Dr. Shane Molitor
Phone 507-364-7500
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www.molitorchiropractic.com

MONTGOMERY FAMILY CHIROPRACTIC

207 First Street South
Montgomery, MN 56069

Patient: _____ Birthday: _____ Sex: M / F

Current Address: _____ City: _____ State: _____ Zip: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ Home Phone: _____ Cell Phone:_____

Marital Status: _____ Employment Status: _____

Occupation: _____ Work Phone: _____

Employer: _____ Address: _____ City: _____

Email address: _____ (for newsletters and clinic updates)

Name of Spouse/Guardian: _____ Spouse/Guardian birthday: _____

Spouse/Guardian Employer: _____

Spouse/Guardian work phone: _____ Relationship to patient: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Females are You Pregnant? _____ If yes, How far along? _____

How did you hear about us?

___ Internet, ___ Radio, ___ Newspaper, ___ Phonebook, ___ Location

OR Whom may we thank for referring you? Dr. _____ OR _____

Insurance Information if Patient is NOT Primary Card Holder:

Card Holder's Name: _____ ID# _____

Card Holder's Birthday: _____ Relationship to Card Holder (Spouse/Child/Other)

Insured's Employer: _____ Secondary Insurance Co. _____

Insured's Address (if different from above): _____

_____

- We invite you to discuss with us any questions regarding our service. The best health services are based on a friendly, mutual understanding between provider and patient.
- I understand and agree that you will submit my claims, however no matter what they pay **I am ultimately responsible for the charges that I incur.** I understand that if I suspend or terminate my care and treatment any fees for professional services rendered will be immediately due and payable.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to my medical status.

Patient's Signature: _____ Date: _____

Parent or Guardian Signature Authorizing Care: _____ Date: _____

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At Montgomery Family Chiropractic we understand the cost of healthcare is a concern for our patients. Although patient care is our main priority, we hope you will assist us by understanding your responsibility as it relates to our financial policy. If you have any questions regarding our policy, a member of our staff will gladly assist you.

Please select one of the following:

____ If you have insurance **full payment** of patient obligation is due at each visit. This includes deductible, copay or co-insurance.
We will verify your coverage as soon as possible. Please be aware that insurance companies offer different coverage for specialties such as chiropractic and true coverage may not be stated on your card. ***You will be responsible for any portion your insurance does not cover.***

____ If you do not have insurance or your insurance does not cover chiropractic care, all payments are required at the time of service. By doing this you qualify for our Time of Service discount.
Please note when you take advantage of the Time of Service discount these charges may NOT be submitted to insurance by you or our office.

____ If you have Medicare we will submit Medicare allowed services **(spinal adjustments only)** to Medicare and your supplemental insurance.
Patients are responsible for the exam, extra-spinal adjustments, x-rays and therapies. When paid at the time of service, these charges qualify for the Time of Service discount.

____ Work Comp or accident claims will be filed by our office. All charges are initially the responsibility of the patient and payment is expected at the time services are rendered.

If you require special consideration for payment, please let us know prior to treatment.

I will be paying today by cash ____, check ____, or debit / credit card ____ .
We accept Visa, Discover and Mastercard.

I have been explained the payment options offered by Montgomery Family Chiropractic and have checked the option **and** payment type that best suits me.

_____ _____
Patient Signature Date

PATIENT HEALTH QUESTIONNAIRE *MONTGOMERY FAMILY CHIROPRACTIC*

PATIENT NAME: _____ **DATE:** _____

1. Describe your symptoms: _____

_____

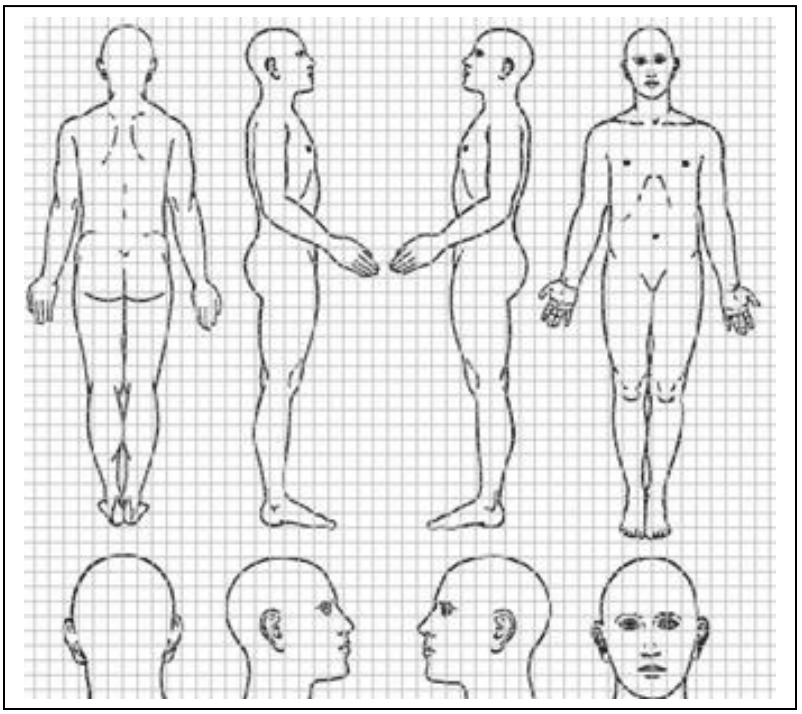
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

