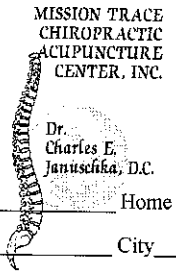

DATE _____

About You

Name_____ Home Phone_____ Cell Phone_____

Address_____ City_____ State_____ ZIP_____

Age_____ Gender (check one) ☐ Female ☐ Male Marital Status_____ Birthdate_____

Height _____ Weight _____ Physician Name_____

Occupation_____ Employer_____

Type of Work_____ Email Address_____

Payment Method (check one) ☐ Cash ☐ Check ☐ Credit Card

Emergency Contact_____ Phone Number_____ Relationship_____

How did you hear about our office? ☐ Medical Doctor ☐ Friend/Family (Name:_____)

☐ Google ☐ Insurance Website (URL:_____)

☐ Other_____

About Your Spouse/Significant Other or Parent

Name_____ Employer_____ Work Phone_____

Experience with Chiropractic

Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No

If yes, reason for the visit:_____

Doctor's Name_____ Approximate Date of Last Visit_____

Health History

Have you ever had surgery or been hospitalized ☐ Yes ☐ No If yes, please explain: _____

_____

Have you had any sports injuries? ☐ Yes ☐ No If yes, please explain: _____

_____

When was the last time you had a spinal x-ray?_____ What medications are you currently taking?_____

What supplements you are currently taking (i.e., vitamins, herbs)?_____

How many glasses of water do you drink each day?_____ How do you sleep (i.e., right side, left side, back, stomach)?_____

Do you smoke?_____ If yes, how many per day?_____ Do you drink alcohol?_____ If yes, how many drinks per day?_____

Do you drink coffee?_____ If yes, how many cups per day?_____ Do you exercise regularly?_____ If yes, how many times per week?_____

Are you aware of any poor postural habits?_____

Reason for This Visit

Describe the purpose of this visit: _____

_____

When did this condition begin?_____ This condition has: Gotten Worse Stayed Constant Comes and Goes

Does this condition interfere with your work, sleep, daily routine, or other activities? ☐ Yes ☐ No

Please explain:_____

Has this condition occurred before? ☐ Yes ☐ No

Please explain:_____

ATTENTION- All Insurance Patients

I agree to be financially responsible for any and all charges incurred at this clinic, including but not limited to my insurance deductable, copayment, and services rejected by my insurance company. This included my New Patient exam, as Insurance does not typically pay for this charge. All new patient exams are $100 unless otherwise stated by the Doctor. In other words, if your insurance does not pay for something, you are responsible.

Patient Signature Date

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me, will become immediately due and payable. I hereby authorize assignment of my Insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient Signature Date Guardian or Spouse Signature Authorizing Care Date

Who should receive bills for payment on your account? O Patient O Parent O Workers Comp O Auto Insurance
O Medicare O Personal Health Insurance

Disclosure Statements (Please Initial)

_____ I have been provided information about the possible risk of Chiropractic Treatment and Acupuncture
_____ I have been given notice that MTCC complies with the Federal HIPPA Laws.
_____ I waive the Statute of Limitations regarding MTCC's right to recover

About My Insurance

I give my consent to release any medical records, x-rays, and any health information that may assist MTCC in my treatment or reimbursement from any 3rd party payer (i.e. insurance). I understand and agree to assist in the event any difficulty is experienced in collecting from the insurance company; I hereby agree to give full cooperation, support and assistance in getting bills paid for services rendered at MTCC. In the event that payment is not made from any other source, I give Dr. Charles E. Januschka, D.C. the unpaid balance of charges for health care services out of any funds received from any such claim before final disbursement.

Insurance Company_____ Group Number (plan, local, policy#)_____
Address_____ Phone Number_____

About the Insured Person

Name_____ Social Security Number_____ Relationship_____
Date of Birth_____ Employer_____

*Please note that you are given the opportunity to request a private conversation with the Doctor

normal postural habits are the result of trauma or stress to the body that has misaligned the vertebrae in our spine. When these tebrae are misaligned from their normal position, they will cause stress to the spinal cord and delicate nerves that pass between vertebrae. These misalignments are called **subluxations** (sub-lux-a-shuns). It has been extensively documented that subluxations, using stress to your nerves, will weaken and distort the overall structure of your spine, which results in a weakened and distorted **sture.** Postural distortions have many serious and adverse effects on your overall health. The most common and detrimental stural distortion is called **forward head syndrome** (a "hunched forward" posture starting in the neck and progressively weakening entire body).

ase check any health conditions you may be experiencing:

RVICAL SPINE (NECK)

you experience:
- O Neck pain
- O Pain into your shoulders/arms/hands
- O numbness/tingling in arms/hands
- O Headaches
- O Hearing disturbances
- O Weakness in grip
- O Dizziness
- O Visual disturbances
- O Coldness in hands/feet
- O Thyroid conditions
- O Sinusitis
- O Allergies/hay fever
- O Recurrent colds/flus
- O Jaw pain/clicking

ORACIC SPINE (UPPER BACK)

you experience:
- O Upper back pain
- O Heart palpitations
- O Heart murmurs
- O Tachycardia
- O Heart attacks/angina
- O Recurrent lung infections
- O Asthma/wheezing
- O Shortness of breath
- O Pain on deep inspiration/expirations

THORACIC SPINE (MID BACK)

Do you experience:
- O Mid back pain
- O Pain into your ribs/chest
- O Indigestion
- O Heartburn
- O Nausea
- O Ulcers/gastritis
- O Tired/irritable after eating or when you haven't eaten for awhile
- O Hypoglycemia

LUMBAR SPINE (LOWER BACK)

Do you experience:
- O Low back pain
- O Pain into your hips/legs/feet
- O Numbness in your hips/legs/feet
- O Sexual dysfunction
- O Frequent/difficulty urinating
- O Recurrent bladder infections
- O Constipation/diarrhea
- O Menstrual irregularities/cramping
- O Hypoglycemia
- O Weakness/injuries in your hips/knees/ankles
- O Coldness in your legs/feet

Please list any health conditions not mentioned_____

Where Do You Feel Pain?

Please circle all areas of pain or discomfort.