



Dr. Scott Mullenmeister
Chiropractic Neurologist

Dr. Melanie Mullenmeister
Chiropractor

MALE

Today's Date _____

First Name _____ Middle Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ Work Phone _____ Mobile Phone _____

Best Contact Method: Primary Phone Work Phone Mobile Phone

If you would like to receive text reminders the day before your appointment, please let us know who your cell phone service is with (Verizon, AT&T, etc.)? _____

EMAIL ADDRESS: _____

Date Of Birth _____ Age _____ Place of Employment _____

Marital Status (check one) Single Married Other

Number of Children _____ How Did You Hear About Us/Referred By: _____

Emergency Contact's Name _____ Relationship _____ Phone _____

Current Health Concerns

Please rank current & ongoing health concerns in order of priority.

Describe Problem	Severity	Severity			Prior Treatment/Approach	Success	Excellent	Good	Fair
		Mild	Moderate	Severe					
Example: Inflammation			X		Elimination Diet-Dairy		X		
1.)									
2.)									
3.)									
4.)									
5.)									
6.)									
7.)									
8.)									
9.)									
10.)									

ALLERGIES

Name of Medication/Suppliment/Food:	Reaction:
1.)	
2.)	
3.)	
4.)	
5.)	
6.)	

LIFESTYLE REVIEW

Sleep

How many hours of sleep do you get each night on average? _____

Do you have problems falling asleep? Yes No Staying asleep Yes No

Do you have problems with insomnia? Yes No Do you snore? Yes No

Do you feel rested upon awakening? Yes No

Do you use sleep aids? Yes No If yes, explain: _____

Exercise

Current Exercise Program:

Activity	Type	# of Times per Week	Time/Duration (minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sport/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise? Yes A little No

Are there any problems that limit exercise? Yes No If yes, please explain: _____

Do you usually feel fatigued or sore after exercise? Yes No If yes, please explain: _____

Nutrition

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply)*

- Vegetarian Vegan Allergy Elimination Low Fat Low Carb
 Blood Type Low Sodium No Dairy No Wheat Gluten Free
 Other: _____

Do you have sensitivities to certain foods? Yes No

If yes list food and symptoms: _____

Do you have an aversion to certain foods? Yes No

If yes, explain: _____

Do you adversely react to: *(Check all that apply)*

- Monosodium Glutamate (MSG) Artificial Sweeteners Garlic/Onion Cheese Citrus Foods
 Chocolate Alcohol Red Wine Sulfite-Containing Foods (wine, dried fruit, salad bars) Preservatives
 Food Coloring Other Food Substances: _____

Are there any foods that you crave or binge on? Yes No

If yes, what foods? _____

Do you eat 3 meals a day? Yes No If no, how many? _____

Does skipping a meal greatly affect you? Yes No

How many meals do you eat out per week? 0-1 1-3 3-5 >5 meals per week

Check the factors that apply to your current lifestyle and eating habits:

- Fast Eater
- Eat too much
- Late-night eating
- Dislike healthy foods
- Time constraints
- Travel frequently
- Emotional Eater
- Eat too much under stress
- Poor snack choices
- Significant other or family members don't like healthy Foods
- Significant other or family members have special dietary needs
- Love to eat
- Eat because I have to
- Have a negative relationship with food
- Struggle with eating issues
- Eat more than 50% of my meals away from home
- Healthy foods not readily available
- Eat too little under stress
- Don't care to cook
- Confused about nutrition advice

Diet

Please record what you eat in a typical day:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Fluids: _____

How many servings do you eat in a typical week of these foods:

Fruits (not juice): _____ Vegetables (not including potatoes): _____ Fish: _____
Legumes (beans, peas, etc.): _____ Red meat: _____ Fats and Oils: _____
Dairy/Alternatives: _____ Nuts and seeds: _____
Can of soda (regular or diet): _____ Sweets (candy, cookies, cake ice cream, etc.): _____

Do you drink caffeinated beverages? Yes No If yes, check amounts:
Coffee (cups per day) 1 2-4 >4 Tea (cups per day) 1 2-4 >4
Caffeinated sodas-regular or diet (cans/bottles per day) 1 2-4 >4 Cans Bottles Liters
Do you have adverse reactions to caffeine? Yes No If yes, please explain: _____
When you drink caffeine do you feel: Irritable or wired Aches or pains

Smoking

Do you smoke currently? Yes No Packs per day: _____ Number of Years: _____
What type? Cigarettes Smokeless Pipe Cigar E-Cig
Have you attempted to quit? Yes No
If yes, using what methods?: _____
If you smoked previously: Packs per day: _____ Number of years: _____

Are you regularly exposed to second-hand smoke? Yes No

Alcohol

How many alcoholic beverages do you drink in a week? (1 drink=5 ounces of wine, 12 ounces of beer, 1.5 ounces of spirits)

1-3 4-6 7-10 >10 None

Previous alcohol intake? Yes (Mild Moderate High) None

Have you ever had a problem with alcohol? Yes No

If yes, when? _____

Explain the problem: _____

Have you ever thought about getting help to control or stop your drinking? Yes No

Other Substances

Are you currently using any recreational drugs? Yes No

If yes, type: _____

Have you ever used an IV or inhaled recreational drugs? Yes No

Stress

Do you feel you have any excessive amount of stress in your life? Yes No

Do you feel you can easily handle the stress in your life? Yes No

How much stress do each of the following cause on a daily basis (Rate 1-10, 10 being unable to get out of bed/ leave house)

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you use relaxation techniques? Yes No

If yes, how often? _____

Which techniques do you use? (Check all that apply)

Meditation Breathing Tai Chi Yoga Prayer Other: _____

Have you ever sought counseling? Yes No

Are you currently in therapy? Yes No

If yes, describe: _____

Have you ever been abused, a victim of crime, or experienced a significant trauma? Yes No

What are your hobbies or leisure activities? _____

Relationships

Marital status: Single Married Divorced Long-Term Partner Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets) _____

Current occupation: _____

Previous occupations: _____

Do you have resources for emotional support? Yes No (Check all that apply)

Spouse/Partner Family Friends Religious/Spiritual Pets Other: _____

History

Patient's Birth/Childhood History:

You were born: Term Premature Don't know

Were there any pregnancy or birth complications? Yes No

If yes, please explain: _____

You were: Breast-fed/How long? _____ Bottle-fed/Type of formula: _____ Don't Know

Age of introduction of: Solid Food: _____ Wheat: _____ Dairy: _____

As a child, were there any foods that were avoided because they gave you symptoms? Yes No

If yes, what foods and what symptoms? (Example: milk=gas and diarrhea)

Did you eat a lot of sugar or candy as a child? Yes No

Dental History

Check if you have any of the following, and provide number if applicable:

Silver mercury fillings _____ Gold fillings _____ Root canals _____ Implants _____
 Caps/Crowns _____ Tooth pain _____ Bleeding gums _____ Gingivitis _____
 Problems with chewing _____ Other dental concerns (explain): _____

Have you had any mercury fillings removed? Yes No If yes, when: _____

How many fillings did you have as a kid? _____ Do you brush regularly? Yes No

Do you floss regularly? Yes No

Environmental/Detoxification History

Do any of these significantly affect you?

Cigarette smoke Perfume/Cologne Auto Exhaust fumes Other: _____

In your work/home environment are you regularly exposed to: (Check all that apply)

Mold Water Leaks Renovations Chemicals Electromagnetic Radiation
 Smokers Carpets or Rugs Old Paint Stagnant/Stuffy Air Damp Environments
 Pesticides Herbicides Cleaning Chemicals Harsh Chemicals (solvents, glues, gas, acids, etc.)
 Paints Airplane Travel Heavy Metals (lead, mercury, etc.) Other: _____

Have you had any significant exposure to any harmful chemicals? Yes No

If yes, chemical name, length of exposure, date: _____

Do you have any pets or farm animals? Yes No

If yes, do they live: Inside Outside Both inside and outside

Men's History

Screening/Procedures: (If applicable, provide date)

