Mason Family Chiropractic
Case History and Patient Information

Date _____ Referred By _____

Patient Name _____ SS# _____

Age _____ Date of Birth _____

Address _____

City /State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address(please print) _____

Employer _____ Occupation _____

Spouse Name _____ DOB _____ SS# _____

Cell Phone _____ Work Phone _____

Emergency Contact/Relationship _____ Ph:_____

Family Doctor _____ Phone _____

Please mark the appropriate coverage to be billed:

Major Medical _____ Medicare _____ Auto Med Pay _____ Self Pay _____

Primary Insurance Carrier _____

Primary Card Holder (as written on card) _____

Date of Birth _____ Social Security Number _____

Secondary Insurance Carrier _____

Secondary Card Holder (as written on card) _____

Date Of Birth _____ Social Security Number _____

Name: _____ **PATIENT HEALTH HISTORY** Date: _____

Major surgery/Operations:

Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken Bones

Other: _____

Hospitalization (other than above) _____

Date of last chiropractic visit _____ Doctors Name _____

For same complaint as now or other YES or NO _____

Do you suffer from any condition other than which you are now consulting us? YES or NO

Please check all that apply:

__ Clotting /clotting disorder
__ Nosebleeds
__ Lumps in breast
__ Prostate trouble
__ Colon trouble
__ Nausea
__ Heartburn
__ Indigestion
___Ulcers
___Diarrhea/constipation
___Cancer

__ Allergies/hay fever
__ Poor circulation
__ Chest pain
__ Dizziness
__ Sinus
__ Asthma
__ Difficult breathing
__ Arthritis
__ Headache
__ Fatigue

__ Ear noises
__ Failing vision
__ Blurred vision
__ Rapid Heartbeat
__ Slow heartbeat
__ Stroke/TIA's
__ High blood pressure
__ Low blood pressure
__ Pain over heart
__ Nervousness/depression
__ Pacemaker

___Varicose veins
__ Bursitis
__ Diabetes
__ Bruise easily
__ Frequent urination
__ Kidney stone/infection
__ Arrhythmias
__ Raynaud's Phenomenon
__ Loss of sleep
__ Tingling or numbness
__ Unsteady walking / balance Issues

__ Neck pain
__ Poor posture
__ Swelling of Ankles
__ Sciatica
__ Foot trouble
__ Low back pain
__ Numbness
__ Swollen Joints
__ Pain between shoulders
___ Difficulty swallowing or speaking

Tingling or Stiffness In: __ Shoulders __ Neck __ Hips __ Arms __ Legs __ Elbows __ Knees __ Hands __ Feet __ Back

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FAMILY HISTORY

Diabetes Y or N Family member _____ Heart disease Y or N Family member _____

Stroke Y or N family member_____ Cancer Y or N family member _____

Rheumatoid arthritis Y or N family member _____ Arthritis Y or N family member _____

Auto Immune conditions? Y or N Type _____ family member _____

PATIENT HABITS

Do you smoke or use tobacco ? Y or N If Yes, what kind and how often? _____

Do you drink alcohol? Y or N If yes, how much and how often? _____

How much water do you drink per day? _____

CURRENT HEALTH CONDITION

Main reason for your visit today:

_____

Other doctors seen for this condition Y or N Who? _____

Type of treatment _____ Results _____

List current Medication and supplement(s):_____

_____

Is patient pregnant ? Y or N If no, Date of last menstrual cycle _____

List any major accidents or falls: _____

COMPLAINT: Name: _____ Date: _____

Major _____

Secondary _____

When did this condition begin? _____ Has this condition occurred before YES or NO

Is this appointment a result of Auto Accident? Yes or No Date of accident _____

Name of **YOUR** Auto Insurance Company _____

Claim # _____ Phone Number _____

Agents Name _____

How often do you experience the symptoms?

___ Constant (100%) ___ Frequent (75%) ___ Intermittent (50%) ___Occasional (25%) ___ Rare (10%)

How many days a month do you feel it _____ How many hours out of a day _____

When: ___ Morning ___ Afternoon ___ Evening ___ Night

What makes it better _____

What makes it worse _____

Type of Pain (mark all that apply) :

___ Sharp ___ Dull ___ Aching ___ Burning ____ Throb ____ Numb ___ Other

Does it radiate YES or NO Where _____

Rate on scale 0 no pain 10 unbearable circle one:

Now	0	1	2	3	4	5	6	7	8	9	10
Average	0	1	2	3	4	5	6	7	8	9	10
Worse	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10

How does this symptom affect your:

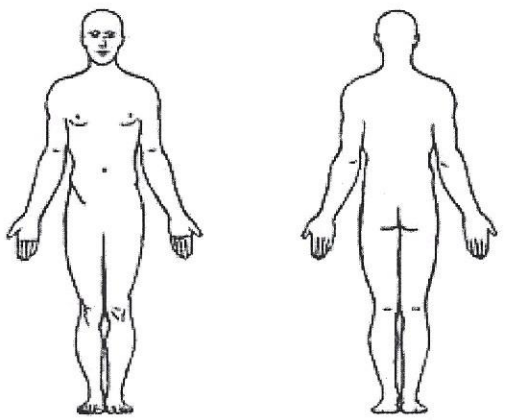
Work _____

Home _____

Leisure activities _____

Sleep _____

Please mark area of this complaint on figures with an X:



NECK DISABILITY INDEX

Name:_____ **Date:**_____ **File #:**_____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Reading
- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all due to pain.

SECTION 5 - Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 - Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 - Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can not do any work at all.

SECTION 8 - Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all.

SECTION 9 - Sleeping
- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 - Recreation
- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreation activities. because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

BACK OSWESTRY INDEX

Name:_____ **Date:**_____ **File #:**_____

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 - Pain Intensity
- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderately increasing
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)
- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 - Walking
- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting
- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 - Standing
- ☐ I can stand as long as I want without pain.
- ☐ I have some pain standing, but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7 - Sleeping
- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life
- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing . . .
- ☐ Pain has restricted my social life and I do not go much.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

SECTION 9 - Traveling
- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel .
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain prevents all forms of travel except done lying down.
- ☐ Pain restricts all forms of travel.

SECTION 10 - Changing Degrees of Pain
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but slowly improves.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

MASON FAMILY CHIROPRACTIC INFORMED CONSENT

I hereby request and consent to physical examination and/or chiropractic services from Richard Mason, D.C. M.S., and/or any authorized persons who might now or in the future treat me while employed by, working or associated with Richard Mason D.C.M.S.

The primary treatment used by doctors of chiropractic is spinal manipulation, sometimes called a spinal adjustment.

- **The nature of the chiropractic adjustment.**
  I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

- Disc herniations, pinched nerves, arthritic changes and spinal mechanical issues are very common. Many people have the above referenced issues and only feel symptoms after daily activities aggravate the underlying conditions, for which they seek out chiropractic care.

- **The material risks inherent in chiropractic adjustment.**
  As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation/treatment. Those complications include but are not limited to: worsening symptoms, fractures, disc injuries, bony dislocations, muscle & ligament strains and sprains, injury to nerves affecting the upper and lower extremities, injury to nerves that affect the diaphragm-which can cause breathing issues and/or shortness of breath, injury to nerves that affect the face (movement and sensation), and rib strains/sprains and separations. Some types of manipulation has been associated with injuries to arteries of the neck(arterial tearing/dissections) leading to or contributing to serious complications including stroke, paralysis, and death. All of the complications listed above rarely occur.

- The most current research indicates that chiropractic care does not cause arterial tearing(dissections) or stroke, and further research is ongoing. It has been reported that patients with arterial dissections experience neck pain, headaches, and dizziness, along with other neurological symptoms that cause them to seek out relief from a chiropractor in the first place.

