



Mason Family Chiropractic  
1414 Country Club Road, Suite 2  
Fairmont, WV 26554  
p 304.534.8493  
f 304.534.8268  
drmariemason.medicfusion.com

Patient: \_\_\_\_\_

## AUTHORIZATIONS AND RELEASES

### Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

Initials: \_\_\_\_\_

### Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initials: \_\_\_\_\_

### Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: [hhs.gov - Understanding Health Information Privacy](https://www.hhs.gov/understanding-health-information-privacy)

- The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
- The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
- The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
- This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
- Patients have the right to file a formal complaint with our privacy official about any suspected violations.
- This office has the right to refuse treatment if the patient does not accept the terms of this policy.

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### Financial Obligation and Appointment Policy

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.

**Initials:** \_\_\_\_\_

### Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

**Initials:** \_\_\_\_\_

### Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

**Initials:** \_\_\_\_\_

### Insurance / Medicare payment-Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct.

I authorize this office and/or doctor to act as my agent in helping me obtain payment of my insurance and/ or Medicare benefits, and I authorize payment of these benefits to this clinic and/or doctor of record on my behalf for any services and materials furnished.

**Initials:** \_\_\_\_\_

### Consent to Chiropractic Treatment

Please read this entire section regarding chiropractic care prior to accepting it. It is important that you understand the information contained in this section. Please ask questions before you accept it if there is anything that is unclear. You are the decision maker for your health care. Part of the role of this clinic is to provide you with information to assist you in making informed choices. This process is often referred to as 'informed consent' and involves your understanding and agreement regarding the care that this clinic recommends, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. The nature of the chiropractic analysis and treatment The primary treatment that is performed by a Doctor of Chiropractic is spinal manipulative therapy. This clinic may use that procedure to treat you. This may include the use of the hands or a mechanical instrument upon your body in such a way as restore normal joint motion. It may cause an audible 'pop' or 'click,' much as you have experienced when you 'crack' your knuckles. You may feel a sense of movement. Analysis/ Examination / Treatment As a part of the analysis, examination, and treatment, the doctor may want to employ a variety of procedures as may be deemed necessary. These procedures include but are not limited to: Spinal manipulative therapy, chiropractic adjustments, vital signs, range of motion



testing, palpation, orthopedic testing, basic neurological testing, postural analysis testing, muscle strength testing, radiographic studies, scanning of feet, EMS, exercises, acupuncture, myofascial treatments, hot/cold therapy, mechanical traction, traction/decompression, laser therapy, vibrational pivot platform, or cranial balloon adjustments (CFR). By accepting this document you are consenting to these procedures as recommended/prescribed by this clinic. The material risks inherent in chiropractic adjustment. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation or from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an 'arterial dissection' that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which the provider will check during the taking of your history during examination and X-ray. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admissions attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons and the risk of death has been estimated at 140 per one million users. The availability and nature of other treatment options. Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
• Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers
• Hospitalization
• Surgery

If you chose 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. The risks and dangers to remaining untreated. Remaining untreated may allow the formulation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed with the clinic any questions and concerns I have and they have been answered to my satisfaction. By accepting, 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.

Initials: \_\_\_\_\_

Females: Consent to X-Ray During Pregnancy

This is to certify that, I am or may be pregnant and that the doctor or certified staff has my permission to perform diagnostic x-rays involving any cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be used over the trunk of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initials: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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Dear Patient:

Welcome to the world of Electronic Health Record keeping! Our practice has created a secure electronic patient record for you, allowing you to log into our site, create and update your private health record, and even schedule and re-schedule your own appointments.

Our free patient portal is available to you 24 hours a day, seven days a week, from the privacy and convenience of your own computer.

This system helps us work together to maintain safe, secure, accurate and up-to-date medical records for you. From now on, your important health information will be available to you when and where you need it, from any computer with a high-speed internet connection.

Registration, security and access are very similar to those used for on-line banking. To register, you will be required to provide the following information:

- Access Code: \_\_\_\_\_
- Your email address (your email address will be your user name for log-in purposes)
- A password (you will create a password during registration)

After registering, you will receive an activation email. This is very important! This email helps us verify that the email address you provide is working. When you receive the activation email, follow the instructions to activate your account and access it securely.

To get started, visit our web site:

[drmariemason.medicfusion.com](http://drmariemason.medicfusion.com)

Look for the Patient login icon. After you register and activate your account, you can log in and look around your electronic medical record. An on-page tutorial, located at the top-right of the page, provides a video tour of the system and its features.

Questions? Just ask us, or contact free tech support:

[support@medicfusion.com](mailto:support@medicfusion.com)

Thank you for helping us provide you with this free service!

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## Patient Profile

### Personal Information

Full Name: \_\_\_\_\_ *Jr / Sr*  
 Last First M.I.

Address: \_\_\_\_\_  
 Street Address Apartment/Unit #

City State ZIP Code

Primary Phone: \_\_\_\_\_ H / M / B Alternate Phone: \_\_\_\_\_ H / M / B

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Social Security Number #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Gender:  Male  Female

Race:  American Indian or Alaska Native  Asian  Black or African American  
 Native Hawaiian or Other Pacific Islander  White  Declined  Unknown/Unavailable  
 Other \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Declined  Unknown/Unavailable

Prim. Language:  Arabic  Chinese  English  French  German  Greek  Hebrew  Italian  
 Japanese  Korean  Spanish  Vietnamese  Declined  Unknown/Unavailable  
 Other \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

Time Zone: \_\_\_\_\_

Does your time zone participate in Daylight Savings Time?  Yes  No

Marital Status:  Single  Married  Widowed  Divorced

Do you have any dependents?  Yes  No

Are you a full-time student?  Yes  No

Health Insurance?  Yes  No

Responsible Party:  You  Other (parent, spouse, etc.) \_\_\_\_\_

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## Physician Form

### Physician Information

Type of Physician:  Chiropractic  Family  Specialist

Physician Name: \_\_\_\_\_  
*First Name Last Name*

Address: \_\_\_\_\_  
*Street Address Unit #*  
 \_\_\_\_\_  
*City State ZIP Code*

Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

Type of Physician:  Chiropractic  Family  Specialist

Physician Name: \_\_\_\_\_  
*First Name Last Name*

Address: \_\_\_\_\_  
*Street Address Unit #*  
 \_\_\_\_\_  
*City State ZIP Code*

Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

Type of Physician:  Chiropractic  Family  Specialist

Physician Name: \_\_\_\_\_  
*First Name Last Name*

Address: \_\_\_\_\_  
*Street Address Unit #*  
 \_\_\_\_\_  
*City State ZIP Code*

Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

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## Employer Form

### Employer Information

Your Employment Status:  Full Time  Part Time  Contract  Not Employed  Retired  Student

Occupation or Title: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street Address Apartment/Unit #

\_\_\_\_\_ City State ZIP Code

Employer Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Fax: \_\_\_\_\_

Start Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ End Date: (If you are no longer working here.) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Your Employment Status:  Full Time  Part Time  Contract  Not Employed  Retired  Student

Occupation or Title: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street Address Apartment/Unit #

\_\_\_\_\_ City State ZIP Code

Employer Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Fax: \_\_\_\_\_

Start Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ End Date: (If you are no longer working here.) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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## Responsible Party Form

### Responsible Party Information

Relationship to You: \_\_\_\_\_

Full Name: \_\_\_\_\_  
*First M.I. Last*

Same as your address?  Yes  No

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*  
\_\_\_\_\_  
*City State ZIP Code*



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### Health Insurance Information

Are you the insured party?  Yes  No (if no please fill out the Policy Holder Information)

#### Policy Holder Information

Full Name: \_\_\_\_\_  
*Last First M.I.*

Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_ *City State ZIP Code*

Birth Date: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Social Security Number #: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Insured's Occupation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
*Street Address Unit #*

\_\_\_\_\_ *City State ZIP Code*

Employer Phone: \_\_\_\_\_ Ext. \_\_\_\_\_

#### Insurance Company Information

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address Unit #*

\_\_\_\_\_ *City State ZIP Code*

Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Fax: \_\_\_\_\_

Group #: \_\_\_\_\_

Policy/Subscriber #: \_\_\_\_\_

Effective Date: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

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Patient: \_\_\_\_\_

## Health History Form

### Prescription Medications

Prescription medications taken on a regular or ongoing basis:

Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						

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**Over-The-Counter Medications**

Over-the-counter medications taken on a regular or ongoing basis:

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per  Day  Week  Month  Other  
 (please describe): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per  Day  Week  Month  Other  
 (please describe): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per  Day  Week  Month  Other  
 (please describe): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per  Day  Week  Month  Other  
 (please describe): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per  Day  Week  Month  Other  
 (please describe): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per  Day  Week  Month  Other  
 (please describe): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per  Day  Week  Month  Other  
 (please describe): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per  Day  Week  Month  Other  
 (please describe): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per  Day  Week  Month  Other  
 (please describe): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per  Day  Week  Month  Other  
 (please describe): \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per  Day  Week  Month  Other  
 (please describe): \_\_\_\_\_





Vitamins, Minerals, Herbs, or Dietary Supplements

Vitamins, minerals, herbs, or dietary supplements taken on a regular or ongoing basis:

Supplement: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per [ ] Day [ ] Week [ ] Month [ ] Other
(please describe): \_\_\_\_\_
Supplement: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per [ ] Day [ ] Week [ ] Month [ ] Other
(please describe): \_\_\_\_\_
Supplement: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per [ ] Day [ ] Week [ ] Month [ ] Other
(please describe): \_\_\_\_\_
Supplement: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per [ ] Day [ ] Week [ ] Month [ ] Other
(please describe): \_\_\_\_\_
Supplement: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per [ ] Day [ ] Week [ ] Month [ ] Other
(please describe): \_\_\_\_\_
Supplement: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per [ ] Day [ ] Week [ ] Month [ ] Other
(please describe): \_\_\_\_\_
Supplement: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per [ ] Day [ ] Week [ ] Month [ ] Other
(please describe): \_\_\_\_\_
Supplement: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per [ ] Day [ ] Week [ ] Month [ ] Other
(please describe): \_\_\_\_\_
Supplement: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per [ ] Day [ ] Week [ ] Month [ ] Other
(please describe): \_\_\_\_\_
Supplement: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per [ ] Day [ ] Week [ ] Month [ ] Other
(please describe): \_\_\_\_\_
Supplement: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: per [ ] Day [ ] Week [ ] Month [ ] Other
(please describe): \_\_\_\_\_