Last PSA test: _____ PSA Level: 0-2 2-4 4-10 >10

Other tests/procedures (list type and dates): _____

Medical History: Illnesses/Conditions

Check YES = a condition you currently have,

Check PAST = a condition you've had in the past

Gastrointestinal	Yes	Past
Irritable Bowel Syndrome		
GERD (reflux)		
Crohn's Disease/Ulcerative Colitis		
Peptic Ulcer Disease		
Celiac Disease		
Gallstones		
Other: _____		
Respiratory		
Bronchitis		
Asthma		
Emphysema		
Pneumonia		
Sinusitis		
Sleep Apnea		
Other: _____		
Urinary/Genital		
Kidney Stones		
Gout		
Interstitial Cystitis		
Frequent Yeast Infections		
Frequent Urinary Tract Infections		
Sexual Dysfunction		
Sexually Transmitted Diseases		
Other: _____		
Endocrine/Metabolic		
Diabetes		
Hypothyroidism (Low Thyroid)		
Hyperthyroidism (Overactive)		
Polycystic Ovarian Syndrome		
Infertility		
Metabolic Syndrome/Insulin Resistance		
Eating Disorder		
Hypoglycemia		
Other: _____		
Inflammatory/Immune		
Rheumatoid Arthritis		
Chronic Fatigue Syndrome		
Food Allergies		
Environmental Allergies		
Multiple Chemical Sensitivities		
Autoimmun Disease		
Immune Deficiency		
Mononucleosis		
Hepatitis		

Musculoskeletal	Yes	Past
Fibromyalgia		
Osteoarthritis		
Chronic Pain		
Other: _____		
Skin		
Eczema		
Psoriasis		
Acne		
Skin Cancer		
Other: _____		
Cardiovascular		
Angina		
Heart Attack		
Heart Failure		
Hypertension (High Blood Pressure)		
Stroke		
High Blood Fats (Cholesterol, Triglycerides)		
Rheumatic Fever		
Arrythmia (Irregular Heart Rate)		
Murmur		
Mitral Valve Prolapse		
Other: _____		
Sexually Transmitted Diseases		
Other: _____		
Neurologic/Emotional		
Epilepsy/Seizures		
ADD/ADHD		
Headaches		
Migraines		
Depression		
Anxiety		
Autism		
Multiple Sclerosis		
Parkinson's Disease		
Dementia		
Other: _____		
Cancer		
Lung		
Breast		
Colon		
Prostate		
Skin		
Other: _____		

Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months.

General	Mild	Moderate	Severe
Cold Hands and Feet			
Cold Intolerance			
Daytime Sleepiness			
Difficulty Falling Asleep			
Early Waking			
Fatigue			
Fever			
Flushing			
Heat Intolerance			
Night Waking			
Nightmares			
Can't Remember Dreams			
Low Body Temperature			
Head, Eyes, and Ears			
Conjunctivitis			
Distorted Sense of Smell			
Distorted Taste			
Ear Fullness			
Ear Ringing/Buzzing			
eye Crusting			
Eye Pain			
Eyelid Margin Redness			
Headache			
Hearing Loss			
Hearing Problems			
Migraine			
Sensitivity to Loud Noises			
Vision Problems			
Musculoskeletal			
Back Muscle Spasm			
Calf Cramps			
Chest Tightness			
Foot Cramps			
Joint Deformity			
Joint Pain			
Joint Redness			
Joint Stiffness			
Muscle Pain			
Muscle Spasms			
Muscle Stiffness			
Muscle Weakness			

Musculoskeletal (cont.)	Mild	Moderate	Severe
Muscle Twitches:			
Around Eyes			
Arms or Legs			
Neck Muscle Spasm			
Tendonitis			
Tension Headache			
TMJ Problems			
Mood/Nerves			
Agoraphobia			
Anxiety			
Auditory Hallucinations			
Blackouts			
Depression			
Difficulty:			
Concentrating			
With Balance			
With Thinking			
With Judgement			
With Speech			
With Memory			
Dizziness (Spinning)			
Fainting			
Fearfulness			
Irritability			
Light-Headedness			
Numbness			
Other Phobias			
Panic Attacks			
Paranoia			
Seizures			
Negative Thoughts			
Tingling			
Tremor/Trembling			
Visual Hallucinations			
Cardiovascular			
Angina/Chest Pain			
Breathlessness			
Heart Attack			
Heart Murmur			
High Blood Pressure			
Irregular Pulse			
Mitral Valve Prolapse			
Palpitations			
Phlebitis			
Swollen Ankles/Feet			
Varicose Veins			

Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months:

Urinary	Mild	Moderate	Severe
Bed Wetting			
Hesitancy			
Infection			
Kidney Disease			
Kidney Stone			
Leaking/Incontinence			
Pain/Burning			
Urgency			
Digestion			
Anal Spasms			
Bad Teeth			
Bleeding Gums			
Bloating of:			
Lower Abdomen			
Whole Abdomen			
Bloating after Meals			
Blood in Stools			
Burping			
Canker Sores			
Cold Sores			
Constipation			
Cracking at Corner of Lips			
Dentures w/Poor Chewing			
Diarrhea			
Difficulty Swallowing			
Dry Mouth			
Farting			
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to:			
Lactose			
All Dairy Products			
Gluten (Wheat)			
Corn			
Eggs			
Fatty Foods			
Yeast			
Liver Disease/Jaundice (yellow eyes or skin)			
Lower Abdominal Pain			

Digestion (cont.)	Mild	Moderate	Severe
Mucus in Stools			
Nausea			
Periodontal Disease			
Sore Tongue			
Strong Stool Odor			
Undigested Food in Stools			
Upper Abdominal Pain			
Vomiting			
Eating			
Binge Eating			
Bulimia			
Can't Gain Weight			
Can't Lose Weight			
Carbohydrate Craving			
Carbohydrate Intolerance			
Poor Appetite			
Salt Cravings			
Frequent Dieting			
Sweet Cravings			
Caffeine Dependency			
Respiratory			
Bad Breath			
Bad Odor in Nose			
Cough-Dry			
Cough-Productive			
Hay fever:			
Spring			
Summer			
Fall			
Change of Season			
Hoarseness			
Nasal Stuffiness			
Nose Bleeds			
Post Nasal Drip			
Sinus Fullness			
Sinus Infection			
Snoring			
Sore Throat			
Wheezing			
Winter Stuffiness			
Other:			

Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months.

Nails	Mild	Moderate	Severe
Bitten			
Brittle			
Curve Up			
Frayed			
Fungus-Fingers			
Fungus-Toes			
Pitting			
Ragged Cuticles			
Ridges			
Soft			
Thickening of:			
Finger Nails			
Toenails			
White Spots/Lines			
Lymph Nodes			
Enlarged/Neck			
Tender/Neck			
Other Enlarged/Tender Lymph Nodes			
Skin, Dryness of			
Eyes			
Feet			
Any Cracking?			
Any Peeling?			
Hair			
And Unmanageable?			
Hands			
Any Cracking?			
Any Peeling?			
Mouth/Throat			
Scalp			
Any Dandruff?			
Skin in General			
Skin Problems			
Acne on Back			
Acne on Chest			
Acne on Face			
Acne on Shoulders			
Athlete's Foot			
Bumps on back of Upper Arms			
Cellulite			
Dark Circles under Eyes			

Skin Problems (cont.)	Mild	Moderate	Severe
Ears get Red			
Easy Bruising			
Eczema			
Herpes-Genital			
Hives			
Jock Itch			
Lackluster Skin			
Moles w Color/Size Change			
Oily Skin			
Pale Skin			
Patchy Dulness			
Psoriasis			
Rash			
Red Face			
Sensitive to Bites			
Sensitive to Poison Ivy/Oak			
Shingles			
Skin Cancer			
Skin Darkening			
Strong Body Odor			
Thick Calluses			
Vitiligo			
Itching Skin			
Anus			
Arms			
Ear Canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Genitals			
Roof of Mouth			
Scalp			
Skin in General			
Throat			

Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months.