  Upon request, patients may undergo treatment utilizing other techniques in our office if the above risks are concerning to them. Using "drop" or instrument adjustments are an additional way of mobilizing the spine without hearing the crack or pop sound and may further reduce the risk of side effects from treatment. Some patients may feel some stiffness or soreness following the first few treatments which is common to manual medicine. If this persists, a change in treatment approach will be used to reduce this outcome.

- **The probability of those risks occurring.**
  Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray (if performed). Stroke has been the subject of tremendous disagreement within and outside the profession, with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we screen patients regularly via history and examination to avoid this from occurring. Please check the following statements if they apply to you:

- _____Do you have a connective tissue disorder, loose joints; or prior diagnosis of Marfans or Ehlers-Danlos syndrome?
- _____Recent head or neck trauma?
- _____Recently suffering the worst headache of your life?
- _____Recent infection?
- _____Fluoroquinolone medication use in the past(Cipro, Levaquin, Levofloxacin, Noroxin, or Avelox, etc.)?
- ____ Recent onset of dizziness?
- ____Have you currently or in the past been diagnosed with a blood clotting disorder?

The availability and nature of other treatment options.
Other treatment options for your condition(s) include:

- Self-administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
- Hospitalization
- Surgery
- Orthopedic consult, Physical therapy, occupational therapy, massage and acupuncture.

MASON FAMILY CHIROPRACTIC INFORMED CONSENT (continued)

At times, certain additional physical therapy treatments may be used to reduce pain, spasm, and inflammation. These can include spinal decompression therapy, cold laser therapy, EMS and ultrasound therapy. These devices are used as needed and a proper history and exam will be performed prior to detect known contraindications to their use. Side effects can occur from use of above treatments, but are usually mild and transient in nature, these can include but are not limited to: headaches, worsening symptoms, muscle soreness/pain, and numbness and tingling into the arms or legs. By signing below I understand these risks and authorize these treatments to be performed at the Doctors discretion toward my care.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____

Date Printed Name

_____

Signature

_____ _____

Dr. Richard G. Mason , D.C.M.S. Signature of Parent or Guardian (if a minor)

_____ _____

Signature

Discussed form: Dr. initials: _____ Patient initial: _____

MASON FAMILY CHIROPRACTIC & WELLNESS PATIENT AGREEMENT AS TO FINANCIAL RESPONSIBLIITY

I, _____ (insert patient name), (hereinafter referred to as "patient") agree that I am financially responsible for the cost of treatment incurred with MCHC, PC, doing business as Mason Family Chiropractic and Wellness.

Patient acknowledges that in order to best serve all of its patients, Mason Family Chiropractic and Wellness requires an appointment for treatment. Patient agrees that twenty-four (24) hour advanced notice is required to cancel and/or reschedule any appointment. In the event that patient fails to contact Mason Family Chiropractic and Wellness within (24) twenty-four hours of Patient's appointment to cancel and/or reschedule then Mason Family Chiropractic may, at its sole discretion charge client a fee of $35.00. In the event that Patient is more than 10 minutes late for an appointment, Mason Family Chiropractic may, at its sole discretion, require that Patient reschedule the appointment. Initial

If the patient does not have medical insurance, the full fee for services rendered is due at the conclusion of each visit. In the event that the patient does have medical insurance, the full co-pay is due at the time of each visit. Patient acknowledges that the insurance co-pay does not always fully cover the cost of Patient's visit with Mason Family Chiropractic and Wellness. Each insurance plan has different deductibles, co-pays and limits for chiropractic treatment. Mason Family Chiropractic and Wellness does attempt to obtain accurate insurance information for our patients. However, it is ultimately the responsibility of Patient to know and understand Patient's insurance benefits. In the event that Patient's insurance plan does not cover the full cost of treatment, Patient is responsible for the full remaining balance according to the terms of Patient's insurance plan. Patient authorizes patient's insurance company to make payment directly to Mason Family Chiropractic & Wellness on my behalf for any services rendered to patient, patient's minor child or patients dependents. Patient authorizes Mason Family Chiropractic & Wellness to release any information concerning patient's health or health care services to patient's insurance company or pre paid health plan.