**Diet and Exercise**

- Check if you have ever smoked cigars or cigarettes.  Yes
- Check if you still smoke.  Yes
- How much do you smoke?  Less than one pack per week  1-2 packs per week  
 1 pack every two days  1 pack per day  More than one pack per day
- Check if you drink alcoholic beverages.  Yes
- How many alcoholic beverages do you consume per week? \_\_\_\_\_
- Check if a physician has ever diagnosed you as an alcoholic.  Yes
- Check if a physician has ever diagnosed you with any liver-related problems.  Yes
- Check if you exercise regularly.  Yes
- How many days do you exercise each week? \_\_\_\_\_



### Allergies

Check if a physician has ever diagnosed you with any allergies.  Yes

Do you have Airborne allergies?  Yes

- |                                   |  |                                     |                                      |
|-----------------------------------|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Animal   | <input type="checkbox"/> Molds/Fungus    | <input type="checkbox"/> Pollens    | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cat Hair | <input type="checkbox"/> Cockroach       | <input type="checkbox"/> Dog Hair   | <input type="checkbox"/> Feather Mix |
|                                   | <input type="checkbox"/> Guinea Pig Hair | <input type="checkbox"/> Dust Mites | <input type="checkbox"/> Other _____ |

Do you have Chemical allergies?  Yes

- |   |   |   |  |                                    |
|---|---|---|--|------------------------------------|
| <input type="checkbox"/> Acetone          | <input type="checkbox"/> Acetylcholine  | <input type="checkbox"/> Auto Exhaust   | <input type="checkbox"/> Benzyl Alcohol    | <input type="checkbox"/> Chlorine  |
| <input type="checkbox"/> Citric Acid      | <input type="checkbox"/> Cologne (all)  | <input type="checkbox"/> Diesel Exhaust | <input type="checkbox"/> Dopamine          | <input type="checkbox"/> Estradiol |
| <input type="checkbox"/> Ethanol          | <input type="checkbox"/> Fluorine       | <input type="checkbox"/> Formaldehyde   | <input type="checkbox"/> Latex             | <input type="checkbox"/> Melatonin |
| <input type="checkbox"/> Newspaper Print  | <input type="checkbox"/> Norepinephrine | <input type="checkbox"/> Progesterone   | <input type="checkbox"/> Propylene         | <input type="checkbox"/> Serotonin |
| <input type="checkbox"/> Silicone Implant | <input type="checkbox"/> Sponge Rubber  | <input type="checkbox"/> Toluene        | <input type="checkbox"/> Trichloroethylene | <input type="checkbox"/> Wood Pulp |
|   |   | <input type="checkbox"/> Xylene         | <input type="checkbox"/> Other _____       |                                    |

Do you have Drug allergies?  Yes

- |  |                                     |   |                                      |                                   |
|--|-------------------------------------|---|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Anticonvulsants | <input type="checkbox"/> Codeine    | <input type="checkbox"/> Insulin Preparations | <input type="checkbox"/> Iodine      | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Novocain        | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa                | <input type="checkbox"/> Other _____ |                                   |

Do you have Food allergies?  Yes

- |   |  |                                     |                                      |                                |
|---|--|-------------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Artificial Colorings | <input type="checkbox"/> Artificial Flavorings | <input type="checkbox"/> Beef       | <input type="checkbox"/> Coffee/Tea  | <input type="checkbox"/> Dairy |
| <input type="checkbox"/> Eggs                 | <input type="checkbox"/> Fish/Shellfish        | <input type="checkbox"/> Fruits     | <input type="checkbox"/> Lamb        | <input type="checkbox"/> Nuts  |
| <input type="checkbox"/> Pork                 | <input type="checkbox"/> Poultry               | <input type="checkbox"/> Vegetables | <input type="checkbox"/> Other _____ |                                |



### Surgical History

Check if you have any implants, screws, plates or other foreign objects in your body.  Yes

- Bullet Wound(s)       Infusion Catheter       Ear Implant       Pacemakers       Eye Implant  
 Brain Plate(s)       Heart Valve(s)       Shrapnel       Other \_\_\_\_\_

Musculoskeletal Surgeries (Check if you have had any of the following surgeries)

- |   |                           |                                   |                           |
|---|---------------------------|-----------------------------------|---------------------------|
| <input type="checkbox"/> Ankle                    | Year(s) of surgery: _____ | <input type="checkbox"/> Head     | Year(s) of surgery: _____ |
| <input type="checkbox"/> Back                     | Year(s) of surgery: _____ | <input type="checkbox"/> Hip      | Year(s) of surgery: _____ |
| <input type="checkbox"/> Cosmetic or Augmentation | Year(s) of surgery: _____ | <input type="checkbox"/> Knee     | Year(s) of surgery: _____ |
| <input type="checkbox"/> Elbow                    | Year(s) of surgery: _____ | <input type="checkbox"/> Neck     | Year(s) of surgery: _____ |
| <input type="checkbox"/> Foot                     | Year(s) of surgery: _____ | <input type="checkbox"/> Shoulder | Year(s) of surgery: _____ |
| <input type="checkbox"/> Hand                     | Year(s) of surgery: _____ | <input type="checkbox"/> Wrist    | Year(s) of surgery: _____ |
| <input type="checkbox"/> Other                    | Please describe: _____    |                                   | Year(s) of surgery: _____ |