Male Reproductive	Mild	Moderate	Severe
Discharge from Penis			
Ejaculation Problems			
Genital Pain			
Impotence			
Infection			
Lumps in Testicles			
Poor Libido (Sex Drive)			

Current Medications (include perscriptions and over-the-counter)

Medication	Dosage	Start Date (mo/yr)	Reason for Use

Nutrition Suppliments (vitamins/minerals/herbs etc)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

Have any medications or supplements ever caused unusual side effects or problems? Yes No

If yes, describe: _____

Have you used any of these regularly or for a long time:

NSAIDs (Advil, Aleve, etc.) Motrin, Asprine? Yes No Tylenol (acetaminophen)? Yes No

Acid-Blocking Drugs (Zantac, Prilosec, Nexium, etc.)? Yes No

How many times have you taken antibiotics?

	<5	>5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Have you ever taken long term antibiotics? Yes No

If yes, explain: _____

How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)?

	<5	>5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Readiness Assessment and Health Goals

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

- | | | | | | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Significantly modify your diet | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Take several nutritional supplements each day | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Keep a record of everything you eat each day | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Modify your lifestyle (e.g., work demands, sleep habits) | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Practice a relaxation technique | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Engage in regular exercise | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above

health-related activities? 5 4 3 2 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through? _____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to you implementing the above

changes? 5 4 3 2 1

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as

you implement your personal health program? 5 4 3 2 1

Comments:

Health Goals

What do you hope to achieve in your visit with us? _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel better? _____

What makes you feel worse? _____

How does your condition affect you? _____

What do you think is happening and why? _____

What do you feel needs to happen for you to get better? _____

CHIROPRACTIC CENTER FOR HEALTHY LIVING/DOBESH CHIROPRACTIC PRIVACY NOTICE

1415 WEST HAVENS SUITE 3

MITCHELL SD, 57301

605-996-1160

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that 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 among the health care providers who may be directly and indirectly involved in providing my treatment
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and accreditation

Printed Name: _____

Signature: _____

Date: _____

Chiropractic Center for Healthy Living and Dobesh Chiropractic Financial Policy

Please read and initial at each bullet point below. Ask if you have any questions!

- Payment is due at time of service. If you have a deductible that has not been met, we ask that you pay at least 50% of your visit today. We will bill you for the remaining amount after we hear back from your insurance.
- A co-pay may or may not cover all of your visit here. Some plans will cover only the actual chiropractic spinal adjustment. If you have a therapy/stretching/rehab these charges may be applied to your deductible in addition to your co-pay. It just depends upon your specific plan. We encourage you to be proactive and look into what your health insurance covers for chiropractic services – keeping in mind that chiropractic may be covered differently than medical.
- If you are here for a nutritional consult or a neurologic exam and treatment, this is not billable to your insurance and we will collect in full on the day of your treatment.
- We ask that you be aware that your insurance may have an annual limit to the number of chiropractic visits. While we do our best to keep track of this, only you are fully aware of how many visits you may have had throughout the calendar year – especially if you have been to other chiropractors. The best way to track this is to look up your specific plan on your insurance company's website. We will also ask that you sign a waiver in regards to this. If a visit gets submitted to your insurance AFTER you have reached your maximum number of visits, we reserve the right to collect for this visit in full if your insurance then denies coverage.

Insurance Waiver:

I, the undersigned, understand and have had it explained to me that my insurance may only cover up to a certain number of visits per calendar year. I am responsible to know how many visits I have through my policy and how many I have used. This will include any other chiropractic visits that I may have had at another facility. I also understand that the Chiropractic Center for Healthy Living/Dobesh Chiropractic may bill me for these items and services if they are not covered by my insurance policy, and/or I run out of chiropractic visits. I agree to be financially responsible for these services. These services may include: chiropractic adjustments, exams, extremity adjustments, rehab exercises, rehab stretching, IST table, electric stimulation therapy and ultrasound therapy.

Patient name: (Printed) _____

Patient Signature: _____ Date: _____

Financial Policy waiver:

I understand that I am ultimately responsible for all charges on my account. I have read the above financial policy and understand and accept the terms as they are stated. I also assign directly to the Chiropractic Center for Healthy Living and/or Dobesh Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature: _____ Date: _____

(If minor, Parent or Policyholder signature)