Patient Health History

Today's Date _____ **Signature of Patient** _____

How did you hear about us? _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name**_____**Suffix** _____

Address _____

City_____ **State** _____ **Zip Code** _____

Primary Phone_____ **Mobile/Secondary Phone** _____

Email _____ *I authorize contacting me via email address.*

Contact Method: ❑ Primary Phone ❑ Secondary/Mobile Phone **SSN** _____

If unable to reach me: ❑leave detailed message ❑leave message asking me to return your call

Emergency Contact: Name_____ Phone Number _____
Relationship: ❑Spouse ❑Relative ❑Friend ❑Other _____

Date of Birth_____ **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified
Marital Status ❑ Single ❑ Married ❑ Other Spouse's Name _____

Spouse's Birth date for insurance: _____

I authorize ***Release of Information*** including diagnosis/treatment to:

❑spouse ❑ other _____ ❑ Information not to be released to anyone

Employment Status ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Business Name_____ Job Title_____

Business Address _____ Phone Number _____

Race *(check one)* ❑ White ❑ Black/African American ❑ Hispanic
❑ American Indian/Alaskan Native ❑ Asian ❑ Japanese ❑ Chinese ❑ Other _____

Multi-Racial ❑Yes ❑No ❑Unknown **Ethnicity** ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Unspecified

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ I choose not to specify ❑ other _____

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to question: _____ *Answer 6 characters minimum*

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker
❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

No interest ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 *Very Interested*

Current medications including frequency/dosage. If no current medications, check here: ❑

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

4) _____ **8)** _____

List known allergies you have had to any medications. If no allergies known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No

If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind?

❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?

❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray/CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

<u>PERFORMED BY STAFF</u>: **Height** _____ inches **Weight** _____ pounds **BP** _____/_____

Patient Name: _____ Date: _____

Current Health Conditon

Unwanted Condition (Why are you here today?):

_____

When did this condition BEGIN? _____/_____/_____

Has it occurred before? □ Yes □ No When?_____

Is the Condition:□ Auto related □ Job related □ Home injury
□ Slip/fall □ Lifting □ Slept wrong □ Unknown cause □ Other
Explain: _____

_____

Date of Accident: _____ Time of Accident: _____am/pm

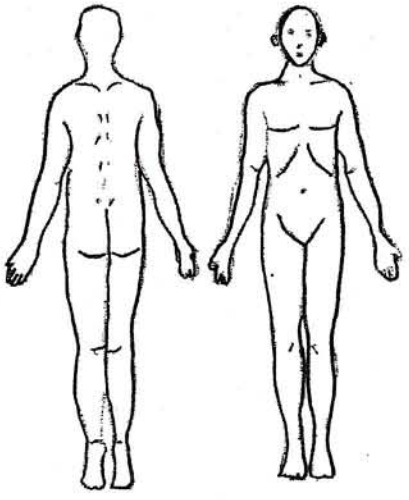
Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER condition that which you are now consulting us? _____

_____

Use the letters below to indicate the type and location of your sensations right now

Key: A=Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing



REVIEW OF SYMPTOMS – Below is a list of symptoms that may seem unrelated to the purpose of your visit; however, these questions must be answered carefully as the problems can affect your overall course of care. MARK ONLY THE SYMPTOMS OR PROBLEMS YOU ARE HAVING OR HAVE HAD.

Constitutional: □ chills □ fatigue □ night sweats □ weight loss/gain □ daytime drowsiness □ fever

Eyes/Vision: □ blindness □ blurred vision □ cataracts □ change in vision □ double vision □ tearing
□ eye pain □ field cuts □ glaucoma □ itching □ photophobia □ wear glasses/contacts

Ears, Nose and Throat: □ bleeding □ dentures □ difficulty swallowing □ discharge □ dizziness
□ ear drainage □ ear pain □ fainting □ frequent sore throats □ headaches □ hearing loss
□ history of head injury □ hoarseness □ loss of sense of smell □ nasal congestion □ sore throat
□ nosebleeds □ postnasal drip □ rhinorrhea (runny nose) □ sinus infections
□ snoring □ tinnitus (ringing in ears) □ TMJ problems

