MADALIAN WELLNESS

Date_____ Birth Date_____ Age_____ Gender □**Male** □ **Female** SS#_____

Name_____ Address_____

City_____ State_____ Zip Code_____ Occupation_____

E-Mail _____ **Referred By**_____

Cell Phone_____ Home Phone_____ Children □YES □NO? If yes, please

list their name (s) _____Marital status: M S W D Spouse Name_____

Emergency Contact_____ Relationship _____Phone_____

Primary Care Provider_____ **Phone**_____

Are you insured? YES NO Insurance Company_____

Confidential Health History

Describe your present complaints: _____ **Date** your complaint began? _____

How did your complaint occur? □Fall □lifting □reaching □performing household chores□Chronic□Other_____

Have you had this condition in the past? □YES □NO when? _____

Is condition interfering with: □Employment □Homemaking □Lifting □Personal care □Traveling/Driving □Sitting □Sleeping □Social Life □Standing □Walking

How do symptoms affect daily activities? (0= no effect 10= severely affects activities) **0 ◊ 1 ◊ 2 ◊ 3 ◊ 4 ◊ 5 ◊ 6 ◊ 7 ◊ 8 ◊ 9 ◊ 1 0**

How often do your symptoms occur? □Constant 100% □Frequent 75% □Occasional 50% □Intermittent 25%

Type of Discomfort: □Sharp □Ache □Burn □Shooting □Tight/Stiff □Dull □Tingly □Numb □Acute □Chronic □Recurring

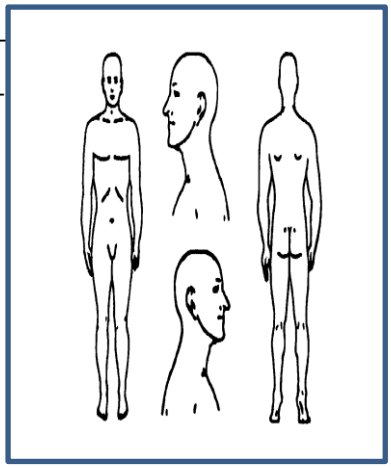
Does the Pain Radiate into □Arm □Hand □Leg □Foot □does not radiate □Other_____

How is your condition changing since onset date? □ Better □Same □Worse

Who treated you for this condition? _____ was anything prescribed to you? _____

Is this a work or car accident related injury? □YES □NO

Please mark off all areas of complaint on diagram



What activities aggravate your condition? _____

What alleviates your pain? _____

Check off if any of the following have happened to you:

□Spinal/neck injury□ falls □Surgeries □Broken bones/knocked unconscious

Please rate the intensity of your Pain from 0-10 (10 being extreme)

0 ◊◊ 1 ◊ ◊ 2 ◊ ◊ 3◊ ◊ 4 ◊ ◊ 5 ◊ ◊ 6 ◊ ◊ 7 ◊ ◊ 8 ◊ ◊ 9 ◊ ◊ 1 0

Height_____ Weight_____ Blood Pressure_____

Please check any of the following that apply to your current/past medical history:

- Allergy
- Asthma
- Ankle Pain
- Arm Pain
- Arthritis
- Asthma
- Back Pain/Stiffness
- Broken Bones
- Cancer
- Chest Pain
- Depression
- Diabetes
- Dizziness
- Elbow Pain
- Epilepsy
- Eye/Vision Problems
- Fainting
- Fatigue
- Foot Pain
- Genetic Spinal Condition
- Hand pain
- Headaches/ Migraines
- Hearing Problems
- Hepatitis
- High Blood Pressure
- Hip Pain
- HIV
- Jaw Pain
- Joint Stiffness
- Knee Pain
- Leg Pain
- Menstrual Problems
- Mid Back Pain
- Multiple Sclerosis
- Neck Pain/ Stiffness
- Nausea
- Neurological Problems
- Pacemaker
- Parkinson's
- Polio
- Prostate Problems
- Shoulder Pain
- Weight Change
- Spinal Cord Injury
- Sprain/ Strain
- Stroke
- Wrist Pain

List Any Surgeries (including dates):

- Back_____
- Neck_____
- Elbow_____
- Foot_____
- Hip_____
- Knee_____
- Wrist_____
- Shoulder_____
- Neurological_____
- Other_____
  _____

For Women Only:

- Premenstrual tension
- Excessive flow
- Tubal ligation
- Unable to get pregnant
- Menstrual cramps
- Hysterectomy
- Lumps in breast
- Irregular cycle
- Pregnant? YES NO

List your **Family History**: Family Member: **M**other, **F**ather, **S**ibling, and **G**randparent

___Arthritis ___Asthma ___Back Pain ___Cancer ___Depression ___Diabetes ___Epilepsy ___Genetic Spinal Condition

___High Blood Pressure ___Heart Problems ___Multiple Sclerosis ___Neurological Problems ___Parkinson's ___Polio

___Prostate Problems ___Stroke/Heart Attack Other: _____

Injuries you have had:	**Description(s)**	**Date(s)**
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____

Date of last physical examination: _____

Do you drink alcohol? □ No □Yes - How much per day? _____

Do you drink caffeine? □ No □Yes - How much per day? _____

Do you exercise? □ No □Yes (what forms and how often): _____

_____

Have you ever had chiropractic care? □ No □Yes

If yes, Where? _____

When? _____Why? _____

Were X-rays taken? □ No□Yes Do you have MRIs of your spine? □ No □Yes

When was your last adjustment? _____
Please list any specific things you liked or disliked about your past chiropractic experiences?
_____
_____
_____
_____

We are a total wellness center, are you interested in more information on any of the following:

□ **Active Release Technique**
-Gold Standard in soft tissue treatment

□ **Acupuncture**
-More than just pain relief

□ **Physical Therapy**
-ART full body certified

□ **Nutritional Testing**
-Blood testing for accuracy

□ **Laser Therapy (MLS)**
-Reduce inflammation & Speed recovery

□ **E-Pat**
-The wave of the future for injuries

Preferred method of communication for patient reminders □ Email □ Phone □Mail □Text

Preferred Language: _____

Smoking Status: □ Every Day Smoker □ Occasional Smoker □ Former Smoker □ Never Smoked

Centers for Medicare Services require providers to report both race and ethnicity.

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □Hispanic/Latino □ White (Caucasian)

□Native Hawaiian/Pacific Islander □ I Decline to Answer

Are you currently taking any medications? □ YES □ NO **If Yes please list them** (include regularly used over the counter medications) □ Pain Killers □ Muscle Relaxers □ Anti-inflammatory □ Cardiovascular □Insulin □ Birth control □Allergy □Anxiety

□Other:

_____

_____

Consent for Treatment/ Consent for Treatment of Minor

I, the undersigned, hereby grant the Providers and whomever they may designate as their assistant(s), to administer treatment as is necessary.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications or treatment and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based open the facts then known is in my best interest. I understand that results are not guaranteed.

Signature_____Date_____

I hereby authorize the Providers and whomever they may designate as their assistant(s) to administer treatment as he deems necessary to my son/daughter.

Patient's Guardian_____Date_____

Assignment of Benefits

◊I irrevocably assign to Dr. Henry Madalian all my rights and benefits under any insurance contacts for payment of services rendered to me by Dr. Henry Madalian. ◊ I authorize all information regarding my benefits under any insurance policy relating to any claims by Dr. Henry Madalian to be released to Dr. Henry Madalian. ◊ I authorize Dr. Henry Madalian to file insurance claims on my behalf for services rendered to me. ◊ I irrevocably direct that all insurance payments go directly to Dr. Henry Madalian. ◊ I authorize Dr. Henry Madalian to act on my behalf and report any suspected violations of proper claims practice to the proper regulatory authorities.

I understand that any insurance checks mailed directly to me must be endorsed and submitted to Dr. Madalian within 30 (thirty) days of the check date. Checks received after 30 (thirty) days are subject to interest, late and collection fees.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Madalian Chiropractic and Physical Therapy 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 Madalian Chiropractic and Physical Therapy will be charged to my account on the receipt. However, I clearly understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. If I fail to make payment, any necessary collection fees will be charged to my account balance

This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Patient Signature _____Date _____

Privacy Policy

I understand & agree to allow Madalian Chiropractic & Physical Therapy office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for you at the office per your request before signing this consent. If there is anyone you do not want to receive your medical records please inform our office

Patient Signature _____Date _____

Cancelation Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full" appointment book. **If an appointment is not cancelled at least 24 hours in advance you may be charged a twenty-five ($25) fee; this will not be covered by your insurance company.**

Patient Signature _____Date _____