30 Philadelphia Drive Suite A
Chico, CA 95973
Work: (530)342-6441
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Demographics (PLEASE PRINT)

Today's Date: ______________________________

Name: ______________________________ Address: ______________________________

City: ______________________________ State: ____________ Zip: ______________________

Home Phone: ______________________________ Birth Date: ______________ Age: ________ Sex: M F

Cell Phone: ______________________________ Email Address: ______________________________

Cell Carrier for text reminders: ______________________ Social Security #: ______________________________

Circle **ALL** that apply: Married Single Widowed Divorced Employed Retired Homemaker Student

Referred to this office by: ____

Employment Information

Employer: ______________________ Job Title: ________________ City, State: ______________________

Name of Spouse: ______________ Spouse's Occupation: ________________ Employer: ______________________

Health Insurance **Name/Policy Number**____

Emergency Contact Information

Last Name: ______________________ First Name: ______________________ MI: ________________

Address: ______________________ City: ______________ State: _____ ZIP: ____________

Phone: ______________________ Relationship: ______________________________________

Is this visit related to worker's compensation? Y N
Is this visit related to any legal actions? Y N
Is this visit related to any sort of motor vehicle accident? Y N

Patient Condition Please Describe the Major Problem That Brings You in Today to See a Chiropractic Neurologist:
____
____
____
____

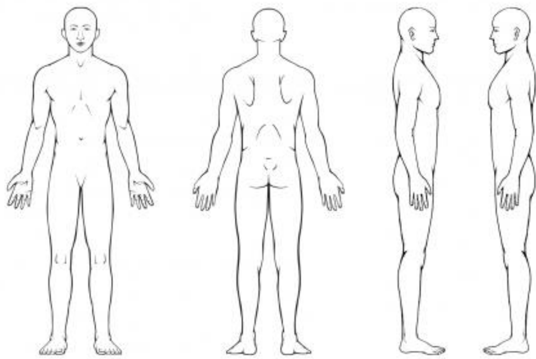
When did this condition begin**?**
____

Have you ever experienced a similar problem in the past? □ Y □ N When: ______________________________
How long has it been since your last medical/chiropractic evaluation? ______________________________
If you follow a specific diet, please describe: ____

Please circle if you have the pain or difficulty performing the following:

Bending	Extended computer use	Lifting children	Sexual activities
Carrying Groceries	Feeding	Pet care	Sleeping
Change position (sit-stand)	Household chores	Reading (concentration)	Static Sitting
Climbing stairs	Kneeling	Self-care (bathing)	Walking
Driving	Lifting	Self-care (dressing)	Yard work

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing? 0 = no pain and 10= the worst pain imaginable?

Please circle:

0 1 2 3 4 5 6 7 8 9 10

How are your symptoms changing?
Please circle:

Getting better Not changing Getting worse

Other: ______________________________

Family History Do you have a family member affected with: (please circle)

Condition	Relative	Condition	Relative

Alcoholism, Diabetes, Depression, Heart Disease, Hypertension, Migraines, Neuromuscular junction disease, Multiple Sclerosis, Neuropathy, Neurological Disorder, Osteoporosis, Parkinson's disease, Seizures or Epilepsy, Stroke, Thyroid Disease, Any Other Condition

Please list all medications and supplements you take routinely, prescribed or over-the-counter, along with the dosages:
____
____

Review of Symptoms Do you currently, or have you had a problem with (please circle):

Allergic / Immunologic:
Autoimmune disease (i.e. lupus)
Cancer
Food, Inhalant (nasal) allergies

Constitutional:
Excessive fatigue
Fever
History of falls
Weight loss >5 lbs.

Cardiovascular:
Chest pain or angina
Circulation problems
Heart Murmur
High blood pressure
High cholesterol
Irregular pulse
Low blood pressure
Pacemaker
Swelling in hands or feet

Ear, Nose, Throat & Mouth:
Balance (vertigo, spinning, etc.)
Ear pain/Infections
Hearing loss
Inability to smell
Nasal congestion/Drainage
Nose bleeds
Ringing in ears
Sinus problems
Wear hearing aid(s)

Endocrine:
Diabetes
Excessive thirst/urination
Thyroid disease

Eyes:
Cataracts
Glaucoma
Wear glasses/contacts

Gastrointestinal:
Abdominal pain
Blood in vomit
Change in bowel habits
Jaundice / liver disease
Nausea / vomiting
Ulcers or gastritis

