MOUNTAIN VIEW CHIROPRACTIC & WELLNESS CENTER

Patient Identification

Name		Date of Birth	Social Security Number (if going through insurance)
Mailing Address		City, State Zip	
Cell Phone	Home Phone	Work Phone	Email
Emergency Contact Name	Emergency Contact Phone		Patient's Occupation
Name of Parent (if minor)		Referred By	

Current Condition

Describe your current problem, what seemed to be the initial cause, and what daily activities it affects:

_____

_____

How long have you had this condition?_____ Is it getting worse? ☐Yes ☐No

Are you under the care of a physician? ☐Yes ☐No If yes, for what reason?_____

Are you pregnant? ☐Yes ☐No If yes, due date?_____

Health History

Have you seen a chiropractor or acupuncturist before? ☐Yes ☐No If yes, how long ago?_____

For what reason?_____

Have you been hospitalized in the last 5 years? ☐Yes ☐No If yes, for what reason?_____

Have you been diagnosed with any mental or emotional disorders? ☐Yes ☐No If yes, when?_____

Have you ever:			If yes, briefly explain:
Had a broken bone?	☐Yes	☐No	_____
Had a surgery?	☐Yes	☐No	_____
Had strains or sprains?	☐Yes	☐No	_____
Used a cane, crutch or other support?	☐Yes	☐No	_____
Been struck unconscious?	☐Yes	☐No	_____

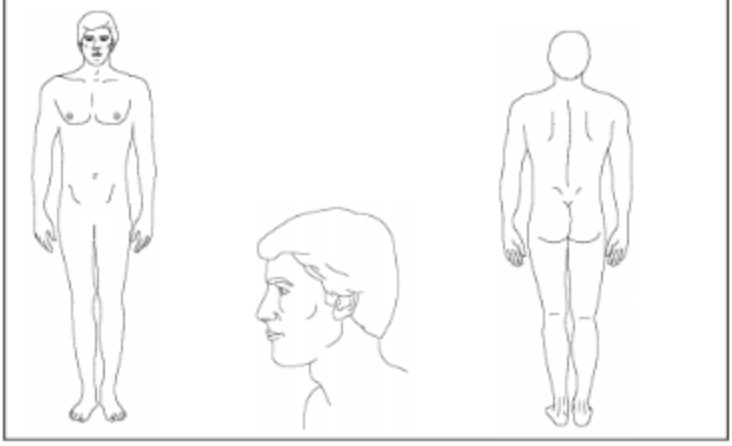
Do you:			
Take medications or supplements?	☐Yes	☐No	_____
Think you need supplements?	☐Yes	☐No	_____
Have a drug allergy?	☐Yes	☐No	_____
Have an implanted device?	☐Yes	☐No	_____

When did you last have:	Never	0-6 mos	6-18 mos	Longer
Spinal x-ray?	☐	☐	☐	☐
Spinal examination?	☐	☐	☐	☐
Physical examination?	☐	☐	☐	☐

Patient Name:_____ Date:_____

Habits	None	Light	Mod	Heavy
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Water	☐	☐	☐	☐

Please mark your areas of pain on the figures below



Please check the conditions you currently have or have had.

- ❑ Alcoholism
- ❑ Allergy
- ❑ Anemia
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma
- ❑ Back pain
- ❑ Bronchitis
- ❑ Bruise easily
- ❑ Cancer
- ❑ Chest pain
- ❑ Cold extremities
- ❑ Constipation
- ❑ Cramps
- ❑ Depression
- ❑ Diabetes
- ❑ Difficult digestion
- ❑ Dizziness
- ❑ Ears ringing
- ❑ Excess menstrual flow
- ❑ Eye pain
- ❑ Fatigue
- ❑ Frequent urination
- ❑ Headache
- ❑ High blood pressure
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Irregular heartbeat
- ❑ Kidney infection
- ❑ Kidney stones
- ❑ Loss of balance
- ❑ Loss of memory
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Lumps in breast
- ❑ Neck pain, stiffness
- ❑ Nervousness
- ❑ Pacemaker
- ❑ Poor posture
- ❑ Prostate trouble
- ❑ Sciatica
- ❑ Shortness of breath
- ❑ Sinus infection
- ❑ Sleep problems
- ❑ Spinal curvature
- ❑ Stroke
- ❑ Swelling of ankles
- ❑ Swollen joints
- ❑ Thyroid condition
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Varicose veins
- ❑ Other:_____ _____

Family History

Some health conditions are hereditary. Please list information about your immediate family members.

