Dr. Mindal R. Donner Family Chiropractor-Patient Information

Name(First, Middle, Last)_____Date_____

Address(no PO boxes)_____City_____State_____Zip_____

Home phone_____Work phone_____ Cell phone_____

How do you prefer your electronic appointment reminder, email or text? _____

For text reminders, please list your cell phone carrier (AT&T, Verizon, T-Mobile, Sprint, etc) _____

Social Security # _____ E-mail address_____

Age _____Birthdate _____/_____/_____ Sex M / F Status M S W D No.Children_____

Occupation _____Employer _____Years Employed_____

Work Address_____City_____State_____ Zip_____

Spouse's Name_____Occupation_____ Employer _____ S.S.#_____

Primary Insurance Plan Name_____ID#_____Group#_____

Policy Holder's Name_____Relationship to policy holder:Spouse___Child___Self___

Policy Holder's Birthdate _____

Secondary Insurance Plan Name _____ ID# _____ Group #_____

Is your condition due to an auto accident? Yes____No____ If yes, what state? _____

Is your condition work related?Yes__No__ Is your condition related to another accident? Yes__No__

What is your deductible_____ Was it met? Yes ____ No ____ Unsure ____

If no, it will be paid by Cash_____ Check_____ Credit Card_____ Other_____

Immediate Family under care in this clinic_____

I understand that the above patient is a minor and I personally guarantee payment for all charges related to:

*(patient name)*_____*Name of guarantor:* _____

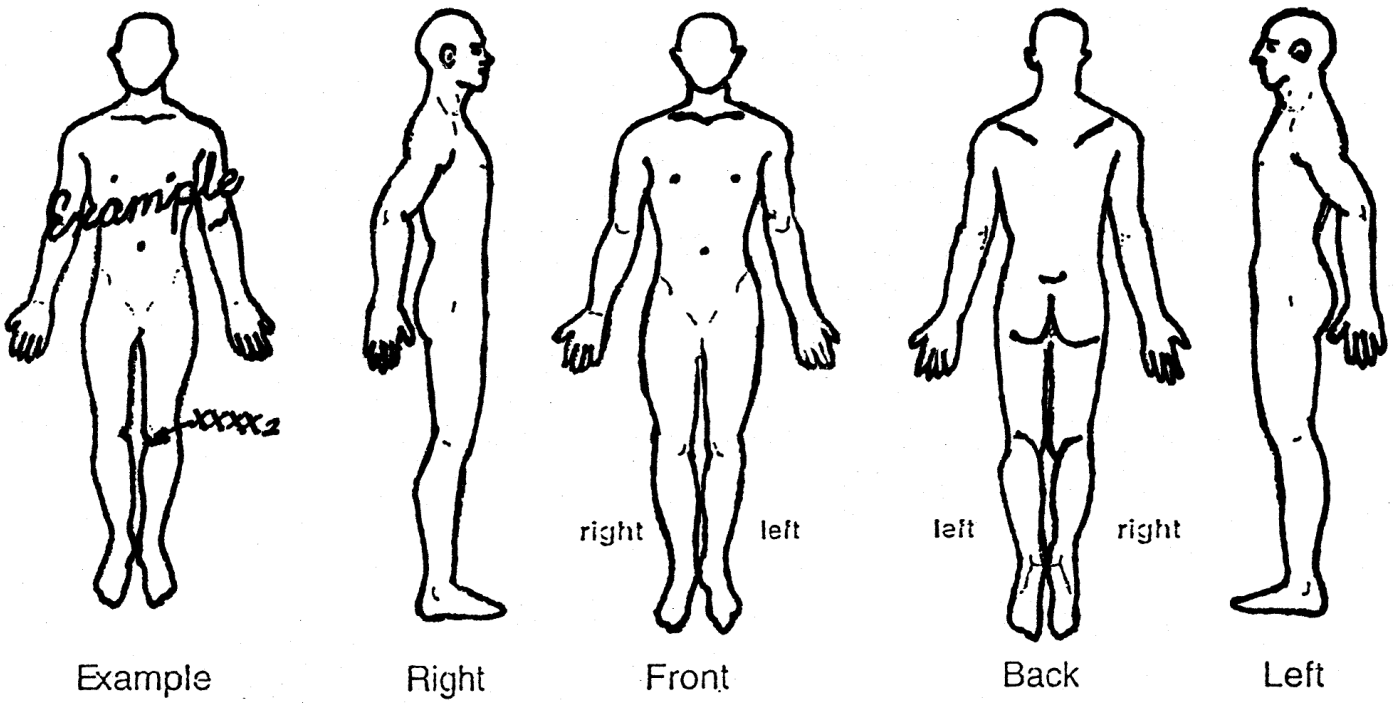
*Signature of guarantor:*_____*Date:*_____

With my signature below, I authorize the assignment of insurance benefits directly to Dr. Mindal R. Donner.

