

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Major Complaint - What brings you to the office, Mondragon Chiropractic?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you last see a chiropractor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­Prior Chiropractic Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How long have you had this condition?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did the condition begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had this similar condition before? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to **Mineral Oil** (topical)? \_\_\_\_\_yes \_\_\_\_\_\_no

**Have you ever lost consciousness? \_\_\_\_\_yes \_\_\_\_\_no**

**If yes please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Keep Going Until You Reach the ClipBoard!!!**

**Medical History**

PAST (P) OR PRESENT (X) CONDITIONS

**A**

\_\_ Fractured Bones

\_\_\_ Auto Accidents

\_\_\_ 0-1 years ago

\_\_\_ 1-5 years ago

\_\_\_ More than 5 yrs

\_\_\_ Accidents/ Falls

\_\_\_ Knocked Unconscious

\_\_\_ Back curvature

\_\_\_ **Arthritis**

\_\_\_ Diabetes

\_\_\_ Painful Joints

\_\_\_ Convulsions/Epilepsy

\_\_\_ Skin Problems

\_\_\_ Itching

\_\_\_ Bruise easily

\_\_\_ **Cancer**

\_\_\_ Frequent Colds/Flu

B

\_\_\_ Nervous

\_\_\_ Tension

\_\_\_ Depressed

\_\_\_ Irritable

\_\_\_ Anemia

\_\_\_ Excess Sweating

\_\_\_ Tremors

\_\_\_ Light Bothers Eyes

\_\_\_ Allergy

\_\_\_ Sinus Problems

\_\_\_ Dizzy upon rising

\_\_\_ Under Stress

\_\_\_ Crave sweets or salt

\_\_\_ Eating disorders

C

\_\_\_ Trouble Sleeping

\_\_\_ Trouble concentrating

\_\_\_ Loss of Memory

\_\_\_ Learning disability

\_\_\_ Mistake sidedness (L from R)

\_\_\_ Stutter

\_\_\_ Dyslexia

\_\_\_ Mood Changes

\_\_\_ Lose temper easily

D

\_\_\_ Headache

\_\_\_ Neck pain R L

\_\_\_ Numbness, tingling, in arms, hands, fingers R L

\_\_\_ Jaw pain or click R L

\_\_\_ Head seems too heavy

\_\_\_ Head & Shoulders Feel Tired

\_\_\_ Difficulty in excessive

Standing, Walking, Sitting, Riding, Bending, Lifting

\_\_\_ Shoulder pain R L

\_\_\_ Dizziness

\_\_\_ Loss of Hearing

\_\_\_ Ringing in ears

\_\_\_ Fainting

\_\_\_ Loss of balance

\_\_\_ Blurred or double vision R L

\_\_\_ Upper back pain

\_\_\_ Mid back pain

\_\_\_ Low back pain

\_\_\_ Numbness, tingling, pain in buttocks, Thighs, legs, feet, toes R L

\_\_\_ Pain with cough, sneeze or strain at stools

\_\_\_ Hip pain R L

E

\_\_\_ Chest pain

\_\_\_ Asthma

\_\_\_ Lung problems

\_\_\_ Difficulty breathing

\_\_\_ Wheezing

\_\_\_ Heart problems

\_\_\_ Stroke

\_\_\_ High or low Blood pressure

\_\_\_ Varicose Veins

\_\_\_ Liver trouble

\_\_\_ Gall bladder trouble

F

\_\_\_ Digestive problems

\_\_\_ Excessive gas

\_\_\_Belching/bloating

\_\_\_Heartburn

\_\_\_Ulcers

\_\_\_Diarrhea/Constipation

G

\_\_\_Kidney Trouble

\_\_\_Kidney Stones

\_\_\_Frequent Urination

\_\_\_Painful Urination

problems/PMS

\_\_\_Menopausal Problems

\_\_\_Breast Lumps, Soreness, Discharge

\_\_\_Pregnant (now)

\_\_\_Hormonal Birth Control

\_\_\_Bedwetting

\_\_\_Ear Infections

\_\_\_Hepatitis

\_\_\_Venereal Disease

\_\_\_AIDS/ARC

\_\_\_Blood Clotting disorder

\_\_\_\_Thrombus

**What surgeries have you had?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List drugs you now take (prescription and non-prescription)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RENDERED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE. Thank you.**

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

Physician Use Only:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BP\_\_\_\_\_\_\_

Pulse\_\_\_\_\_

Orientation\_\_\_\_\_\_\_

Informed Consent to Care

**I**nformed consent involves your understanding and agreement regarding the care that is recommended, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. Dr. Brenda Mondragon may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Please inform the physician if you feel uncomfortable at any moment.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. 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 hot or cold therapies, fractures, disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. It has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in 1 in 1 million to 1 in 2 million cervical adjustments. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care at **Mondragon Chiropractic** as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

# ****Patient Health Information Consent Form****

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own 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. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Signature Date

Please list the name(s) of any person(s) that you authorize **Mondragon Chiropractic** to: release health records to, schedule appointments, and discuss any financial obligations:(Example: husband, wife, mother, father…etc.