Genitourinary:
Bladder control / incontinence
Blood in your urine
Difficult starting/stopping stream
Kidney stones
Painful urination
Urinary tract infections

Hematologic/Lymphatic:
Anemia
Blood transfusion
Fainting spells / blacking out
Hemophilia
Persistent swollen glands/lymph nodes

Musculoskeletal:
Arm or leg pain/weakness/numbness
Arthritis
Back pain
Broken bones
Joint pain or swelling
Neck pain
Padgett's disease
TMJ pain

Neurological:
Difficulty with balance
Difficulty with memory
Difficulty with speech
Disorientation
Double or blurred vision
Fainting spells / black outs
Headaches / migraines
Inability to concentrate
Loss of sensation
Seizures
Stroke
Weakness in arms or legs

Psychiatric:
Anxiety / Depression
Panic Attacks

Respiratory:
Asthma
Emphysema / lung disease
Shortness of Breath

Surgical History Please list all operations you have had:
____
____
____
____

Please List Any Other Active Medical Condition:
____
____
____

Social History

Occupation: ______________________ Marital Status: _______________

Hobbies: ____

Please list all **allergies** and **sensitivities** (E.g. medications, foods, latex, iodine, etc.)
____
____
____
____
____
____

Are you taking any **blood thinning** medications including aspirin? Yes- indicate below No

Other:
____

Do you smoke cigarettes? Y / N How many a day? _______ At what age did you start? ______ At what age did you stop? _____
Do you drink alcohol? Y N If yes, how much daily? __________________________________
Do you use recreational drugs? Y N Type? ____
Do you exercise regularly? Y N How frequently? ____

Female Medical History:
Are you pregnant? Y N If yes, how many weeks? _____ Age at first menstrual period? _____ Age at last? ____
Have you ever used oral contraceptives? ___________________Have you ever used hormone replacement therapy? Y N

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ Relief Care is the care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, not fixing the leak, or cause of the symptom.

□ Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time but is longer lasting.

□ Check here if you want the Doctor to select the type of care appropriate for your condition.

Financial Agreement
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Dr. Masulas' Office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. The patient also agrees that he/she is responsible for all bills incurred at this office. **Parental Consent for Minor Patient**
My signature below indicates that I have read, understand and agree to all of the above listed information.

____ **Date:** _______/_______/______
Responsible Party/Guardian Signature

Masula Chiropractic Neurology and Family Wellness Center

Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

Please Initial at Each Line Below:

Regarding Insurance If you have insurance; we will bill them as a courtesy and assist you in receiving the maximum reimbursement benefits possible.

____I understand I am financially responsible to the physician for all charges rendered to me. I hereby promise to pay the physician for the services I receive.

____**Assignment of Benefits** (Personal Injury case or Worker's Comp case)
I hereby authorize payment directly to the physician of all benefits otherwise payable to me, but not to exceed the total charges for the services rendered.

____**Authorization to Release Information**
I authorize the physician and/or his or her representatives to release any and all information contained in my complete medical and billing record to:

- My insurance company or its representatives.
- Other persons or entities financially responsible for my care or treatment.
- The Medicare program and its fiscal intermediaries, if applicable or otherwise required/permitted/regulated by law.
- Federal and state agencies, as required or permitted by laws and regulations.

Notice of Privacy Practices

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

Masula Chiropractic Neurology and Family Wellness Center is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Would you like a copy of our Notice of Privacy Act Form?

______ **Yes** (Patient *needs to sign NPP form*)

_______ **No –** I decline a copy of the NPP form

X ____
Patient's Signature

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition, there are reported cases of stroke associated with visits to Medical Doctors, Osteopaths, Chiropractors, Physical Therapists, and Occupational Therapists.

Would you like a copy of our Informed Consent Form?

_______ **Yes** (Patient *needs to sign Consent form*)

_______ **No –** I decline a copy of the (ICF) form

X ____ Signature

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAS BEEN ANSWERED TO MY SATISFACTION.
HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE MASULA FAMILY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

X ________________________ ________________________
Patient Signature Doctor's Signature

Parental Consent for Minor Patient:

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Patient Name: ____________________________
Patient age: ___________ DOB: ____________
Printed name of person legally authorized to sign for
Name: ________________________________
Relationship to Patient: ____________________

X Signature: ______________________________

DATED THIS ____ DAY OF _____________, 20___