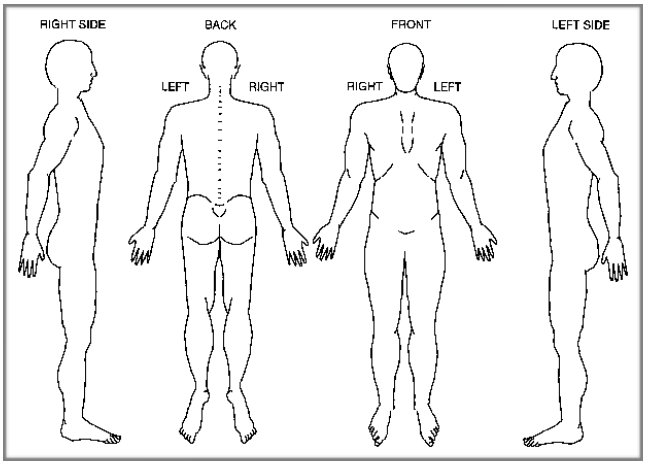
Mid-America Family Chiropractic, LLC
Mark Walters, D.C.

Health Questionnaire

Date: _____/_____/_____

First Name: _____ Last Name: _____ Middle Initial: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____ Gender: ☐ Male ☐ Female
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____ Marital Status: ☐ Single ☐ Married ☐ Other
Employer: _____ Occupation: _____
Emergency Contact: _____ Phone: _____ Relation: _____
How did you learn about this clinic? _____



Please mark your pain on the diagram

What is your current complaint?

_____

_____

When did your symptoms begin?

_____/_____/_____ _____

Please rate your current discomfort on a scale of 1-10
(1 being no symptoms, 10 being extreme)
1 2 3 4 5 6 7 8 9 10

Did it begin: ☐ Gradual ☐ Sudden ☐ Progressively **Does it radiate into your:** ☐ Arm ☐ Leg ☐ Does Not

How often do you experience your symptoms?
☐ Constantly (76-100%) ☐ Frequent (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

What describes the type of pain you're currently experiencing? (Mark all that apply)
☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Numbness ☐ Shooting ☐ Tightness ☐ Throbbing ☐ Tingling
☐ Other: _____

What activities make your symptoms worse? _____
What actives make your symptoms better? _____

Have you had any previous treatments for this condition? _____

Females: Are you pregnant? ☐ No ☐ Yes If yes how many weeks? _____

Goals for care:
☐ Relief: Symptomatic relief ☐ Corrective: Correct cause and symptoms ☐ Wellness: Highest state

Patient Signature:

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Social History				
Alcohol Use	☐ Never	☐ Occasional	☐ Daily	☐ Former
Coffee Use	☐ Never	☐ Occasional	☐ Daily	☐ Former
Tobacco Use	☐ Never	☐ Occasional	☐ Daily	☐ Former
Exercise	☐ Never	☐ Occasional	☐ Daily	

Have you had any major surgeries		
Type of Surgery	**Approximate Date(s)**	**Comments**

Are you currently taking any medications? (include regularly used over the counter medications)		
Medication Name	**Purpose (i.e. Blood Pressure)**	**Frequency & Dosage (i.e. 5 mg once a day)**

Review of Systems: Please select all that you currently have or have suffered from in the past

☐ Allergies	☐ Arm & Hand Pain	☐ Arthritis	☐ Cancer	☐ Depression
☐ Diabetes	☐ Digestive Issues	☐ Dizziness	☐ Fatigue	☐ Gallbladder Issues
☐ Gout	☐ Headaches/Migraines	☐ Hearing Loss	☐ Heart Problems	☐ Blood Pressure Issues
☐ Hip Pain	☐ Joint Swelling	☐ Knee Pain	☐ Kidney Issues	☐ Leg/Foot Pain
☐ Lower Back Pain	☐ Lung Issues	☐ Mid Back Pain	☐ Neck Pain	☐ Numbness
☐ Osteoporosis	☐ Osteopenia	☐ Ringing in Ears	☐ Scoliosis	☐ Shoulder Pain
☐ STD	☐ Stroke	☐ Urinary Problems	☐ Vision Issues	☐ Weakness
If you have other conditions not mentioned, please list them below:				

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Would you like us to file claims to your insurance company? ☐ Yes ☐ No

Insurance provider: _____ Policy #: _____ Group #: _____

Name as it appears on the card: _____ 1-800 #: _____

Insurance Agreement:

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

_____ _____

Patient Signature Date Guardian/Spouse Signature Date

Authorization for Care:

I hereby authorize the doctor to work with my condition through the use of adjustments to my spine as he/she seems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all the bills incurred at this office. The doctor will not be held responsible fore any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees from professional services rendered to me will become immediately due and payable. I nearby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

_____ _____

Patient Signature Date Guardian/Spouse Signature Date

Health Insurance Portability & Accountability Act (HIPPA) Consent:

(Describes how health related information about you may be used and disclosed, and how you can get access to this information)

In the course of you care as a patient at our office, we may use or disclose personal and health related information about you in the following ways 1.) Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. 2.) Your health records as well as your billing records may be disclosed to another party, such as an insurance carrier or your employer (if they are responsible for payment). 3.) Your name, address, phone number and your health records may be used to contact you regarding appointment reminders and a message may be left on your answering machine. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provides us with authorization, it will not affect the care provided to you. Under federal law we are also permitted to use or disclose your health information without your consent or authorization in the following circumstances..

- If we are providing health care services to you based on the orders of another healthcare provider.
- If we provide health care services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you but in our professional judgement we believe that you intend for us to provide care.

We normally provide information about your health care to you in personal at the time you receive chiropractic are from us. We may also mail information to you regarding your health care or about the status of your account. By signing below I acknowledge that I have read the above information and give full disclosure of my information.

_____ _____

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Patient Signature: