



PATIENT INFORMATION - PLEASE PRINT

GENERAL INFORMATION

Patient Last Name _____ First Name _____
Address _____ Care of _____
City _____ State _____ Zip Code _____ (Parent or financially responsible person)
Phone _____ Email Address _____

| | | | | |
|------------|---------------------------------|-----|----------------------|------------|
| Sex M F | Married Single Widowed Divorced | Age | Date of Birth / / | # Children |
|------------|---------------------------------|-----|----------------------|------------|

Occupation _____
Employer's Name _____
Address _____
City _____ State _____ Zip Code _____

Spouse's Name _____ Spouse's Employer _____
Spouses Birth of Date _____

| |
|----------------------|
| EMPLOYED |
| Full Time Part Time |
| Retired Not Employed |
| STUDENT |
| Full Time Part Time |
| Non-Student |

EMERGENCY CONTACT Check here if spouse is emergency contact

Name _____ Phone Number _____
Relationship _____

REFERRED BY: _____

INSURANCE INFORMATION

| | |
|---------------------------------------|--|
| Primary Insurance Company Name _____ | <i>Complete only if patient is not the insured</i> |
| Insured's Name _____ | Patient's Relationship to Insured _____ |
| ID/Membership # _____ | Insured's Date of Birth _____ |
| Policy/Group # _____ | Insured's Employer _____ |
| Provider Customer Service Phone _____ | |

Are you seeing the Doctor today due to a:

(If yes, please inform front desk)

Work-Related Injury? Yes No Date of Injury _____
Auto Accident? Yes No Date of Injury _____

FEMALES ONLY

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period _____

Signature _____ Date _____

Our mission at Munn Chiropractic is to help as many people as possible to regain and maintain their health through chiropractic care in Aurora. We are passionate believers that "the power that made the body heals the body", and that when given the proper environment and care- through balancing structure and neurology with function and nutrition, the body will heal on its own as God created it to. We are a family-based chiropractic practice and love to help people of all ages- from their first breath to their last. We desire to see people in his community living healthier, more abundant lives. We're excited to serve, educate, empower, love, and positively impact the lives of those in our community and beyond.

PATIENT HISTORY/EXAMINATION FORM

Complete ALL questions below

1. What are your **major complaint(s)/illnesses**? _____

2. What are your **minor complaint(s)/illnesses**? _____

3. How **long** have you been experiencing your major complaint? Days Weeks Months Years

Mechanism of Injury

4. What was the **cause** of your major complaint that brought you into the office today (how did it happen)?

5. **When** did you first experience your major complaint? _____

6. What have you done **prior** to coming to this office to treat your major and minor complaints?

7. When do you **notice** your complaint or complaints the most? AM PM BOTH

8. How long does it last? _____ Minutes _____ Hours

9. What makes it feel **worse**? Sitting Standing Lying Activity Other _____

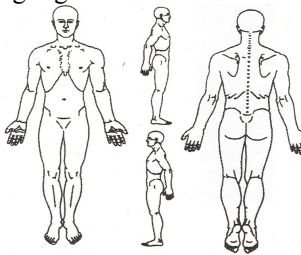
10. What makes it feel **better**? Sitting Standing Lying Activity Drugs Other _____

11. What best describes the character and quality of your major illness or pain?

A: ache B: burning pain T: tingling N: numbness S: sharp K: cramping D: dull pain

12. Have you ever had this problem in the past? Yes No

13. On the diagram below, please **show** where you are experiencing all of your present complaints using the following letters: A: ache B: burning pain T: tingling N: numbness S: sharp K: cramping D: dull pain



14. On the scale below, please **circle** the **severity and intensity** of your **main complaint** (at its' worst):

| None | Slight | Mild | Moderate | Severe | | | | | |
|------|--------|------|----------|--------|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

15. On the scale below, please **circle** the **percentage of time** you experience your **main complaint**:

| Occasional | Intermittent | Frequent | Constant | | | | | | |
|------------|--------------|----------|----------|-----|-----|-----|-----|-----|------|
| 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |

16. Does your pain radiate? _____ Y _____ N Where does it radiate to? _____

Signature _____ Date _____

PATIENT HISTORY

Please check (x) all present and past symptoms

HEAD:

- Headache
 - Sinus
 - Entire Head
 - Back of Head
 - Forehead
 - Temples
 - Migraine
- Loss of memory
- Light-headed
- Fainting
- Light bothers eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of balance
- Loss of taste
- Loss of hearing
- Dizziness
- Pain in ears
- Ringing or noises in ears

NECK:

- Pain in neck
 - Sharp
 - Dull
 - Ache
- Neck pain in movement
 - Forward
 - Backward
 - Turning (L) (R)
 - Bending (L) (R)
- Pinched nerve in neck
- Neck Feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck

SHOULDERS:

- Pain in joint (L) (R)
- Pain across shoulders
- Arthritis (L) (R)
- Can't raise arm
 - Above shoulder level
 - Over head
- Tension in shoulders
- Pinched nerve in shoulder (L) (R)
- Muscle spasms in shoulder

ARMS AND HANDS:

- Pain in arm
- Tennis elbow
- Pain in hands/fingers (L) (R)
- Pins and needles sensation (L) (R)
- Numbness (L) (R)
- Hands cold
- Loss of grip strength
- Sore/swollen joints in fingers

MIDBACK:

- Mid-back pain
- Pain between shoulder blades
- Sharp stabbing
- Dull ache
- Muscle spasms

CHEST:

- Chest pain
- Shortness of breath
- Rib pain
- Breast pain
- Irregular heartbeat

ABDOMEN:

- Nervous stomach
- Foods can't eat
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:

- Lower back pain
 - Sharp
 - Dull
 - Ache
- Location: _____
 - Upper lumbar
 - Lower lumbar
 - Hip
- Low back pain is worse when
 - Working
 - Lifting
 - Stooping
 - Standing
 - Sitting
 - Bending
 - Coughing
 - Lying down
 - Walking
- Pain relieved when
 - Slipped disc
- Low back feels out of place
- Muscle spasms

HIPS, LEGS, & FEET:

- Pain in buttocks (L) (R)
- Pain in hip joint (L) (R)
- Pain down leg (L) (R)
- Knee pain (L) (R)
 - Outside
 - Inside
- Leg cramps
- Feet cramps
- Pins and needles in legs
- Numbness in legs/feet
- Swelling in legs/feet

WOMEN ONLY:

- Menstrual pain
- Cramping
- Irregularity
- Cycle Days _____
- Birth Control _____ type
- Hysterectomy
- Tumors/Cancer
- Discharge
- Menopause
- Abortions
- Are you pregnant

MEN ONLY:

- Urinary frequency
- Difficulty urination
- Night urination
- Prostate swelling

GENERAL:

- Nervousness
- Irritable
- Depressed
- Fatigue
- Run-down feeling
- Hyperactivity
- Restlessness
- Normal sleep _____ hrs
- Loss of sleep
- Loss of weight _____ lbs
- Weight gain _____ lbs
- Coffee _____ cups/day
- Soda _____ cups/day
- Tea _____ cups/day
- Cigarettes _____ pack/day
- Diabetes
- Hypoglycemia
- High blood pressure
- Heart Disease
- Stroke
- High Cholesterol
- Cancer

OTHER:

MEDICATIONS:

INFORMED CONSENT FOR TREATMENT

Physicians and other health care providers are required to obtain your informed consent before starting treatment.

I _____ do hereby give my consent to the performance of chiropractic treatment that may consist of manipulations/adjustments, physical medicine, exercises and traction. I understand that the manipulations/adjustments will involve movement of the joints and soft tissues that is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems.

