Patient Information

Legal First Name: _____ MI: _____ Last Name: _____

Street: _____ Apt. _____

City: _____ State: _____ Zip: _____

SS#: _____ Marital Status: S M W D Spouse: _____

Language: English____ Spanish____ Indian____ Japanese____ Chinese____ Korean____ French____ German____
Russian____ Other_____

Race: White____ American Indian or Alaska Native____ Asian____ Native Hawaiian/Other Pacific Islander____
Black or African American____ Hispanic or Latino____ Decline to answer____

Ethnicity: Hispanic or Latino____ Not Hispanic or Latino____ Decline to answer____

Date of Birth: _____ E-mail: _____ Cell Phone Carrier: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Contact preference: Home Cell Work E-mail Postal Mail

Emergency Contact: _____ Phone Number: _____

Occupation: _____ Employer: _____

Whom may we thank for referring you to our office? _____

Insurance Information

Are you the policy holder? Yes____ No____ *(If yes, leave this area blank and continue to the next page. If no, please fill out the following information.)*

Who is the policy holder? Spouse Parent Employer Other_____
Policy Holder
Legal First Name: _____ MI: _____ Last Name: _____
Policy Holder's Date of Birth: _____

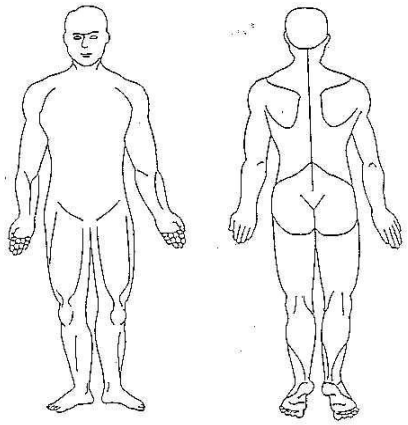
Do you have secondary insurance? Yes____ No____ If yes, please complete the following:
Policy Holder
First Name: _____ MI_____ Last Name: _____
Policy Holder's Date of Birth: _____
Patient Name: _____ Date: _____

Present Weight: _____lbs. **Height:** ____ft. ____inches

Please describe your complaint: _____
_____
_____

Description	**Frequency**
__ Sharp Pain	__ Constant (76-100%)
__ Dull Pain	__ Frequent (51-75%)
__ Ache	__ Occasional (26-50%)
__ Weak	__ Intermittent (25% or less)
__ Throbbing	
__ Numb	
__ Shooting	
__ Gripping	
__ Burning	
__ Tingling	

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



c. Indicate intensity of your pain at its lowest and highest level. No Pain 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 Unbearable Pain

d. Your symptoms are: __ decreasing __ not changing __increasing

e. Symptoms are worse in the: __ morning __ afternoon __ night __ increase during the day __ same all day

When did your problem begin (a specific date, if possible)? _____

Describe how your problem began: _____
_____

Have you been treated for this episode? __ Yes __ No

If yes, by whom? __ Chiropractor __ M.D. __ Osteopath __Physical Therapist __ Occupational Therapist
__ Other: _____

Are you currently being seen? __ Yes __ No

When were you seen and what treatment was given? _____
_____

In the past, have you been treated for the same or similar problem? __ Yes __ No

If yes, by whom? __ Chiropractor __ MD __ Osteopath __ Physical Therapist __ Occupational Therapist
__ Other: _____

When were you seen and what treatment was given? _____
_____
_____

What makes your problem better? __ Nothing __ Lying Down __Walking __ Standing __ Sitting __ Movement/Exercise __ Inactivity

What makes your problem worse? __ Nothing __ Lying Down __ Walking __ Standing __ Sitting __ Movement/Exercise __ Inactivity

How would you rate your general stress level? __ Little or No Stress __ Minimal Stress __ Moderate Stress __ Greatly Stressed

General Physical Activity: __ No regular exercise program __ Light exercise program __ Moderate exercise program __ Strenuous exercise program

Are your complaints affecting your ability to be active?

__ No effect __ Some physical restrictions (able to perform light duty work and household tasks)
__ Need limited assistance with common everyday tasks. __ Need assistance often
__ Have a significant inability to function without assistance. __ Am totally disabled (impaired). Cannot care for self.