If patient's account with Mason Family Chiropractic & Wellness is not paid in full within 90 days the balance will accrue interest at 8% until the balance is paid in full. Mason Family Chiropractic & Wellness may, at its discretion, assign any account not paid within 90 days of the date of service to a collection agency. In the event that a draft tendered by patient for payment of account at Mason Family Chiropractic and Wellness is returned for any reason, Patient will pay a $35.00 returned check fee to Mason Family Chiropractic and Wellness in addition to the full fee owed for services.

This Agreement reflects and contains the entire agreement between Patient and Mason Family Chiropractic and Wellness and no statements, promises or inducements made by or on behalf of any party or its counsel that are not contained herein shall be binding. No amendment or modification to this Agreement shall be effective unless and until agreed to in writing and signed by the parties. In any action to enforce this agreement, Mason Family Chiropractic and Wellness shall be entitled to recover all costs of enforcement, including, but not limited to, attorneys' fees, filing fees, and collection costs. Each party agrees to personal jurisdiction in any action brought within the County of Hamilton, State of Indiana having subject matter jurisdiction over the matters arising under this agreement. Any suit, action, or proceeding arising out of or relating to this agreement shall only be instituted in the county of Hamilton, State of Indiana. Each party waives any objection which it may have now or hereafter to the laying of the venue of such action or proceeding and irrevocably submits to the jurisdiction of any such court in any suit, action or proceeding.

MINOR/CHILD CONSENT

I am the parent or legal guardian of _____ (insert name of minor child, hereinafter referred to as "minor child"). I do hereby request and authorize Mason Family Chiropractic and Wellness to perform chiropractic treatment on minor child. I certify that minor child is covered by insurance with _____(insert name of insurance company) and assign directly to Mason Family Chiropractic and Wellness all insurance benefits payable to me for services rendered by Mason Family Chiropractic and Wellness. I understand that I am financially responsible for all charges whether or not paid by insurance and in the event the minor child is not covered by insurance that payment for services rendered is due at the conclusion of each visit. Parent/Legal Guardian has read and understood Mason Family Chiropractic and Wellness' Agreement as to Financial Responsibility, agrees he or she is a "Patient" as defined therein, and agrees to financial responsibility of charges associated with the care of minor child as a Patient of Mason Family Chiropractic and Wellness.

Date:_____

_____
Signature of Patient

_____
Printed Name

_____
Signature of Parent or Guardian (if minor)

_____
Printed Name of Witness

_____
Signature of Witness

Mason Family Chiropractic & Wellness

Patient Name: _____ Date of Birth: _____

To Our Patients:

In an effort to continually improve our patient service and office efficiency, you have the option of keeping your credit card on file. This information will be held securely, as are all of your medical records. Once your insurance carrier has paid their contracted fees, **any remaining balance owed by you will be charged to your credit card and reflected on your credit card statement. There is a cap of $350.00 on this authorization. If your bill is over $350.00, your credit card will be charged for $350.00 and you will be mailed a statement for any remaining balance.**

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everyone in helping to keep the cost of health care down.

This will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have further questions about this payment method, please ask our staff. If we do not have your credit card information on file, you will be responsible for your co-payment today and any outstanding balance due.

Sincerely,

Mason Family Chiropractic & Wellness

I authorize Mason Family Chiropractic & Wellness to charge my outstanding patient balances to the following credit card:

_____ Visa _____ Master Card _____ Discover _____ I would like to receive a receipt by mail

Credit Card Number: _____

Expiration Date: _____ Security Code: _____ Billing Zip Code: _____

Signature: _____ Date: _____

Name on card (please print): _____

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