Organ System Surgeries (Check if you have had any of the following surgeries)

- |   |                           |  |                           |
|---|---------------------------|--|---------------------------|
| <input type="checkbox"/> Brain            | Year(s) of surgery: _____ | <input type="checkbox"/> Intestine, large    | Year(s) of surgery: _____ |
| <input type="checkbox"/> Colon            | Year(s) of surgery: _____ | <input type="checkbox"/> Liver               | Year(s) of surgery: _____ |
| <input type="checkbox"/> Esophagus        | Year(s) of surgery: _____ | <input type="checkbox"/> Lung                | Year(s) of surgery: _____ |
| <input type="checkbox"/> Eye              | Year(s) of surgery: _____ | <input type="checkbox"/> Mastectomy          | Year(s) of surgery: _____ |
| <input type="checkbox"/> Heart            | Year(s) of surgery: _____ | <input type="checkbox"/> Reproductive Organs | Year(s) of surgery: _____ |
| <input type="checkbox"/> Kidney           | Year(s) of surgery: _____ | <input type="checkbox"/> Skin                | Year(s) of surgery: _____ |
| <input type="checkbox"/> Intestine, small | Year(s) of surgery: _____ | <input type="checkbox"/> Throat              | Year(s) of surgery: _____ |
| <input type="checkbox"/> Other            | Please describe: _____    |  | Year(s) of surgery: _____ |
| <input type="checkbox"/> Transplant       | Please describe: _____    |  | Year(s) of surgery: _____ |



Your Cancer History

Check if a physician has ever diagnosed you with cancer.  Yes

Check all that apply

- Bladder
- Brain
- Breast
- Cervical
- Colon or Rectal
- Endometrial
- Eye
- Kidney (renal cell)
- Leukemia
- Other \_\_\_\_\_
- Lung
- Non-Hodgkin's Lymphoma
- Ovarian
- Pancreatic
- Prostate
- Skin
- Basal Cell Carcinoma
- Squamous Cell Carcinoma
- Melanoma
- Stomach
- Thyroid
- Uterine







**Family Cancer History**

Check if a physician has ever diagnosed your family with cancer.  Yes

Check all that apply and the family member(s) who had this condition:

- Bladder (M, F, S, MG, PG)
- Brain (M, F, S, MG, PG)
- Breast (M, F, S, MG, PG)
- Cervical (M, F, S, MG, PG)
- Colon or Rectal (M, F, S, MG, PG)
- Endometrial (M, F, S, MG, PG)
- Eye (M, F, S, MG, PG)
- Kidney (renal cell) (M, F, S, MG, PG)
- Leukemia (M, F, S, MG, PG)
- Other \_\_\_\_\_ (M, F, S, MG, PG)
- Lung (M, F, S, MG, PG)
- Non-Hodgkin's Lymphoma (M, F, S, MG, PG)
- Ovarian (M, F, S, MG, PG)
- Pancreatic (M, F, S, MG, PG)
- Prostate (M, F, S, MG, PG)
- Skin (M, F, S, MG, PG)
- Basal Cell Carcinoma (M, F, S, MG, PG)
- Squamous Cell Carcinoma (M, F, S, MG, PG)
- Melanoma (M, F, S, MG, PG)
- Stomach (M, F, S, MG, PG)
- Thyroid (M, F, S, MG, PG)
- Uterine (M, F, S, MG, PG)

Family Members	
(M)	Mother
(F)	Father
(S)	Sibling
(MG)	Maternal Grandparent
(PG)	Paternal Grandparent