Physical activity at work: __ Sitting more than 50% of your workday __ Light manual labor __ Manual labor
__ Heavy manual labor __ Repeated motion
Occupation: _____ __ Full Time __ Part Time
Has your work status changed because of this complaint? __ Yes __ No

What is your current work status?
__ Full time, no restriction __ Part time, with restrictions __ Unemployed Other: _____
__ Full time with restrictions __ Off work due to restrictions __Retired
__ Part time, no restrictions __ Full time homemaker __ Full time student

SURGERIES: Please list any surgeries you have had, including the dates:

_____
_____
_____

MAJOR ILLNESSES: If you have ever had a listed condition in the past, please check it in the ***Past*** column. If you are presently troubled by a particular condition, check it in the ***Present*** column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

Past	Present		Past	Present	
__	__	Abdominal Pain	__	__	General Fatigue
__	__	Abnormal Weight __ Gain __ Loss	__	__	Headache/Migraines
__	__	Angina	__	__	Heart Attack
__	__	Anorexia	__	__	Heartburn/Indigestion
__	__	Aortic Aneurysm	__	__	High Blood Pressure
__	__	Arthritis	__	__	HIV/AIDS
__	__	Asthma	__	__	Hormonal/Estrogen Replacement
__	__	Birth Control Pills	__	__	Irregular Menstrual Flow
__	__	Bladder Infection	__	__	Irritable Colon
__	__	Blood Disorder	__	__	Kidney Disorders (by condition)
__	__	Breast Soreness/Lumps	__	__	Kidney Stones
__	__	Cancer	__	__	Liver/ Gallbladder problems
__	__	Chest Pains	__	__	Loss of Bladder Control
__	__	Chronic Cough	__	__	Loss of Appetite
__	__	Chronic Sinusitis	__	__	Muscular Incoordination
__	__	Colitis	__	__	Painful Urination
__	__	Constipation/Irregular Bowel Habits	__	__	PMS
__	__	Convulsions	__	__	Pregnancy
__	__	Depression	__	__	Profuse Menstrual Flow
__	__	Dermatitis/Eczema/Rash	__	__	Prostate Problems
__	__	Diabetes	__	__	Rapid Heart Beat
__	__	Difficulty in Swallowing	__	__	Rheumatoid Arthritis
__	__	Dizziness	__	__	Stroke
__	__	Drug or Alcohol Dependence	__	__	Swelling/Stiffness of Joint(s)
__	__	Emphysema (chronic lung disorders)	__	__	Systemic Lupus
__	__	Endometriosis	__	__	Tinnitus (Ear Noises)
__	__	Epilepsy	__	__	Tumors
__	__	Excessive Thirst	__	__	Visual Disturbances
__	__	Fainting	__	__	Ulcer
__	__	Frequent Urination			

If a family member has had any of the following please mark the appropriate box.

__ Cancer
__ Rheumatoid Arthritis
__ Diabetes
__ Heart Problems
__ Lung Problems
__ High Blood Pressure
__ Epilepsy
__ Chronic Back Problems
__ Chronic Headaches
__ Lupus
__ Other Conditions: _____
_____

Yes	No	
__	__	Do you have a permanent disability rating?

Location_____
Date rating received: _____
Rating Percentage: _____%

Assignment & Release

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Mediquest, LLC will be credited to my account upon receipt. However, 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 also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient/Parent/Guardian Signature: _____ Date: _____

Consent of Professional Services and Release of Information

I hereby authorize and release Dr. Marlene N. Mahipat and whomever she may designate as her assistants, to administer treatment, physical examination, chiropractic care or any clinical services she deems necessary in my case; I furthermore authorize her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to hospital or medical service companies, insurance companies, workers' compensation carriers, welfare funds or the patient's employer.

Patient/Parent/Guardian Signature: _____ Date: _____

Missed Appointment and Cancellation Policy

I understand and agree that if I am unable to keep my scheduled appointment, I must give a **24 hours** advance notice, and I will make up my missed appointment by rescheduling, otherwise I will be charged a **$30** missed appointment fee and/ or a **$30** cancellation fee.

Patient/Parent/Guardian Signature: _____ Date: _____

Notice of Privacy Practices Written Acknowledgement

I have been informed of the Notice of Privacy Practices of this office.

Patient/Parent/Guardian Signature: _____ Date: _____

Mediquest. LLC. Marlene N. Mahipat D.C.

5310 Old Court Rd. Suite 301 Randallstown, MD 21133 (410) 655-8900 fax (410) 655-0498

Informed Consent

It is our responsibility to fully inform you of all aspects of your treatment. Part of this includes a discussion of any potential side effects or complications. All treatments potentially can cause these reactions, and chiropractic manipulation is no different. It however, has one of ***safest*** records of the wide range of treatments that can be used for spinal disorders.