Respiration: □ asthma □ coughing up blood □ cough
□ sputum production □ wheezing □ shortness of breath

Cardiovascular: □ angina(chest pain/discomfort) □ high/low blood pressure □ shortness of breath □ chest pain
□ heart problems □ swelling of legs □ claudication (leg pain/ache) □ ulcers □ varicose veins
□ palpitations □ paroxysmal nocturnal dyspnea (walking at night w/shortness of breath) □ heart murmur

Gastrointestinal: □ abdominal pain □ diarrhea □ indigestion □ abnormal stool caliber □ vomiting blood
□ belching □ difficulty swallowing □ jaundice □ abnormal stool color □ black-tarry stools □ heartburn
□ nausea □ abnormal stool consistency □ constipation □ hemorrhoids □ rectal bleeding □ vomiting

Patient Name: _____ Date: _____

Female: □ birth control □ irregular menstruation □ vaginal bleeding □ vaginal discharge
□ breast lumps/pain □ frequent urination □ burning urination □ cramps
□ hormone therapy □ urine retention □ pregnancy

Male: □ burning urination □ frequent urination □ prostate problems
□ erectile dysfunction □ hesitancy/dribbling □ urine retention

Endocrine: □ cold/heat intolerance □ excessive hunger □ excessive appetite □ excessive thirst □ diabetes
□ abnormal frequency of urination □ goiter □ hair loss □ unusual hair growth □ voice changes

Skin: □ changes in nail texture/color □ hair growth/loss □ hives □ itching □ rash
□ paresthesias □ varicosities □ skin lesions/ulcers □ history of skin disorders

Nervous System: □ dizziness □ facial weakness □ headache □ limb weakness □ numbness
□ loss of consciousness □ seizures □ sleep disturbance □ unsteadiness of gait/loss of balance
□ loss of change in appetite □ loss of memory □ slurred speech □ strokes □ tremor

Psychologic: □ anhedonia □ anxiety □ loss of change in appetite □ behavioral change □ convulsions
□ bi-polar disorder □ confusion □ depression □ insomnia □ memory loss □ mood change

Allergy: □ anaphalaxis □ itching □ sneezing □ rash
□ food intolerance □ acute nasal congestion □ chronic nasal congestion

Hematologic: □ anemia □ blood clotting □ bruising easily □ lymph node swelling
□ bleeding □ blood transfusion □fatigue

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:_____
□ I have not previously seen a doctor for this condition OR Fill in the information BELOW:

Have you seen other doctors for THIS CONDITION? □ Yes □ No If yes, Who: (Name)_____
Type of Treatment: _____ Was treatment beneficial in resolving condition? □ Yes □ No
Explain:_____

Previous Chiropractic Care: □ I have not previously seen a Chiropractor OR Fill in the information below

Doctor's Name:_____ Location:_____ Date of Last Visit:_____

Current Medication(s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have You been taking this?

Patient Name: _____ Date: _____

Childhood Illness(es): List all health conditions. CIRCLE all CURRENT conditions:

- ☐ ADD
- ☐ atopic dermatitis (eczema)
- ☐ allergies/hayfever
- ☐ anemia
- ☐ asthma
- ☐ bedwetting
- ☐ cerebral palsy
- ☐ chicken pox
- ☐ crohn's/colitis
- ☐ depression
- ☐ diabetes
- ☐ ear infections
- ☐ fetal drug exposure
- ☐ food allergies (list below)
- ☐ headaches
- ☐ hepatitis
- ☐ HIV
- ☐ measles
- ☐ mumps
- ☐ psoriasis
- ☐ rash
- ☐ scoliosis
- ☐ seizure disorder
- ☐ sickle cell anemia
- ☐ spina bifida
- ☐ other:_____

Adult Illness(es): List all health conditions. CIRCLE all CURRENT conditions:

- ☐ ADD
- ☐ alzheimers
- ☐ anemia
- ☐ arthritis
- ☐ asthma
- ☐ cancer
- ☐ cerebral palsy
- ☐ chicken pox
- ☐ crohn's/colitis
- ☐ CRPS (RSD)
- ☐ CVA (stroke)
- ☐ cystic kidney disease
- ☐ depression
- ☐ diabetes (insulin dep)
- ☐ diabetes (non insulin)
- ☐ eczema
- ☐ emphysema
- ☐ eye problems
- ☐ fibromyalgia
- ☐ heart disease
- ☐ hepatitis
- ☐ HIV
- ☐ hypertension
- ☐ influenza pneumonia
- ☐ liver disease
- ☐ lung disease
- ☐ lupus erythemia (discoid)
- ☐ lupus erythemia (systemic)
- ☐ multiple sclerosis
- ☐ parkinson's disease
- ☐ unspecified pleural effusion
- ☐ HIV
- ☐ measles
- ☐ psychiatric problems
- ☐ scoliosis
- ☐ seizures
- ☐ shingles
- ☐ past history of similar symptoms
- ☐ STD's (unspecified)
- ☐ suicide attempt(s)
- ☐ thyroid problems
- ☐ vertigo
- ☐ other: _____

Surgery(ies): LISTAll Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- ☐ angioplasty
- ☐ appendectomy
- ☐ cesarian section
- ☐ cardiac catheterization
- ☐ carpal tunnel repair
- ☐ coronary artery bypass
- ☐ cosmetic
- ☐ D&C
- ☐ dental surgery
- ☐ gall bladder
- ☐ hemorrhoidectomy
- ☐ hernia repair
- ☐ hysterectomy
- ☐ joint reconstruction
- ☐ joint replacement
- ☐ knee repair
- ☐ laminectomy
- ☐ mastectomy
- ☐ pacemaker insertion
- ☐ rotator cuff
- ☐ spinal fusion
- ☐ tonsillectomy
- ☐ other:_____

Injury(ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- ☐ back injury
- ☐ broken bones
- ☐ disability(ies)
- ☐ fall (severe)
- ☐ fracture
- ☐ head injury (loss of consciousness)
- ☐ head injury (no loss of consciousness)
- ☐ industrial accident
- ☐ joint injury
- ☐ laceration (severe)
- ☐ motor vehicle collision
- ☐ soft tissue injury (mild)
- ☐ soft tissue injury (moderate)
- ☐ soft tissue injury (severe)
- ☐ other: _____

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

General family	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
Father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
Mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
Paternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
Paternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
Maternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
Maternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
Son(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
Daughter(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
Brother(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
Sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Print Patient's Name: _____ **Date**_____

Patient's Signature: _____ **Date** _____

Miklos Center for Health and Wellness, LLC
R. David Miklos, DC

4550 Liberty Ave., Suite 100
Vermilion, OH 44089
440-967-5545

5 S. Main St., Suite 306
Oberlin, OH 44074
440-775-0602

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of _____Miklos Center for Health and Wellness, LLC_____.

I understand that the Notice describes the uses and disclosures of my protected health information by_____Miklos Center for Health and Wellness, LLC_____ and informs me of my rights with respect to my protected health information.

_____ _____
Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____
Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____
Employee Name *Today's Date*

INFORMED CONSENT

PATIENT NAME _____

Miklos Center for Health and Wellness, LLC
Dr. R. David Miklos
Chiropractic Physician
4550 Liberty Avenue, Suite 100
Vermilion, Ohio 44089
440.967.5545

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.

- **The nature of the chiropractic adjustment.**
  I will 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 feel or sense movement.

- **The material risks inherent in chiropractic adjustment.**
  As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. 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.

- **The probability of those risks occurring.**
  Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

- **Ancillary treatment.**
  In addition to chiropractic adjustments, I intend to use the following treatments:

  _____

  _____

  These treatments involve the following additional significant risks:

  _____

  _____

- **The availability and nature of other treatment options.**
  Other treatment options for your condition include:

  - Self-administered, over-the-counter analgesics and rest
  - Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
  - Hospitalization with traction
  - Surgery

- **The material risks inherent in such options and the probability of such risks occurring include:**

- Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

- Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.

- Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

- The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

- **The risks and dangers attendant to remaining untreated.**
  Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

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

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. Miklos 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 myself 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 _____

_____
Printed Name

_____
Signature

WITNESSES

_____
Signature of Parent or Guardian (if a minor)

_____
Printed Name

_____
Signature

Miklos Center for Health and Wellness
Financial Policy

Thank you for choosing us as your Health Care Provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. The purpose of our financial policy is to keep HEALTH CARE COSTS DOWN. All patients must complete and sign our new patient forms and financial policy before seeing the doctor.

NUTRITION AND CASH PATIENTS

Payment in full is due at the time of service. New patient visit is $85.00, adjustment $45.00 or 4 visits for $160.00 (saving $20.00). Massages are $60.00 per hour or 2 for $100 (saving $20.00) plus tax, if applicable. Acupuncture is $50.00 per visit. Stop smoking acupuncture is $350 per month. The lab fee for nutrition blood work is $150.00 w/Vitamin D or $120.00 w/o Vitamin D. Follow up visits for nutrition are $57.50 up to $115.00, this does not include supplements. ALL sales are final. We accept cash, checks, Visa, MasterCard, or Discover. **We do not allow any returns on all supplements** as we are unable to control the temperature of these products once they leave the office.

INSURANCE

We may accept assignment of insurance benefits; however, we do require the initial visit to be paid at the completion of the first visit. We cannot bill your insurance unless you give us your current insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If you wish to have this office file your insurance claims for you, we will require you to pay the insurance policy deductible and the patient's percentage as stated in your policy. If you insurance company denies your claim, the balance will automatically be transferred to your patient account. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable by your insurance policy. Any personal balance 90 days or older will be assessed interest. Please see the paragraph titled INTEREST CHARGE. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the paragraph for cash patients.

USUAL AND CUSTOMARY FEES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ON THE JOB INJURY

Worker's compensation pays in full for chiropractic care. Upon being released from care, a 90 days time period is allowed for settlement of your claim. If settlement has not been reached within this period, or if you have suspended or terminated your care without your doctor's approval, payment for services is due immediately.

PERSONAL INJURY AND AUTO ACCIDENT INJURIES

Please present your auto insurance information upon arrival at your first visit. If an attorney is handling your case, please bring that information with you also. The insurance department must have this information to process your claims correctly. Although you are ultimately responsible for your bill, our office will wait for settlement. If you suspend or terminate care, any fees for services are due immediately. Upon being released from treatment, your account balance becomes your responsibility. If the account personal balance reaches an age of 90 days, an 18% annual interest rate will be added to the balance until paid in full.

MEDICARE

We do accept assignment from Medicare. After your deductible has been met for the year, Medicare will pay 80% of the visits they approve. The other 20% is due by the patient. Medicare does not cover office visits or therapy. Initial office visit is $85.00 and re-exam is $45. Therapy is $10.

MEDICARE SUPPLEMENTAL INSURANCE

This office does not process Medicare supplemental insurance. However, we will give you any information necessary to help you file these claims in a timely manner. Follow-up on supplemental insurance is the responsibility of the patient.

MISSED APPOINTMENTS & NSF CHARGES

All visits must be cancelled at least 24 hours in advance to avoid a "Failed To Show" charge of $50.00. Please help us serve you better by keeping your scheduled appointments. There will be a $30.00 charge for all checks returned for non-sufficient funds.

***PLEASE INITIAL*: _____**

INTEREST CHARGE: Any personal balance that is 90 days old will be assessed an interest charge of 18% annual rate.

I understand and agree that health and accident insurance policies are an agreement between my insurance company and myself, not between my insurance company and this office. I authorize Miklos Center for Health & Wellness to release any medical information and to complete any usual and customary reports and forms to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I have read, understand, and agree to this financial policy.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Staff Witness Date

Miklos Center
for Health & Wellness
Dr. R. David Miklos
Chiropractic Physician

4550 Liberty Ave
Suite 100
Vermilion, OH 44089
440-967-5545

Oberlin Chiropractic
5 S. Main St.,
Suite 306
Oberlin, OH 44074
440 775-0602

www.mikloscenter.com

Website Membership Enrollment

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:

First name: _____

Last name: _____

Date of birth: _____ / _____ / _____

Email address: _____

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Exercise and Fitness
- ❑ Diet and Nutrition
- ❑ Stress Management
- ❑ Wellness Topics
- ❑ Women's Health Issues

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:	
Chiropractor:	