CHIROPRACTIC CENTER
FOR HEALTHY LIVING

Dr. Scott Mullenmeister
Chiropractic Neurologist

Dr. Melanie Mullenmeister
Chiropractor

FEMALE

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	Mild	Moderate	Severe	Prior Treatment/Approach Success	Excellent	Good	Fair
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 counselling? ☐ 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

Women's History

Obstetric History: *(Check all that apply)*

☐ Pregnancies _____ ☐ Miscarriages _____ ☐ Abortions _____ ☐ Living Children _____ ☐ Cesarean _____

☐ Vaginal Deliveries ☐ Term Births _____ ☐ Premature Births _____

Birth weight of largest baby _____ Birth weight of smallest baby _____

Did you develop any problems in or after the pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.? ☐ Yes ☐ No

If yes, please explain: _____

Menstrual History:

Age at first period: _____ Date of last menstrual period: _____ Length of cycle: _____

Time between cycles: _____ Cramping? ☐ Yes ☐ No Pain? ☐ Yes ☐ No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? ☐ Yes ☐ No

If yes, please describe: _____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? ☐ Yes ☐ No

If yes, please describe: _____

Use of hormonal birth control: ☐ Birth control pills ☐ Patch ☐ Nuva ring

☐ Other: _____ How Long? _____

Any problems with hormonal birth control? ☐ Yes ☐ No

If yes, please explain: _____

Use of other contraception? ☐ Yes ☐ No ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

Are you in menopause? ☐ Yes ☐ No If yes, age of last period: _____

Was it surgical menopause? ☐ Yes ☐ No If yes, explain surgery: _____

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

☐ Hot Flashes ☐ Mood Swings ☐ Headaches ☐ Joint Pain ☐Concentration/Memory Problems

☐ Vaginal Dryness ☐ Weight Gain ☐ Decreased Libido ☐ Palpitations ☐ Loss of Control of Urine

Are you on hormone replacement therapy? ☐ Yes ☐ No

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)? _____

Other Gynecological Symptoms: *(Check if applicable)*

☐ Endometriosis ☐ Infertility ☐ Fibrocystic breasts ☐ Vaginal infection ☐ Fibroids ☐ Ovarian cysts

☐ Pelvic inflammatory disease ☐ Reproductive cancer ☐ Sexually transmitted disease (describe) _____

Gynecological Screening/Procedures: *(If applicable, provide date)*

Last Pap test: _____ ☐ Normal ☐ Abnormal

Last mammogram: _____ ☐ Normal ☐ Abnormal

Last bone density: _____ Results: ☐ High ☐ Low ☐ Within normal range

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

Family History:

Check family members that have/had any of the following:

	Mother	Father	Brother(s)	Sister(s)	Child (ren)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)										
Age at Death (if deceased)										
Cancer										
Heart Disease										
Hypertension										
Obesity										
Diabetes										
Stroke										
Autoimmune Disease										
Arthritis										
Kidney Disease										
Thyroid Problems										
Seizures/Epilepsy										
Psychiatric Disorders										
Anxiety										
Depression										
Asthma										
Allergies										
Eczema										
ADHD										
Autism										
Irritable Bowel Syndrome (IBS)										
Dementia										
Substance Abuse										
Genetic Disorders										
Other:										

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		
Ovarian		
Skin		
Other:		

Medical History (cont.)

Diagnostic Studies	Date	Comments
Bone Density		
CT Scan		
Colonoscopy		
Cardiac Stress Test		
EKG		
MRI		
Upper Endoscopy		
Upper GI Series		
Chest X-Ray		
Other X-Rays		
Barium Enema		
Other: _____		
Injuries		
Broken Bones		
Back Injury		
Neck Injury		
Head Injury		
Other: _____		
Surgeries		
Appendectomy		
Dental		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Joint Replacement		
Heart Surgery		
Other: _____		
Hospitalizations		

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 Dullness			
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.

Female Reproductive	Mild	Moderate	Severe
Breast Cysts			
Breast Lumps			
Breast Tenderness			
Ovarian Cysts			
Poor Libido (Sex Drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal Discharge			
Vaginal Odor			
Vaginal Itch			
Vaginal Pain			
Premenstrual:			
Bloating			
Breast Tenderness			
Carbohydrate Craving			
Chocolate Carving			
Constipation			
Decreased Sleep			
Diarrhea			
Fatigue			
Increased Sleep			
Irritability			
Menstrual:			
Cramps			
Heavy Periods			
Irregular Periods			
No Periods			
Scanty Periods			
Spotting Between			

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	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Take several nutritional supplements each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Keep a record of everything you eat each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Modify your lifestyle (e.g., work demands, sleep habits)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Practice a relaxation technique	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Engage in regular exercise	☐ 5	☐ 4	☐ 3	☐ 2	☐ 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/stretches/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)