Patient/Guarantor Signature: _____Date:_____

Show Us Where It Hurts:

In the diagram below, please draw an arrow pointing to the area(s) of your pain or condition:



Authorization for Care, Insurance Assignment & Fees Please read and sign

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. I understand that Dr. Mindal R. Donner will prepare any necessary documents to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Mindal R. Donner will be credited to my account on receipt (insurance assignment of benefits). However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment as well as collection manager/attorney's fees of 33.3% and any and all related costs of collection, including filing fees, should such action become necessary. Interest rate on unpaid balances is the greater of 1.65% per month or $5.00 per month and begins from the time an account has been considered delinquent. I also understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable. I also authorize the doctor to bill any unpaid balance to my credit card if it was used previously in the office to pay for services rendered, to obtain a credit report if deemed necessary and verify my employment should that information be needed in the collection of unpaid balances.

I hereby authorize the doctor to provide for me manual adjustments to my spine and therapy. The patient also agrees that he/she is responsible for all bills incurred at this office including interest on unpaid balances. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnoses.

Patient Name_____ Date_____

Patient Signature _____ Date_____

Guardian/Spouse/or Guarantor's Name Authorizing Care_____Date:_____

Guardian/Spouse/or Guarantor's Signature Authorizing Care_____Date:_____

CURRENT HEALTH CONDITION: Name_____ Date:_____

- **Please describe your pain or health problem** - including where you feel the pain, how often you feel it, and what you think may have caused it:_____

  _____

  _____
- **Which best describes your discomfort?** □ ache □ sharp/stabbing □ burning □ pins & needles □ numbness
- **Rate how much it bothers you - on a scale of 1 (discomfort) to 10 (extreme pain)**_____
- **What activities/positions/etc. makes it feel worse?**_____
- **What makes it feel better?**_____
- **Does your current condition ever cause you to be:** □ moody □ irritable □ unpleasant □ depressed □ angry
- **What is your occupation?**_____**How does your condition interfere with your work?**

□ decreased productivity □ hard to concentrate □ can't work without pain □ had to stop working/disabled

- **What activities have you been forced to stop or hesitate doing because of your condition?**

□ athletic/exercise activities □ household work - lifting, etc. □ gardening □ walking □ biking □ dancing

□ running □ lovemaking □ other (please list):_____

- **Check any of the following drugs & treatments you have used unsuccessfully to get rid of this problem:**

  □ Tylenol □ Advil □ aspirin □ Aleve □ Motrin □ antacids □ sinus medicine □ blood pressure pills

  □ Muscle relaxers □ ice □ heat □ massage □ herbal or remedies □ ben-gay or other ointments

  □ pain medicine injections □ prescription pain medicine (please list):_____

  □ bed rest □ other (please list):_____

- **Check off any tests or evaluations you have had for this condition(s):**

□ x-ray □ MRI □ CAT scan □ bone scan □ blood tests □ other_____

- **Check off any type of doctors you've consulted for this condition(s):**

□ general medical physician □ orthopedist's □ neurologist □ rheumatologist □ cardiologist's

□ dermatologist □ podiatrist □ dentist □ pediatrician □ psychiatrist □ allergist □ Ob/Gyn □ herbalist

□gastrointestinal/internal medicine □ urologist □ oncologist □ opthalmologist □ pain clinic

□ lung specialist □ ear, nose & throat □ sports medicine □ physical therapist □ osteopath □ physiatrist