Your Cardio-pulmonary / Circulatory Health

Check if a physician has ever diagnosed you with any of the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Anemia                             | <input type="checkbox"/> HIV/AIDS                         |
| <input type="checkbox"/> Hemophilia                         | <input type="checkbox"/> Hepatitis                        |
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Hypotension (low blood pressure) |
| <input type="checkbox"/> Hemorrhoids                        | <input type="checkbox"/> Lung Disorders                   |
- |  |   |
|--|---|
| <input type="checkbox"/> Acute Respiratory Distress Syndrome       | <input type="checkbox"/> Alpha-1 Antitrypsin Deficiency   |
| <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Asbestos/Dust Disease            |
| <input type="checkbox"/> Bronchitis (chronic)                      | <input type="checkbox"/> Bronchiectasis                   |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease     | <input type="checkbox"/> Bronchopulmonary Dysplasia (BPD) |
| <input type="checkbox"/> Farmer's Lung                             | <input type="checkbox"/> Cystic Fibrosis                  |
| <input type="checkbox"/> Histoplasmosis                            | <input type="checkbox"/> Emphysema                        |
| <input type="checkbox"/> Lymphangioleiomyomatosis                  | <input type="checkbox"/> Hantavirus                       |
| <input type="checkbox"/> Pneumonia                                 | <input type="checkbox"/> Legionellosis                    |
| <input type="checkbox"/> Primary Alveolar Hypoventilation Syndrome | <input type="checkbox"/> Pleurisy                         |
| <input type="checkbox"/> Pulmonary Fibrosis                        | <input type="checkbox"/> Pneumothorax                     |
| <input type="checkbox"/> Respiratory Syncytial Virus               | <input type="checkbox"/> Pulmonary Alveolar Proteinosis   |
| <input type="checkbox"/> Severe Acute Respiratory Syndrome         | <input type="checkbox"/> Pulmonary Embolus                |
|  | <input type="checkbox"/> Respiratory Distress Syndrome    |
|  | <input type="checkbox"/> Sarcoidosis                      |
|  | <input type="checkbox"/> Spontaneous Pneumothorax         |
|  | <input type="checkbox"/> Tuberculosis                     |
- |   |   |
|---|---|
| <input type="checkbox"/> Raynaud's Phenomenon       | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Sinus Infections (chronic) | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Wegener's Granulomatosis   | <input type="checkbox"/> Other _____        |



Family Cardio-pulmonary / Circulatory Health

Check if a physician has ever diagnosed your family with any of the following:

- Anemia (M, F, S, MG, PG)
- Hemophilia (M, F, S, MG, PG)
- Hypertension (high blood pressure) (M, F, S, MG, PG)
- Hemorrhoids (M, F, S, MG, PG)
- HIV/AIDS (M, F, S, MG, PG)
- Hepatitis (M, F, S, MG, PG)
- Hypotension (low blood pressure) (M, F, S, MG, PG)
- Lung Disorders (M, F, S, MG, PG)

<input type="checkbox"/> Acute Respiratory Distress Syndrome (M, F, S, MG, PG)	<input type="checkbox"/> Alpha-1 Antitrypsin Deficiency (M, F, S, MG, PG)
<input type="checkbox"/> Asthma (M, F, S, MG, PG)	<input type="checkbox"/> Asbestos/Dust Disease (M, F, S, MG, PG)
<input type="checkbox"/> Bronchitis (chronic) (M, F, S, MG, PG)	<input type="checkbox"/> Bronchiectasis (M, F, S, MG, PG)
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (M, F, S, MG, PG)	<input type="checkbox"/> Bronchopulmonary Dysplasia(BPD) (M, F, S, MG, PG)
<input type="checkbox"/> Farmer's Lung (M, F, S, MG, PG)	<input type="checkbox"/> Cystic Fibrosis (M, F, S, MG, PG)
<input type="checkbox"/> Histoplasmosis (M, F, S, MG, PG)	<input type="checkbox"/> Emphysema (M, F, S, MG, PG)
<input type="checkbox"/> Lymphangiomyomatosis (M, F, S, MG, PG)	<input type="checkbox"/> Hantavirus (M, F, S, MG, PG)
<input type="checkbox"/> Pneumonia (M, F, S, MG, PG)	<input type="checkbox"/> Legionellosis (M, F, S, MG, PG)
<input type="checkbox"/> Primary Alveolar Hypoventilation Syndrome (M, F, S, MG, PG)	<input type="checkbox"/> Pleurisy (M, F, S, MG, PG)
<input type="checkbox"/> Pulmonary Fibrosis (M, F, S, MG, PG)	<input type="checkbox"/> Pneumothorax (M, F, S, MG, PG)
<input type="checkbox"/> Respiratory Syncytial Virus (M, F, S, MG, PG)	<input type="checkbox"/> Pulmonary Alveolar Proteinosis (M, F, S, MG, PG)
<input type="checkbox"/> Severe Acute Respiratory Syndrome (M, F, S, MG, PG)	<input type="checkbox"/> Pulmonary Embolus (M, F, S, MG, PG)
<input type="checkbox"/> Tuberculosis (M, F, S, MG, PG)	<input type="checkbox"/> Respiratory Distress Syndrome (M, F, S, MG, PG)
	<input type="checkbox"/> Sarcoidosis (M, F, S, MG, PG)
	<input type="checkbox"/> Spontaneous Pneumothorax (M, F, S, MG, PG)

- Raynaud's Phenomenon (M, F, S, MG, PG)
- Sinus Infections (chronic) (M, F, S, MG, PG)
- Wegener's Granulomatosis (M, F, S, MG, PG)
- Sickle Cell Anemia (M, F, S, MG, PG)
- Stroke (M, F, S, MG, PG)
- Other \_\_\_\_\_ (M, F, S, MG, PG)

Family Members	
(M)	Mother
(F)	Father
(S)	Sibling
(MG)	Maternal Grandparent
(PG)	Paternal Grandparent

Endocrine, Gastrointestinal and Neurologic Health

Check if a physician has ever diagnosed you with any of the following:

Autoimmune Disorder

<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Churg-Strauss (Allergic Granulomatosis)
<input type="checkbox"/> Eosinophilic Fasciitis	<input type="checkbox"/> Dermatomyositis/Polymyositis
<input type="checkbox"/> Goodpasture's Syndrome	<input type="checkbox"/> Interstitial Granulomatous Dermatitis
<input type="checkbox"/> Lupus	<input type="checkbox"/> with Arthritis
<input type="checkbox"/> Lupus SLE	
<input type="checkbox"/> Lupus DLE	
<input type="checkbox"/> Lupus SCLE	
<input type="checkbox"/> Anti-Phospholipid Antibody Syndrome (Lupus Anticoagulant)	
<input type="checkbox"/> Mixed Connective Tissue Disease	<input type="checkbox"/> Relapsing Polychondritis
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Sarcoidosis
<input type="checkbox"/> Scleroderma	<input type="checkbox"/> Sjogren's Syndrome
<input type="checkbox"/> Skin Immunofluorescence	<input type="checkbox"/> Vasculitis

- |  |   |
|--|---|
| <input type="checkbox"/> Bladder Disease       | <input type="checkbox"/> Candida                        |
| <input type="checkbox"/> Chicken Pox           | <input type="checkbox"/> Chronic Fatigue Syndrome       |
| <input type="checkbox"/> Crohn's Disease       | <input type="checkbox"/> Diabetes                       |
| <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Fibromyalgia                   |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Headaches                      |
| <input type="checkbox"/> Cluster Headaches     | <input type="checkbox"/> Migraine Headaches             |
| <input type="checkbox"/> Sinus Headaches       | <input type="checkbox"/> Stress-induced Headaches       |
| <input type="checkbox"/> Tension Headaches     |   |
| <input type="checkbox"/> Incontinence          | <input type="checkbox"/> Irritable Bowel Syndrome (IBS) |
| <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Liver Disease                  |
| <input type="checkbox"/> Liver Problems        | <input type="checkbox"/> Measles                        |
| <input type="checkbox"/> Mumps                 | <input type="checkbox"/> Seizures                       |
| <input type="checkbox"/> Shingles              | <input type="checkbox"/> Stomach Ulcers                 |
| <input type="checkbox"/> Thyroid Dysfunction   | <input type="checkbox"/> Urinary Tract Infection        |
| <input type="checkbox"/> Other _____           |   |



Emotional and Mental Health

Check if a physician has ever diagnosed you with an emotional or mental condition.  Yes

- |  |   |
|--|---|
| <input type="checkbox"/> Anger Disorders                                   | <input type="checkbox"/> Anxiety Disorders                                    |
| <input type="checkbox"/> Asperger Syndrome                                 | <input type="checkbox"/> Attention Deficit Disorder with Hyperactivity (ADHD) |
| <input type="checkbox"/> Autistic Disorder                                 | <input type="checkbox"/> Avoidant Personality Disorder (AvPD)                 |
| <input type="checkbox"/> Bipolar Disorder                                  | <input type="checkbox"/> Borderline Personality Disorder                      |
| <input type="checkbox"/> Capgras Syndrome                                  | <input type="checkbox"/> Child Behavior Disorders                             |
| <input type="checkbox"/> Combat Disorders                                  | <input type="checkbox"/> Cyclothymic Disorder                                 |
| <input type="checkbox"/> Dependent Personality Disorder (DPD)              | <input type="checkbox"/> Depressive Disorders (depression)                    |
| <input type="checkbox"/> Dissociative Disorders                            | <input type="checkbox"/> Dysthymic Disorders (mood disorder)                  |
| <input type="checkbox"/> Eating Disorders                                  | <input type="checkbox"/> Firesetting Behavior                                 |
| <input type="checkbox"/> Hypochondriasis (Somatoform Disorder)             | <input type="checkbox"/> Impulse Control Disorders                            |
|  | <input type="checkbox"/> Kleine-Levin Syndrome                                |
| <input type="checkbox"/> Kleptomania                                       | <input type="checkbox"/> Multiple Personality Disorder                        |
| <input type="checkbox"/> Munchausen Syndrome                               | <input type="checkbox"/> Narcissistic Personality Disorder                    |
| <input type="checkbox"/> Narcolepsy  | <input type="checkbox"/> Obsessive Compulsive Disorder (OCD)                  |
| <input type="checkbox"/> Phobic Disorders (Phobias)                        | <input type="checkbox"/> Psychotic Disorders                                  |
| <input type="checkbox"/> Restless Legs Syndrome                            | <input type="checkbox"/> Schizophrenia  |
| <input type="checkbox"/> Seasonal Affective Disorder                       | <input type="checkbox"/> Sexual or Gender Disorders                           |
| <input type="checkbox"/> Sexual Dysfunctions (psychological, not physical) | <input type="checkbox"/> Sleep Disorders                                      |
|  | <input type="checkbox"/> Post-traumatic Stress Syndrome                       |
| <input type="checkbox"/> Substance Abuse                                   | <input type="checkbox"/> Suicidal Tendencies                                  |
| <input type="checkbox"/> Other _____                                       |   |



