CHIROPRACTIC CENTER
FOR HEALTHY LIVING

Dr. Scott Mullenmeister
Chiropractic Neurologist

Dr. Melanie Mullenmeister
Chiropractor

Today's Date _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Suffix (Jr./Sr./III) _____ **Preferred Name/Nickname** _____

Address _____ **City** _____ **State**_____ **Zip** _____

Mobile Phone _____ **Work Phone** _____ **Home/Other Phone** _____

Best Contact Method: ___ **Primary Phone** ___ **Work Phone** ___ **Mobile Phone**

EMAIL ADDRESS: _____

Date Of Birth _____ **Age** _____ **Place of Employment** _____

Gender (check one) ____**Male** ____ **Female** ____**Non-Binary** ____**Prefer Not to Disclose**

Marital Status (check one) ____ **Single** ____ **Married** ____**Other**

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

Emergency Contact's Name _____**Relationship**_____ **Phone**_____

Is English your primary language? ☐**Yes** ☐**No**

Race: _____ (White, African American, Asian, etc.) ☐ I choose not to specify

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What *specific spinal complaint* brings you to our office today?_____

When did your symptoms start?_____

Describe the cause (if known): _____

Have you had the same/similar problems before? Yes____ No____

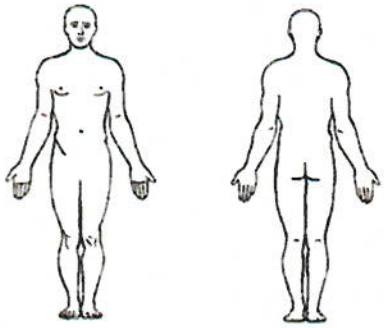
Are your problems interfering with your: Work___ Daily routine___ Sleep___ All___

What activities worsen your problem? _____

What activities improve your problem? _____

Are your problems getting progressively worse? Yes____ No ____

Mark an X on the diagram where you are experiencing your symptoms:



If your condition involves pain, please characterize type:
Ache____ Sharp____ Radiating____ Constant____ Intermittent____

Please rate the amount of pain you are generally experiencing (circle one):
Minor 1 2 3 4 5 6 7 8 9 10 *Severe*

Have you received any previous treatment for your condition? Yes___ No___
If yes, what type of treatment did you receive? _____

When?(date) _____

Any Diagnostic Imaging Done? (X-ray, MRI, CT Scan) _____

Name of doctor/therapist? _____

Condition or diagnosis: _____

Results of treatment: _____

PLEASE CHECK "C" for Current Conditions and "P" for Conditions you have delt with in the past:

C	P		C	P		C	P	
___	___	Acid reflux/heart burn	___	___	Diabetes	___	___	Depression
___	___	Ulcer	___	___	Hypoglycemia	___	___	Anxiety
___	___	Irritable Bowel	___	___	Seizures	___	___	Poor memory/confusion
___	___	Diarrhea	___	___	Headaches	___	___	Arthritis
___	___	Constipation	___	___	Migraines	___	___	Rheumatoid arthritis
___	___	Sinus problems	___	___	Dizziness	___	___	Osteopenia or osteoporosis
___	___	Chronic cough	___	___	Vertigo	___	___	Herniated disc
___	___	Asthma	___	___	Balance problems	___	___	Muscle cramping
___	___	High blood pressure	___	___	Fatigue	___	___	Bladder problems
___	___	Stroke	___	___	Insomnia	___	___	Prostate problems
___	___	Heart Attack	___	___	Hypo/Hyper Thyroid	___	___	Cancer
___	___	High Cholesterol	___	___	Fibromyalgia	___	Other_____	
___	___	Clotting disorder	___	___	Autoimmune disease			

Would you like to discuss and or seek treatment for any of these additional health concerns? Yes___ No___

Do you have a pacemaker? ____Yes ____No

Do you have a history of a stroke? _____Yes _____No

Do you have a blood clotting disorders? _____Yes ____No

FEMALES: Are you pregnant? _____Yes _____No

Are you on birth control? _____ Yes _____No If yes, what type? (Injection, pill, etc.) _____

Please list any injuries and or surgical history: _____

LIFESTYLE HABITS

Exercise: None_____ Moderate_____ Daily_____ What kind of exercise? _____

Work Activity: Sitting_____ Standing_____ Light Labor_____ Heavy Labor_____

Coffee/Caffeine Drinks per Day 0_____ 1-3_____ 3-5_____ 5-7_____ More than 7_____

Alcohol Drinks per Week 0_____ 1-3_____ 3-5_____ 5-7_____ More than 7_____

Do you smoke/use tobacco products? _____Yes _____No Do you vape or use vape products? _____Yes _____No

Stress Level 0 1 2 3 4 5 6 7 8 9 10

0=Not Stressed 10=Extremely Stressed

Reason for Stress: _____

Please List any Nutritional Suppliments/Vitamins:_____

Current PERSCRIPTION MEDICATIONS ONLY, including frequency and dosage if known. Please be as specific as possible. IF THERE ARE NO CURRENT MEDICATIONS, CHECK HERE

	Dosage			Dosage
1)_____	I_____I		4)_____	I_____I
2)_____	I_____I		5)_____	I_____I
3)_____	I_____I		6)_____	I_____I

FAMILY HEALTH HISTORY

BY USING ONE OF THE FOLLOWING LETTERS, PLEASE INDICATE IF THERE IS A MEMBER IN YOUR FAMILY THAT HAS SUFFERED WITH ONE OF THESE ALIMENTS:

F=Father M=Mother B=Brother S=Sister C=Child

_____No Known Conditions	_____Clotting Disorder	_____Dementia/Alzheimer's
_____Diabetes/Pre-Diabetes	_____Heart Disease	_____High Cholesterol
_____High Blood Pressure	_____Lung Disease	_____Osteoporosis
_____Depression	_____Anxiety	_____Stroke/Brain Hemorrhage
_____Autism	_____Attention Deficit Disorder (ADD)	

Patient Name: _____ Date: _____

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)

Informed Consent Form

Patient Name: _____ **Date:** _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The Nature of the Chiropractic Adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may also feel a sense of movement.

Analysis/Examination/Treatment

- Spinal manipulative therapy
- Range of motion testing
- Muscle strength testing
- Ultrasound
- Palpation
- Orthopedic testing
- Postural analysis
- Hot/cold therapy
- Mechanical traction
- Vital signs
- Basic neurological testing
- Electric stimulation
- Laser Therapy

The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during the examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter pain medications
- Prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Melanie Mullenmeister/Dr. Scott Mullenmeister/Dr. Kelsey Dobesh and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _____

_____
Patients Name (Print)

_____
Patient Signature

_____
Signature of Parent/Guardian

Date: _____

Scott Mullenmeister DC
Doctor's Signature

Melanie Pueta Mullenmeister, D.C.
Doctor's Signature

Kelsey Dobesh, D.C.
Doctor's Signature