Possible adverse effects of spinal manipulation can include soreness in the area of treatment, reactive muscle spasm, injury to the disc causing pressure on nerve tissue, fractures in weakened bone such as ribs, and injury to arteries in the neck resulting in stroke. Soreness or reactive muscle spasms or tightening are common but usually brief reactions to treatment. The other potential complications are rare. It is best to examine the frequency of these potential complications versus the relative frequency of the complications of the other typical treatments which may be used for a spinal disorder.

Disc injury from manipulation causing spinal cord pressure	**Neurological complication from Neck surgery**	**Back surgery**
1 per 100 million	**1 per 64**	**1 per 333**

Artery injury from Manipulation causing stroke	**Death rate from neck surgery**
1 per 1 million	**1 per 145**

Perhaps the most common alternative to spinal manipulations is the use of anti-inflammatory drugs. These drugs cause fairly and potentially serious complications

Complications associated with anti-inflammatory drug use:

Serious stomach or intestinal bleeding	**1-4 per 1000 users**
Hospitalizations from complications	**20,000 per year**
Deaths from complications	**16,500 per year**

(New England Journal of Medicine, 6/99)

I have read the above and understood the risk of complication that may occur from spinal manipulation. With this understanding, I consent to treatment with spinal manipulation by Mediquest, LLC.

Name: _____ Signature: _____ Date: _____

"Gentle, Effective, Quality Chiropractic Care"

*** Member, Maryland Chiropractic Association***

Mediquest. LLC. Marlene N. Mahipat D.C.

5310 Old Court Rd. Suite 301 Randallstown, MD 21133 (410) 655-8900 fax (410) 655-0498

ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to _____Mediquest_____such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, workmen's compensation benefits, or any other Insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be adequately necessary to protect this office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is an assignment of my rights and benefits to the extent of the Office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name of in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute and consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any Insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien AND Authorization. I agree that the above mentioned office be given power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

Date:_____ Signed:_____

Personal Injury

Auto/Attorney Information

FILL OUT THE HIGHLIGHTED AREAS BEFORE RETURNING TO FRONT DESK PLEASE

Patient's Name: _____

Date of Accident: _____

CAR Insurance Carrier (YOURS): _____

Insured's Name: _____

Claim #: _____

Adjuster:_____ **Phone**:_____ **Fax:**_____
Claim Address:_____
_____

PIP has been:_____Filed_____Exhausted_____Waived
Med Pay: _____Yes_____No Amount: _____
Attorney Name: _____**Phone#:**_____
Address: _____
_____
_____

For Office Use Only

Initial Report Date:_____Mailed:_____

Interim Reports Date:_____Mailed:_____

_____ _____

_____ _____

Discharge Date:_____Final Report Date:_____Final Bill Date:_____

Assignment of Benefits/Lien signed by Patient/Attorney: _____

Notes _____

Automobile Accident Questionnaire

Please answer all questions completely

(All information is considered confidential)

Name: _____ Date/Time of accident: _____

Please explain in detail how your accident happened _____

_____

_____

_____

Where did you feel pain immediately after the accident? _____

List the extent of injuries as you know them: _____

_____

Check symptoms you have noticed since the accident: _____

__Headache	__Dizziness	__Fatigue
__Stomach upset	__Light Bothers Eyes	__Neck Pain
__Head seems too heavy	__Loss of Memory	__Ears Ring
__Neck Stiff	__Feet/Hands Cold	__Fainting
__ Face Flushed	__Pins and Needles	__Back Pain
__Sleeping problems	__Loss of Balance	__Tension
__Nervousness	__Loss of Smell	__ Fever
__Loss of taste	__Chest pain	__Cold Sweats
__Shortness of breath	Other Symptoms: _____	

Were you wearing your seat belt/shoulder harness? ____Yes _____No

Did airbag deploy? ____Yes ____No

Did you strike head on any part vehicle? _____ Did you lose consciousness? _____

Was your head turned left or right at impact? _____

Were you aware that you were about to be struck? ____Yes ____No

Was your car: ____stopped? ____rolling? ____moving with traffic?

Was your foot on brake? ____Yes ____No

Where were you taken after accident? _____

If yes, for how long were you admitted? _____

Name of hospital/doctors: _____

Was any other doctor consulted after your accident? ____Yes ____No

If yes, what was the diagnosis/treatment? _____

Have you ever had any complaints in the involved area before? ____Yes ____No

If so, what were the complaints? _____

_____

Are your work/daily activities restricted as a result of this accident? ____Yes ____No

Since this injury are your symptoms: ____improving? ____getting worse? ____same?

What type of vehicle were you driving? Year_____ Make_____ Model_____

What was the other vehicle involved? Year_____ Make_____ Model_____

Signature: _____ Date: _____