□ **other chiropractor(s):** Who?_____

How long and often did you go?_____ When was your last appointment?_____

PAST HEALTH HISTORY - *Check any of the following conditions you have ever had:*

□ Pneumonia □ Mumps □ Influenza □ Rheumatic Fever □ Small Pox □ Pleurisy □ Polio □ Chicken Pox
□ Arthritis □ Tuberculosis □ Diabetes □ Epilepsy □ Whooping Cough □ Cancer □ Mental Disorders
□ Measles □ Thyroid □ Eczema □ Psoriasis □ Tonsillitis □ Tested HIV positive

- **Have you ever had any surgery?** □ yes □ no Type:_____
- **Have you ever been hospitalized?** □ yes □ no Why?_____
- **Please list all medications currently taking** _____

Please describe any other pertinent health information you are aware of:

_____

_____

_____

General Health History

CHECK ANY OF THE FOLLOWING YOU HAVE HAD OVER THE PAST **6** MONTHS

General Symptoms
□ Headaches/Migraines
□ Allergies
□ Sleeping Problems
□ Frequent Colds/Flu
□ Fever/Chills

Muscle & Skeletal System
□ Low Back Pain
□ Pain Between Shoulders
□ Neck Pain/Stiffness
□ Shoulder/Elbow/Arm Pain
□ Hand/Wrist/Finger Pain
□ Walking Problems
□ Hip/Leg Pain/Sciatica
□ Foot Pain
□ Jaw Pain or Clicking
□ Difficulty Chewing

Nerve System
□ Numbness - Where?
□ Cold/Tingling Extremities - Where?
□ Weakness/Paralysis - Where?
□ Dizziness
□ Confusion/Depression
□ Seizures/Convulsions
□ Face Pain/Tic Doulareaux
□ Hyperactivity

Gastro-intestinal System
□ Abdominal Pain/Cramps
□ Heartburn/Indigestion
□ Hiatal Hernia
□ Constipation
□ Diarrhea
□ Gas/Bloating
□ Nausea/Vomiting
□ Hemorrhoids
□ Colitis
□ Black/Bloody Stool
□ Liver Problems/Jaundice
□ Gall Bladder Problems
□ Poor/Excessive Appetite
□ Excessive Thirst

Cardiovascular & Respiratory Systems
□ Breathing Difficulty/Wheezing/Asthma
□ Lung Problems/Congestion/Cough
□ Chest Pain
□ Heart/Artery Disease
□ Circulation Problems
□ Irregular Heartbeat
□ Blood Pressure Problems
□ Varicose Veins
□ Ankle Swelling
□ Stroke

Eyes - Ears - Nose - Throat
□ Vision Problems
□ Crossed Eyes
□ Hearing Difficulty
□ Sore Throat/Laryngitis
□ Chronic Stuffed/Runny Nose
□ Sinus Problems/Infections/Headaches
□ Nose Bleeds
□ Itchy/Watery Eyes
□ Enlarged Glands
□ Loss of Smell or Taste Perception
□ Ear Aches/Noises/Infection

Urinary System
□ Pain or Burning Upon Urination
□ Discolored Urine
□ Excessive Urination Frequency
□ Urinary Hesitancy
□ Kidney Disorders
□ Bladder Disorders
□ Bed-Wetting/Incontinence

For Men Only:
□ Impotence
□ Prostate Disorders

For Women Only:
□ PMS
□ Menstrual Cramps
□ Menstrual Irregularity
□ Vaginal Pain
□ Yeast Infection
□ Breast Pain/Lumps
□ Menopause Symptoms
□ Infertility

Date of your last menstrual period_____

Are you Pregnant?
□ Yes □ No □ Not Sure

Update Patient Information

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Name: _____ Birth Date: _____ / _____ / _____

Preferred Language?

- ☐ English
- ☐ Spanish
- ☐ Other_____

Height: _____ feet _____ inches

Weight: _____ lbs

Phone #: _____

Zip Code: _____

Race?

- ☐ I do not wish to provide this information.
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other _____

Ethnicity?

- ☐ I do not wish to provide this information.
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino
- ☐ Other _____

Smoking Status?

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

Do you have any medication allergies?

- ☐ No known medication allergies
- ☐ Yes. What? _____

Are you currently taking any medications?

- ☐ Not currently prescribed any medications
- ☐ Yes…

What? _____ _____ mg

What? _____ _____ mg

What? _____ _____ mg

Last known blood pressure reading? _____/_____

If unknown was it normal? _____

Are you medicated for blood pressure? _____