1) Constantly (76-100% of the day)
2) Frequently (51-75% of the day)
3) Occasionally (26-50% of the day)
4) Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms:



3. What describes the nature of your symptoms?

1) Sharp 4) Shooting
2) Dull ache 5) Burning
3) Numb 6) Tingling

4. How are your symptoms changing?

1) Getting better
2) Not changing
3) Getting worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None Unbearable
0 1 2 3 4 5 6 7 8 9 10

b. How much has pain interfered with your normal work (including both work outside of the home, and housework)

1) Not at all 2) A little bit 3) Moderately 4) Quite a bit 5) Extremely

6. During the <u>past 4 weeks</u>, how much of the time has your condition interfered with your social activities?

1) All of the time 2) Most of the time 3) Some of the time 4) A little of the time 5) None of the time

7. In general how would you say your overall health is right now?

1) Excellent 2) Very Good 3) Good 4) Fair 5) Poor

8. Who have you seen for your symptoms? 1) No one 3) Medical Doctor 5) Other
2) Other Chiropractor 4) Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms And when were they performed? 1) Xrays *date:* _____ 3) CT scan *date:* _____ 2) MRI *date:* _____ 4) Other *date:* _____

9. Have you had similar symptoms in the past? 1) Yes 2) No

a. If you have received treatment in the past for the same or similar symptoms, who did you see? 1) This office 3) Medical Doctor 5) Other 2) Other Chiropractor 4) Physical Therapist

Patient Signature:_____ **Date:** _____

Patient Health Questionnaire- page 2 ***MONTGOMERY FAMILY CHIROPRACTIC***

Patient Name: _____ **Date:** _____

What type of regular exercise do you do? 1) None 2) Light 3) Moderate 4) Strenous

What is your height and weight? Height: _____ Weight: _____lbs.

For each of the conditions listed below, place a check mark in the *PAST* column if you have had the condition in the past. If you presently have a condition listed below, place a check mark in the *PRESENT* column.

Past	Present		Past	Present		Past	Present	
__	__	Headaches	__	__	High Blood Pressure	__	__	Diabetes
__	__	Neck Pain	__	__	Heat Attack	__	__	Excessive thirst
__	__	Upper back pain	__	__	Chest Pains	__	__	Frequent urination
__	__	Mid-back pain	__	__	Stroke			
__	__	Low back pain	__	__	Angina	__	__	Tobacco products
						__	__	Drugs/Alcohol
__	__	Shoulder pain	__	__	Kidney stones			
__	__	Elbow/ arm pain	__	__	Kidney disorders	__	__	Allergies
__	__	Wrist pain	__	__	Bladder infection	__	__	Depression
__	__	Hand pain	__	__	Bladder control	__	__	Systemic Lupus
			__	__	Prostate problems	__	__	Dermatitis/eczema
__	__	Hip/upper leg pain				__	__	HIV/AIDS
__	__	Knee/lower leg pain	__	__	weight gain/loss			
__	__	Ankle/foot pain	__	__	appetite loss			**Females only**
			__	__	abdominal pain	__	__	Birth control pills
__	__	Jaw pain	__	__	Ulcer	__	__	Hormone therapy
__	__	Joint swelling/stiffness	__	__	Hepatitis	__	__	Pregnancy
__	__	Arthritis	__	__	Liver/Gall bladder			
__	__	Rheumatoid arthritis	__	__	Cancer			**Other health issues?**
__	__	General fatigue	__	__	Tumor			
__	__	Muscular Incoordination	__	__	Asthma			
__	__	Visual disturbances	__	__	Chronic sinusitis			
__	__	Dizziness						

Indicate if an immediate family member has had any of the following:

O Rheumatoid arthritis O Heart problems O Diabetes O Cancer O Lupus O_____

List all prescriptions and over-the-counter medications, and nutritional supplements you are taking:

_____

_____

List all surgical procedures and times that you have been hospitalized if any:

_____

Patient Signature: _____ **Date:** _____

Additional Comments: _____

_____

_____

_____

Doctor's Signature: _____ **Date:** _____