MUSSLER CHIROPRACTIC & WELLNESS

Confidential Patient Information:

Date: ___________

First Name:_____________________ **Last Name:**_______________________________ **Initial:**_______

Major Complaint Information

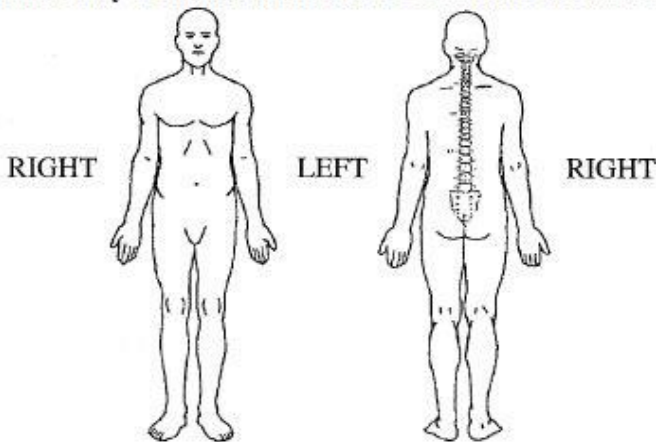
What is your major complaint(s)____

____

When did this symptom(s) begin?____

If this is an injury, describe what happened?____

Using the symbols provided in the Pain Index, mark the areas on the illustrations below where you are experiencing pain, followed by a number from 1 to 10 indication the extent of the pain. (1 being minor, 10 being severe)



Pain Index

D	Dull Nagging Ache
B	Burning
S	Sharp / Stabbing
N	Numbness / Tingling
M	Muscle Spasm / Pulling

For example: if you are experiencing moderately severe burning pain in the back of the neck, you should note a 'B8' on the neck of the illustration.

On a scale of 1 to 10, how do you feel now? (1 being best, 10 being worst)

Please Circle or write answer to the following questions:

Have you ever experienced these symptoms before? Yes No If Yes, When?_________________________________

What aggravates this condition?____

What decreases the symptoms / pain?____

Does this condition interfere with your sleep? Yes No If so, how many times do you wake up in pain per night?________

In what position do you sleep? Back Side Stomach

Do you sleep with a pillow? Yes No **How many?**____

Does heat affect the pain? Yes No **If so, how?**____

Does cold affect the pain? Yes No **If so, how?**____

Do you wear a heel lift? Yes No **If so, which side? Right Left**

Does it cause pain to cough, grunt, or sneeze? Yes No **If so, where?**____________________________________

Circle or Check those activities below during which you experience difficulty or pain:

Lying on back	Getting in/out of car	Pulling	Sitting	Standing for long periods
Lying on side	Dressing Self	Reaching	Bending forward	Sneezing
Turning over in bed	Sexual Activity	Kneeling	Bending backward	Coughing
Lying flat on stomach	Pushing	Stooping	Walking	Other:______________________

Lower Back Pain

Does pain radiate into the leg? Yes No Does pain radiate to the abdomen? Yes No

Do you ever have impairment of bowel or urinary function? Yes No Explain:________________________

Do you have numbness or tingling into the legs? Yes No Explain:_________________________________

Neck Pain

If you have a neck injury, does it affect: (Circle all that apply) Hearing Vision Balance Cause ringing in your ears

Do you hear grating sounds? Yes No Do you feel pressure or pain behind your eyes? Yes No

Does pain radiate into the arm? Yes No Where?____________________________

Do you have difficulty lifting or turning your head? Yes No If so, in which direction? Right Left Up Down

Headaches

Do you get headaches? Yes No Frequency:___________ Do you have a family history of headaches? Yes No

Do you experience the following along with your headaches: Pain or cracking in your jaw? Yes No

Abnormal blood pressure? Yes No High Low Nausea, Vomiting or Visual disturbances? Yes No

When was your last eye exam by a doctor? 1-6 months 6-12 months 1-2 years over 2 years Results:___________

If female, are you pregnant? Yes No Not Sure If yes, what is your due date:_________________________________

List all medication you are taking now, including over the counter medication:_________________________________

____

Are you allergic to any medications: Yes No Not sure Please list:____

Do you smoke? Yes No How much? ____________

Have you ever had any surgeries or hospitalizations? Yes No If Yes, please explain to Dr. during exam.

Additional Complaints

Please circle or check all additional complaints that you have at this time:

Loss of Concentration	Vision Problems	Vomiting	Allergies (Please List)
Eyes Sensitive to Light	Sinus Trouble	Diarrhea	____________
Memory Loss	Nervousness	Constipation	____________
Heavy Feeling of Head	Chest Pain	Cold Hands	____________
Dizziness	Shortness of Breath	Cold Feet	____________
Ringing in Ears	Irritable	Jaw Pain	Other (Please List)
Loss of Balance	Anxiety	Hypertension	____________
Loss of Smell	Depression	Diabetes	____________
Loss of Taste	Insomnia	Convulsions	____________
Pain Behind Eyes	Fatigue	HIV (Aids)	____________
Fainting	Digestive Problems	Cancer	____________
Palpitation	Nausea	Arthritis	____________

Do you have, or have you ever had, any diseases or medical problems not listed? Yes No If so, please list:_____________

____

Have you ever had: Motor Vehicle Injury Sports Injury Work Injury Slip and Fall Injury If yes, please explain:

____

Any additional information you would like the doctor to know about before beginning care at our office:______________

____

General Information

First Name ______________________
Middle Initial ______________________
Last Name ______________________
Suffix ______________________
Called Name ______________________
Address ______________________
City ______________________
State ______________________
Zip Code ______________________
Home Phone ______________________
Work Phone ______________________
Cell Phone ______________________
Other No. ______________________
Email Address ______________________
Marital Status Single Married Other __________
Birth Date ______________________
Social Security ______________________
Referred By ______________________
Work Status Employed Full-time student Part-time student

Coverage Information

Insured's Information

Patient is the Same/Self Husband Wife Child Other of Insured
First Name ______________________
Middle Initial ______________________
Last Name ______________________
Suffix ______________________
Address ______________________
City, State, Zip ______________________
Phone Number ______________________
Social Security ______________________
Date of Birth ______________________
Sex Male Female

Carrier Information

Name/Code ______________________
Address ______________________
City, State, Zip ______________________
Contact ______________________
Phone ______________________

Plan Information

Plan Name ______________
Insurance ID ______________
Group No ______________
Benefits Primary Secondary Other
Coordination ______________
Claim Receiver ______________
Coverage Effective Date ______________

Employer Information

Employer/Code ______________
Attn: ______________
Address ______________
City, State, Zip ______________
Contact ______________
Phone ______________

Authorization & Assignment

I authorize Mussler Chiropractic & Wellness to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

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 understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Mussler Chiropractic & Wellness authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. 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 and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Informed Consent

I hereby authorize physicians and staff at Mussler Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.
I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Mussler Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.
Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care.
While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.
Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office.
An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.
Specific Risk Possibilities Associated with Chiropractic Care:
Soreness: Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care
and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.
Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft-tissue injury.
Rib Injury -Manual adjustments to the thoracic spine, in rare cases,may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed
carefully to minimize such risk.
Physical Therapy Burns - Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.
Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.
Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.
If you have any questions concerning this form or the above statements, please ask your doctor.
Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Health Information Consent Form

We want you to know your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all our staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Date_______________ Patient's Signature_______________________________________