MILADIN CHIROPRACTIC, INC.

ADULT HISTORY FORM

First Name: _____ Middle: _____ Last: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Mobile Phone: _____ Work Phone: _____ Home Phone: _____

Email Address: _____ SS#: _____

Date of Birth: _____/_____/_____ Gender: ☐M ☐F

Height: _____ Weight: _____

Marital Status: ☐ Single ☐Married ☐ Separated ☐Divorced ☐Widowed ☐Other

Number of Children _____ Spouse's Name: _____

Emergency Contact Information:

Name: _____ Phone: _____

Relation to You: _____

Health History: _____

_____

_____

Referral Information:

How did you hear about us? ☐Word of Mouth ☐Advertisement ☐Social Media ☐Direct marketing ☐ Google

Referring Physician _____ Phone: _____

Referring Patient: _____

Are you working with an Attorney? : ☐Y ☐ N

Employer Information:

☐ Full time
☐Part Time
☐Unemployed
☐ Full Time Student

Employer Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Work Supervisor: _____

Work Duties: _____

Miladin
Chiropractic

Dr. Craig J. Miladin
48892 Calcutta Smith Ferry Rd.
East Liverpool, OH 43920
330-382-7350

24 Hour Cancellation & "No Show" Fee Policy

24 Hour Cancellation & "No Show" Fee Policy recognizing that everyone's time is valuable and that appointment times are limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Miladin Chiropractic, Inc. reserves the right to charge a fee of $30.00 for each missed (No Show) appointment, which is, absent for a compelling reason, and is not cancelled within a 24 hour advance notice. "No Show" fees will be charged to the patient's credit card on file. This fee is not covered by insurance, and will be charged to your credit card on file the day of your missed appointment.

By signing below, you acknowledge that you have received this notice and understand this policy and its limitations.

_____ _____

Printed First and Last Name Date

_____

Signature

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the boxes for each symptom or condition you have experienced – including both past and present.

REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐ Colic & Excessive Crying	☐	☐ Epilepsy & Seizures
		☐	☐ Ear & Sinus Infections	☐	☐ Sensory & Spectrum
		☐	☐ Allergies & Congestion	☐	☐ ADD / ADHD
		☐	☐ Immune Deficiency	☐	☐ Focus & Memory Issues
		☐	☐ Headaches & Migraines	☐	☐ Anxiety & Stress
		☐	☐ Vertigo & Dizziness	☐	☐ Balance & Coordination
		☐	☐ Sore Throat & Strep	☐	☐ Speech Issues
		☐	☐ Swollen Tonsils & Adenoids	☐	☐ TMJ / Jaw Pain
		☐	☐ Vision & Hearing Issues	☐	☐ Stiff Neck & Shoulders
		☐	☐ Low Energy & Fatigue	☐	☐ Depression
		☐	☐ Difficulty Sleeping	☐	☐ High Blood Pressure
		☐	☐ Pain, Numbness & Tingling in Arms to Hands	☐	☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐ Reflux / GERD	☐	☐ Bronchitis & Pneumonia
		☐	☐ Chronic Colds & Cough	☐	☐ Functional Heart Conditions
		☐	☐ Asthma		
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐ Gallbladder Pain / Issues	☐	☐ Indigestion & Heartburn
		☐	☐ Jaundice	☐	☐ Stomach Pains & Ulcers
		☐	☐ Fever	☐	☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐ Behavior Issues	☐	☐ Allergies & Eczema
		☐	☐ Hyperactivity	☐	☐ Skin Conditions / Rash
		☐	☐ Chronic Fatigue	☐	☐ Kidney Problems
		☐	☐ Chronic Stress	☐	☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐ Constipation	☐	☐ Sciatica & Radiating Pain
		☐	☐ Chrohn's, Colitis & IBS	☐	☐ Lumbopelvic / SI Joint Pain
		☐	☐ Diarrhea	☐	☐ Hamstring Tightness
		☐	☐ Bed-wetting	☐	☐ Disc Degeneration
		☐	☐ Bladder & Urination Issues	☐	☐ Leg Weakness & Cramps
		☐	☐ Cramps & Menstrual Issues	☐	☐ Poor Circulation & Cold Feet
		☐	☐ Cysts & Endometriosis	☐	☐ Knee, Ankle & Foot Pain
		☐	☐ Infertility	☐	☐ Weak Ankles & Arches
		☐	☐ Impotency	☐	☐ Lower Back Pain
		☐	☐ Hemorrhoids	☐	☐ Gluten & Casein Intolerance