Sensory Health

Check if a physician has ever diagnosed you with any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Blindness            | <input type="checkbox"/> Cataract                  |
| <input type="checkbox"/> Cholesteatoma        | <input type="checkbox"/> Deafness or Hearing Loss  |
| <input type="checkbox"/> Ear ringing          | <input type="checkbox"/> Eczema                    |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Laryngitis (chronic)      |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Mumps                     |
| <input type="checkbox"/> Meniere's Disease    | <input type="checkbox"/> Nasal Polyps              |
| <input type="checkbox"/> Perforated Eardrum   | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Rhinitis             | <input type="checkbox"/> Sinusitis                 |
| <input type="checkbox"/> Tinnitus             | <input type="checkbox"/> Unusual Vision Impairment |
| <input type="checkbox"/> Vertigo              | <input type="checkbox"/> Other _____               |



Musculoskeletal Health

Check if a physician has ever diagnosed you with any of the following:

Arthritis

<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Behets Disease
<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Diffuse Idiopathic Skeletal Hyperostosis (DISH)
<input type="checkbox"/> Ehlers-Danlos Syndrome (EDS)	<input type="checkbox"/> Felty's Syndrome
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Infectious Arthritis
<input type="checkbox"/> Mixed Connective Tissue Disease (MCTD)	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Paget's Disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Polymyositis and Dermatomyositis	<input type="checkbox"/> Polymyalgia Rheumatica
<input type="checkbox"/> Reactive Arthritis	<input type="checkbox"/> Pseudogout
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Psoriatic Arthritis
<input type="checkbox"/> Sjogren's Syndrome	<input type="checkbox"/> Repetitive Stress Injury
	<input type="checkbox"/> Scleroderma
	<input type="checkbox"/> Stills Disease

Gout

Herniated Disk

Lyme Disease

Multiple Sclerosis

Muscular Dystrophy

Numbness or Tingling in feet

Numbness or Tingling in hands

Osteoporosis

Parkinson's Disease

Pinched Nerve

Polio

Rheumatism

Sciatica

Temporomandibular Joint Syndrome (TMJ)

Other \_\_\_\_\_



Mason Family Chiropractic  
 1414 Country Club Road, Suite 2  
 Fairmont, WV 26554  
 p 304.534.8493  
 f 304.534.8268  
 drmariemason.medicfusion.com

Reproductive Health

Check if you have ever given birth.  Yes

How many births vaginally? \_\_\_\_\_

How many births by C-section? \_\_\_\_\_

Check if a physician has ever diagnosed you with any of the following:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Chlamydia              | <input type="checkbox"/> Dysplasia                  | <input type="checkbox"/> Erectile Dysfunction               | <input type="checkbox"/> Genital Herpes       |
| <input type="checkbox"/> Gonorrhea              | <input type="checkbox"/> Human Papillomavirus (HPV) | <input type="checkbox"/> Impotency                          | <input type="checkbox"/> Syphilis             |
| <input type="checkbox"/> Infertility            | <input type="checkbox"/> Cystitis                   | <input type="checkbox"/> Menopause                          | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Testicular Dysfunction | <input type="checkbox"/> Uterine Fibroid            | <input type="checkbox"/> Vaginal Yeast Infections (chronic) | <input type="checkbox"/> Other _____          |







Mason Family Chiropractic  
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 Fairmont, WV 26554  
 p 304.534.8493  
 f 304.534.8268  
 drmarimason.medicfusion.com

Patient: \_\_\_\_\_

## New Case Questionnaire - Injury / Complaint Short Form

### CHIEF COMPLAINT

Your current concern(s):

- Headaches     Neck pain     Low back pain     Mid back pain     Shoulder pain  
 Elbow pain     Hip pain     Knee pain     Other

Other concern(s):

\_\_\_\_\_

When did your symptoms begin? If unknown please estimate:

\_\_\_\_\_

[Female Patients] Are you pregnant?     Yes     No

If yes, estimate your due date: \_\_\_\_\_    If no, date of most recent menstrual cycle: \_\_\_\_\_

Which word best describes the frequency of your symptoms:

- Occasional (0-25%)     Intermittent (26-50%)     Frequent (51-75%)     Constant (75-100%)

Which phrases best describe changes in your symptoms during the day? (select all that apply)

- Worse in the morning     Worse in the afternoon     Worse at night  
 Changes with the weather     Does not change

What helps to relieve your symptoms? (select all that apply)

- Ice     Heat     Medication     Physical therapy  
 Acupuncture     Massage     Nothing     Other

Other relief:

\_\_\_\_\_

What activities are limited by your symptoms? (select all that apply)

- Bending     Bowel movement     Coughing     Daily routine  
 Driving     Getting up     Lifting     Lying down  
 Pulling     Pushing     Reading     Sitting  
 Sleeping     Sneezing     Standing     Turning head  
 Urination     Walking     Working     Other

Other activities:

\_\_\_\_\_

Approximate date of your most recent Physical Exam:

\_\_\_\_\_

Approximate date of your most recent Spinal x-ray:

\_\_\_\_\_

Approximate date of your most recent MRI:

\_\_\_\_\_

Approximate date of your most recent CT scan:

\_\_\_\_\_

Approximate date of your most other scans:

\_\_\_\_\_

Approximate date of your most recent Dental x-rays:

\_\_\_\_\_

Other scans description:

\_\_\_\_\_

### PRIOR TREATMENT

Have you tried other medical treatments for this condition?  Yes  No

Specify treatment provider:

- Hospital or Urgent care   
  Medical Physician   
  Chiropractor   
  Massage Therapist  
 Physical Therapist   
  Acupuncturist   
  Other

Other treatment provider:

\_\_\_\_\_

Start date of prior treatment:

\_\_\_\_\_

End date of prior treatment:

\_\_\_\_\_

This office requires a copy of the medical report detailing your treatment:

- I will provide a copy   
  i will fax it  
 I will e-mail it   
  I authorize my former facility to release my records

### Physician Information:

Name of Physician:

\_\_\_\_\_

Name of facility:

\_\_\_\_\_

Address:

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

Zip

\_\_\_\_\_

Phone Number

\_\_\_\_\_

## ACCIDENT DETAILS

Are your symptoms a result of an accident?

- Yes  
 No

Date of accident? If unknown, please estimate;

\_\_\_\_\_

In what State did the accident happen?

\_\_\_\_\_

What type of accident did you have?

- Other

Other accident information

\_\_\_\_\_

Have you taken time of work as a result?

- Yes  
 No

Are you still off work?

- Yes  No

Beginning date

\_\_\_\_\_

Ending date

\_\_\_\_\_

Were you compensated for time lost from work?

- Yes  No

## ACCIDENT PARTIES

Is there an attorney handling your case?

- Yes  No

### Attorney information:

Attorney name:

\_\_\_\_\_

Firm name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City:

\_\_\_\_\_

State:

\_\_\_\_\_

Zip:

\_\_\_\_\_

Phone number:

\_\_\_\_\_

Fax number:

\_\_\_\_\_

Email address:

\_\_\_\_\_

Other financially involved party:

- Yes  No  Unknown

### Other financially involved party information:

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City:

\_\_\_\_\_

State:

\_\_\_\_\_

Zip:

\_\_\_\_\_

Phone number:

\_\_\_\_\_

Other insurance party:

Yes

No

Unknown

**Other insurance party information**

Contact name:

---

Company name:

---

Address:

---

City:

---

State:

---

Zip:

---

Phone number:

---

Fax number:

---

Email address:

---

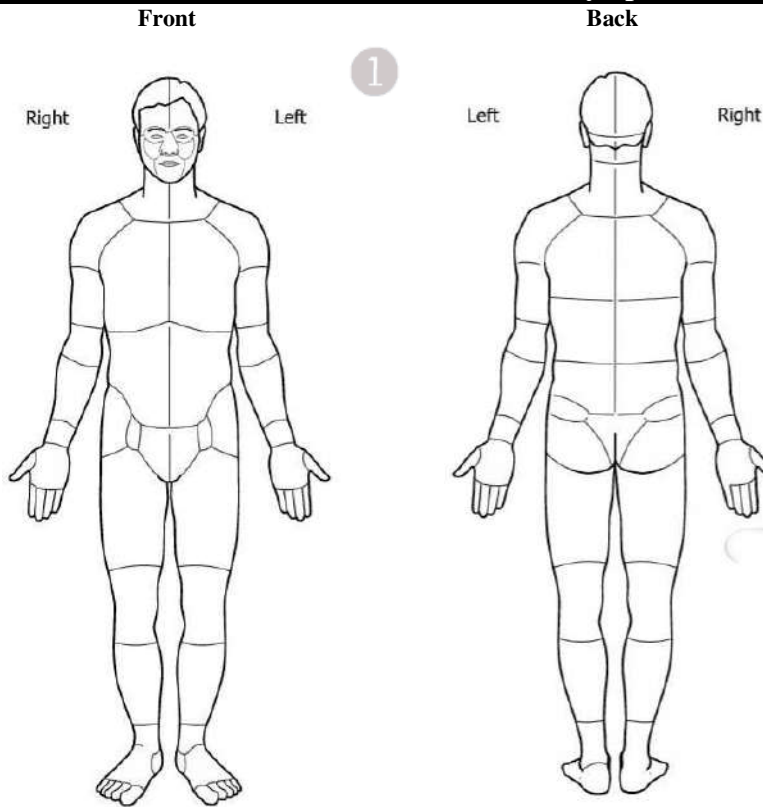
Claim number:

---

Patient: \_\_\_\_\_

## Patient Symptom Illustrator

### Patient Symptom Illustrator



Instructions:

- 1 Identify your areas of discomfort by marking the affected body parts in the illustration.
- 2 Indicate the area name along with your specific symptoms associated with each selected area.
- 3 Rate your discomfort associated with each selected area.

		Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness											
Ex.	L (R) Lower Back			X			X			X	0 = No Discomfort 10 = Severe Discomfort										
											0	1	2	3	4	5	6	X	8	9	10
1.	L R										0	1	2	3	4	5	6	7	8	9	10
2.	L R										0	1	2	3	4	5	6	7	8	9	10
3.	L R										0	1	2	3	4	5	6	7	8	9	10
4.	L R										0	1	2	3	4	5	6	7	8	9	10