I am aware that there are possible risks/complications associated with my treatment. Tests have been performed to minimize these risks. I freely assume the risks of treatment after having been informed of the possible risks/complications associated with my treatment as follows:

- Soreness: It is common to experience muscle soreness during treatment
- Uncomfortableness: Temporary symptoms (dizziness, nausea) can occur, but are rare.
- Fractures/Joint Injury: Underlying physical defects, deformities or pathologies (osteoporosis) may cause susceptibility to injury.
- C.V.A.: Cerebral vascular accidents from chiropractic adjustments are extremely rare.

Treatment Results

I understand there are benefits associated with treatment including decreased pain, improved mobility and function and reduced muscle spasms. However, I also understand there is no guarantee that I will achieve these benefits during my care, as the practice of medicine, including chiropractic, is not an exact science.

Alternative Treatment Available

Reasonable alternatives to treatment have been explained to me including rest, home therapy, exercises medication and possible surgery.

I agree to treatment by my doctor and such persons of the doctor's choosing, and hereby provide my informed consent for treatment.

I HAVE READ OR HAVE HAD READ TO ME THE ABOVE EXPLANATION OF CHIROPRACTIC TREATMENT. ANY QUESTIONS REGARDING TREATMENT HAVE BEEN ANSWERED TO MY SATISFACTION.

AUTHORIZATION

Additionally this office may use your name, address and/or telephone number for the purposes of contacting you to remind you about scheduled appointments, reevaluations, other appointment issues, newsletters, flyers, birthday cards, thank you cards, health related meetings, and/or Advanced talks/classes. During the course of your care with Munn Chiropractic it may be the desire of our office to request the use of your name for our referral/thank you board(s) and/or to obtain a patient testimonial or patient photo for the purpose of promoting chiropractic.

This authorization may be revoked by you, the patient, at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Your signature indicates your authorization and consent of the above described.

Printed Name _____

Signature _____ Date _____

PATIENT PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Munn Chiropractic we may use or disclose personal and health related information about you in the following ways:

- 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.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- 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 communicating with you, but in our professional judgment we believe you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of activities you should direct your complaint to the Privacy Officer, Tyler Munn, D.C. at 14 New Hudson Rd Ste. D, Aurora, OH 44202, (216) 509-14498. If you would like further information about our privacy policies and practices please contact: Tyler Munn, D.C.

This office utilizes an "open treatment" environment for ongoing patient care. "Open treatment" involves the possibility of other patients being seen in the same "treatment environment" at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within hearing of other patients and staff. A private, closed and confidential setting is provided for history taking, examinations, report of findings, etc. as determined by the doctor or staff. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted or use traction in an "open treatment" environment other arrangements will be made for you. This office also requests the presence of your spouse or significant other at your Doctor's Report Appointment for purposes of health education.

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Printed Name _____

Signature _____ Date _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion and disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature _____ Date _____

POLICIES

1. All first visit charges are payable when services are rendered.

2. The fee paid for treatment x-rays is for analysis only. X-rays are the property of this office and are used for treatment purposes. A copy of your x-rays may be requested today for only \$20. A copy of your x-rays requested after today can be obtained for only \$50.

Furthermore, I understand Munn Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Munn Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered me are charged directly to me and that I am responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. If an account balance remains unpaid for three months or longer, a monthly interest fee of 2% will apply to account balance. I authorize Munn Chiropractic to obtain a credit report if deemed necessary.

Please Note:

This will be our only notice to you. Due to our efforts to keep costs down and control our outstanding accounts, all accounts over 30 days past due are subject to collection agency procedures and additional costs.

Printed Name _____

Signature _____ Date _____

Parent/Guardian _____ Date _____



There is a proverb which states: ***"When you have your health you have 1,000 dreams, ad when you don't, you have one."***

This is the most profound concept because it is so true.

Health is our greatest asset because we can never reach our goals in life without it! Our purpose is to help you restore your health to ensure your goals and dreams have opportunity to become reality. We'd like to know what that looks like for you.

**WHAT ARE YOUR LIFE GOALS AND WHERE DO YOU
SEE YOURSELF IN THE NEXT 10 TO 20 YEARS?**

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

Signature _____ Date _____