INTERNAL USE: E:__ Health Goal:___ Other:___ PC:___
Staff Init. _____ Date:_____

Wellness Intake Form

Name: _____ **Date:** _____ **Age:** _____

Email Address: _____ **Phone:** _____

DIETARY INTAKE SUMMARY:

How many servings of fruit do you consume per day? _____
How many servings of vegetables do you consume per day? _____
How many servings of protein do you consume per day? _____
How many servings of bread/crackers/pasta do you consume daily? _____
Do you consume artificial sweeteners? __Yes __No If yes, what brands? _____
Do you consume fast food? __Yes __ If yes, what do you typically eat? _____
Do you eat breakfast? __Yes __No If no, what time is your first meal of the day? _____
Do you consume alcoholic beverages? __Yes __No If yes, how many per week? _____
Do you consume coffee? __No __Yes If yes, how many cups per day? _____
Do you consume dietary supplements? __No __Yes If yes, please list all of them below. Additionally, please bring them in so we can check for ingredients that are not healthful or may have contraindications with medications.

_____

Please indicate the areas of health that you want to improve:

___ 1.Lose weight ___ 2.More energy ___ 3.Sleep better ___ 4.Improve digestion ___ 5. Allergies ___ 6. Improve bloodwork

___ 7.Immune Support ___ 8.Anti-aging support ___ 9.Improve general health ___ 10.Stress Management

If you could improve ONE THING about your health, what is your priority?

_____

IDENTIFYING YOUR HEALTH GOALS:

To help our office understand your wellness goals and give you the type of care that you want, please use this chart to answer the questions below.

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
I have serious concerns about my overall health	I feel worried about my health	I have constant concerns that affect my health	I have health challenges that affect me on a daily basis	I have some minor complaints about my health	I feel okay about my health with no complaints	I feel good most days	I feel well on a daily basis	I feel energetic and healthy	I feel active, energetic and fit	I feel great and am proactive about my health

1. What number best describes how you feel about your health today? _____
2. What health goal do you want to achieve?: _____

NOTE: In our commitment to your health, our office provides our patients with access to a free online resource for education, science and wellness support. We will create your login ID and provide access information. Please indicate which free wellness classes you wish to be informed of:

__ Health Reality Check __ The Meaning of Essential Nutrients __ Creating Optimal Health __ Other _____
__ Customizing Your Health Plan __Healthy Age Management __ Genetics and Health __ Healthy Weight Loss

The Stress Test

Name: Date:

For your First Evaluation circle all stresses you have experienced mild or severe:
C = Child, T = Teenager, A = Adult or N = None. You may circle all three if they apply.

All Re-Evaluation exams mark as follows:
RS for Reduced Stress or NS for New or Reoccurring Stress

		First Evaluation	Re-Evaluation 1	Re-Evaluation 2	Re-Evaluation 3
I.	**PHYSICAL STRESS:**				
	Birth Traumas as a child	C T A N			
	Delivery Traumas as a mother	C T A N			
	Slips / Falls	C T A N			
	Car Accidents	C T A N			
	Sport Injuries	C T A N			
	Physical Abuse	C T A N			
	Work Injuries	C T A N			
	Poor Posture	C T A N			
	Texting	C T A N			
	Sleeping on your stomach	C T A N			
	Long Hours For Computer Work	C T A N			
	Carrying Heavy Purse / Backpack	C T A N			
	Repetitive Lifting / Bending	C T A N			
	Long Hours Sitting / Standing / Driving	C T A N			
	Bone Fracture / Surgery	C T A N			
II.	**EMOTIONAL STRESS**				
	Relationships	C T A N			
	Career	C T A N			
	Children	C T A N			
	Money	C T A N			
	Fast-Paced Life	C T A N			
	Hold in Feelings	C T A N			
	Quick Tempered	C T A N			
	Verbal Abuse	C T A N			
	Perfectionist	C T A N			
	Procrastinator	C T A N			
	Sickness or Loss of Loved One	C T A N			
III.	**CHEMICAL STRESS**				
	Environment Pollution	C T A N			
	WiFi Signal (EMF)	C T A N			
	Smoker or Second Hand Smoke	C T A N			
	Poor Diet	C T A N			
	Caffeine - Amount?	C T A N			
	Excessive Sugar	C T A N			
	Artificial Sweeteners	C T A N			
	Prescription Drugs	C T A N			
	Over-the- counter Drugs	C T A N			
IV.	**Which do you feel is your primary stress?**	**__ Physical / __ Chemical / __ Emotional**			

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ Date: ____/____/____