Relationship	Present and past health problems

Patient Confirmation

I confirm that the information on pages 1 and 2 is current and accurate and that it is my responsibility to update it with Mountain View Chiropractic and Wellness Center as it changes.

_____ _____

Patient/Personal Representative/Guardian Signature Date

MOUNTAIN VIEW CHIROPRACTIC & WELLNESS CENTER

Patient Name:_____

Informed Consent and Acknowledgement of Privacy Rights

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat, ice application, traction, laser, x-ray, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however complications may arise including but not limited to sprains, fractures, disc and arterial injuries (estimate 1 per 2 million adjustments).

Acupuncture includes needling, electro-acupuncture, cupping, moxabustion and other specialized treatments.

Massage includes various styles of therapeutic massage (hot stone, cupping, deep tissue, etc.).

For purposes of this consent, "protected health information" means any information, including my demographic information, created or received by Mountain View Chiropractic and Wellness Center (MVC) that relates to my past, present, or future physical or mental health condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of MVC, but that MVC is not required to agree to these restrictions. However, if MVC agrees to restriction(s) that I request, the restriction(s) is/are binding on MVC.

I understand I have a right to review MVC Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent in writing at any time, except to the extent that MVC has acted in reliance of this consent.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself, or unless law requires it. I understand that I may look at my record and can request a copy by paying the appropriate fee. I understand my medical record will be kept no more than 10 years after the date of my last treatment.

I give consent to the examination and therapeutic treatment procedures as necessary to facilitate my diagnosis and treatment. I do not expect MVC to be able to anticipate and explain all risks and complications, but based on the facts known, I rely on MVC's judgement during the procedures, which they feel are in my current best interest.

I disclose and give consent to MVC to use my Protected Health Information for the purposes of providing treatment to me, for the purposes relating to the payment of services rendered to me, and for MVC's general healthcare operations purposes.

_____ _____

Patient/Personal Representative/Guardian Signature Date

_____

Description of Personal Representative (if applicable)

Patient Name:_____ Date:_____

Financial Policy

1. Once insurance benefits have been verified, all payments are due at the time of service, unless special arrangements have been agreed upon prior to the visit.
2. We will bill your insurance company for you. We will do our best to provide sufficient information to your carrier to obtain payment for your treatment. In some instances, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that treatment is not covered for any reason, you are ultimately responsible for full payment.
3. If you have a credit balance, we will reimburse you after all visits have processed through your insurance.
4. Supplements, vitamins, lab tests, equipment, and other supplies must be paid for at the time they are received.
5. All workers' compensation cases and personal injury or auto accident claims will be billed to the insurance company, provided the appropriate paperwork has been completed and a claim opened. If your claim is denied, you are responsible for full payment.
   a. We will process third party claims if you have an attorney or pay a lien filing fee to ensure we receive payment.
   b. If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a wellness account and all fees are due at the time of service.
6. If you suspend or terminate your care or treatment, any and all unpaid balance after 60 days will be charged a 1% fee per month or 12% fee per year in interest.

Late Cancellation Fee Policy

Your appointment is reserved for you. In order to offer timely and optimal care for all our patients, we require 24 hours notice for cancellation of visits. In the case of massage and acupuncture appointments, you will be charged a $40 fee for any cancellations without 24 hours notice (including the same day). As a courtesy, we will attempt to give reminder calls for massage and acupuncture appointments, but it is ultimately your responsibility to know when your scheduled appointment is.

I have read and understand the above clinic financial and fee policies.

_____ _____

Patient/Personal Representative/Guardian Signature Date

Cupping Disclosure (Optional)

The most common misunderstanding regarding the after-effects of cupping is the potential marks that result. Where there are dead, static blood, lymph, cellular debris, pathogenic factors, and toxins present in the body; cupping can leave marks which indicate that the stagnation or disease has been moved from the deeper tissue layers to the surface, allowing fresh, oxygenated blood to nourish and heal the underlying areas. The color and pattern of the marks depend on the level of stagnation in the area, and range from a bright red to dark purple, usually lasting anywhere from 1 to 14 days - sometimes longer if the person is in a state of chronic congestion or leads a sedentary lifestyle.

I have been informed about cupping and its potential marking side effects. Mountain View Chiropractic and Wellness Center has educated me as to how cupping is beneficial in the detoxification of tissue and that cupping is an accelerated healing process. Depending on the integrity of my Lymphatic System and underlying tissue, I understand that the marks that may result from cupping are temporary and may take 1-14 days to resolve. I do not hold MVC responsible for any esthetic issues the marks may cause.

_____ _____

Patient/Personal Representative/Guardian Signature Date

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____