding balance. When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for treatment(s) will be due as it/they are rendered.

3. **Personal Injury/Third Party Claims:**

A. If You Have Medical Payments (MedPay or PIP) Coverage on Your Auto Policy: Whether or not you are the responsible (at fault) party involved in the accident, you are entitled to use your MedPay benefits to pay for your care. It is our policy that we will file on your MedPay coverage if you have it and may decline services if you refuse to use your MedPay coverage.

B. If You Have Health Insurance: We may be able to file your health insurance to assist in payment of your Personal Injury claim with the following conditions: a) MedPay benefits have been exhausted, and b) it is our policy that we will not file to carriers that do not allow us to balance bill for Usual and Customary Rates.

C. Liens: If you do not have MedPay coverage, we will consider taking your case on a lien basis at the discretion of the doctor. In most cases, you will need a lawyer representing you before we will agree to work on a lien.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim(s) submitted or any authorized payment plans. Returned checks are subject to a $35 handling fee. We will send a statement of your account with any thirty (30) day balances due. At sixty (60) days, you will receive a statement with late charges applied. At ninety (90) days, if we have not received payment on your past due balance, we will send the account to collections. If it becomes necessary to turn your account over for collection, you accept responsibility for any fees involved in that process.

By signing below, I acknowledge that I have fully read and understand the Office Financial Policy for Malina Chiropractic.

Patient's Printed Name: ______________________________________ Date:_______________

Patient's Signature: ______________________________________

Witness Signature: ______________________________________

MALINA CHIROPRACTIC
INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below.

As a part of the analysis, examination and treatment, you are consenting to the following procedures: Spinal manipulative therapy, palpitation, range of motion testing, orthopedic testing, basic neurological muscle strength testing, postural analysis testing, hold/cold therapy, spinal decompression, cervical traction, radiographic studies, vital signs and low level laser light therapy. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of these chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I also acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read and understand the Notice.

PATIENT NAME:______________________________ TODAY'S DATE:______________

PATIENT SIGNATURE (Or Guardian's signature if Patient is a minor):______________________________

(If applicable) NAME OF GUARDIAN/RELATIONSHIP TO PATIENT:______________________________

NAME OF TREATING D.C. ______________ SIGNATURE______________ DATE__________

PREGNANCY RELEASE

This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her associates have permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

The date of my last menstrual cycle:_________________

____________________________________ Patient Signature

______________________ Today's Date