Mason Family Chiropractic and Wellness

11580 Overlook Drive
Suite 200
Fishers, IN 46037
Phone 317-577-9558 Fax 317-577-9559

Date ____/____/_____ Referred by: _____

Name _____ Date of Birth ____/____/_____

Address _____ SS# _____-____-_____

City _____ St _____ Zip _____ Home _____ Cell _____

Email (please print) _____

What is your major complaint? _____

_____

_____

Other complaints? _____

_____

_____

How long has it been since you really felt good? _____

_____

Please answer all questions frankly, to the best of your knowledge. All information is confidential

Weight _____ Height _____ Blood Pressure _____% Body Fat _____

1. Are you presently taking any medications, nutritional supplements or vitamins?
   Please list (attach sheet if necessary)

_____

_____

2. In the past, have you used birth control pills and/or antibiotics? _____

   A. For how long? _____

3. If you have fillings, please list material (s) used: _____

4. Do you presently, or have you ever had any of these conditions? (circle)

Anemia	Frequent Headache	Osteoporosis
Arthritis	Heartburn	Skin conditions
Asthma	Heart condition	Thyroid condition
Chest pains	High blood pressure	Unexplained pain anywhere
Chronic cold/flu symptoms	High cholesterol	Unexplained weight change
Chronic fatigue	Hypoglycemia	
Depression	Kidney problems	

4 A). Do you have a primary medical doctor that you see? Yes or No

Doctors Name _____ Date of last physical _____

4 B). Do you currently or within the last 3 months have been treated for an infection.
What was the outcome? _____

_____

4 C). Could you describe your history of surgery. Please include the type and date? _____

_____

_____

_____

4 D). Do you have any history of cancer of chronic disease? Is there a family history of chronic disease or cancer? please list dates, relation and outcome. Please be specific.

_____

_____

_____

_____

5. On average how much sleep do you get each night? _____

6. Do you have any food allergies, sensitivities or restrictions? _____

_____

7. Do you smoke Yes or No If so how often _____
Drink alcohol or use recreational drugs? Yes or No How much, how often? _____

8. Please list foods you tend to overeat or crave? _____

_____

9. Are there foods that you eat on a daily basis, almost daily? _____

_____

A. do you "miss" these foods if you do not eat them? _____

10. Write briefly about your weight gain/loss history: _____

_____

_____

A. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits

B. Was your weight gain/loss: (circle) sudden gradual problem since childhood boredom

11. Please list close relatives that have diabetes, heart disease or obesity: _____

_____

12. What methods have you tried to lose/gain weight? _____

_____

13. How is your energy level? _____

A. Are there times in the day that you feel best? _____ Worse? _____

14. Are you happy in your life right now? _____

15. What are your main sources of stress? _____

_____

_____

16. How do you deal with your stress? _____

_____

_____

17. Please answer the following questions Yes or No:

A. If I'm feeling down, a snack makes me feel better? Yes or No

B. I sometimes have a hard time going to sleep without a bedtimes snack? Yes or No

C. I get tired and/or hungry in the mid-afternoon? Yes or No

D. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert. Yes or No

E. Now and then I think I am a secret eater ? Yes or No

F. At a restaurant, I almost always eat too much bread before the meal is served? Yes or No

G. I have difficulty concentrating , or frequent fuzzy or spacey thinking patters? Yes or No

H. I experience cravings for sugar, breads, pasta and baked goods? Yes or No

I. I feel shaky if I don't' eat on time or if I don't snack? Yes or No

J. I often find myself irritable or angry? Yes or No

18. Check off any of the following that have applied to you within the last 30 days:

_____ do you feel nauseous?

_____ do you have bloating?

_____ do you get heartburn?

_____ do you have constipation?

_____ do you have gas?

_____ do you belch following meals?

_____ do your bowel movements alternate between constipation and diarrhea?

_____ do you have abdominal/intestinal pain?

_____ do you get bloated after meals?

_____ do you have diarrhea?

_____ are your stools compact/hard to pass?

_____ do you have gurgles in your stomach?

19. In your estimation, how physically fit re you right now? (circle) Unfit Below average Average Very fit

20. How often do you exercise? _____

A. What is your regime? _____

_____

21. If you do not currently exercise, what types of exercise have you enjoyed in the past? _____

_____

22. What are your fitness goals? (check all that apply)

_____ General fitness endurance
_____ Weight loss/maintain weight
_____ osteoporosis prevention
_____ Specific sport enhancement
_____ Flexibility
_____ Muscle toning
_____ Muscle strengthening
_____ Muscle coordination/balance
_____ Other _____
_____

23. Surgeries, starting with most recent: _____

_____

24. Hospitalizations: _____

25. Briefly describe where you have lived since childhood: _____

_____

_____

26. What is your heritage? (Irish, German, Spanish etc.) _____

27. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply.

Is your life:

Satisfactory	Now or Past
Boring	Now or Past
Demanding	Now or Past
Unsatisfactory	Now or Past

Do you worry over:

Home life	Now or Past
Marriage	Now or Past
Children	Now or Past
Job	Now or Past
Income	Now or Past
Money	Now or Past

Do you often:

Feel depressed	Now or Past
Have anxiety	Now or Past
Have irrational fears	Now or Past
Feel upset	Now or Past
Feel things go wrong	Now or Past
Feel shy	Now or Past
Cry	Now or Past
Feel Inferior	Now or Past

Have you:

Seriously considered suicide
Attempted suicide

Functional Medicine Informed Consent

We, the Staff of Mason Family Chiropractic & Wellness, Inc, want to thank you for your interest in our services and congratulate you on taking the first step in becoming responsible for your health. The most vital ingredients needed to achieve optimum health are your commitment, patience, and dedication.
Functional Medicine is about identifying factors that may be contributing to your health concerns. Once identified these factors may be addressed with, but are not limited to, diet and nutritional supplementation, lifestyle recommendations, and stress management/sleep recommendations. Dr. Mason obtained a master's degree in nutrition to help his patients achieve optimal health through dietary and lifestyle changes.
Dr. Mason also believes in teaching his patients and he expects you to be a willing participant in your treatment. Natural treatments do not typically work quickly but work over time and in a cumulative fashion. It is important that you follow those protocols and recommendations given to you exactly as recommended to receive maximum benefits.

All elements of treatment are important and work synergistically. If you feel that you will have difficulty or are unable to comply with treatment, please let us know and our Staff will endeavor to offer options or help you seek a practitioner who might better meet your needs. Also, If you are currently under the care of other licensed clinicians, our protocols and recommendations are designed to work in conjunction with any existing protocols and prescriptions your healthcare providers have recommended or prescribed.

Dr. Mason does not advise nor recommend that treatment with other physicians or healthcare providers be discontinued. Please let your him know if you are being treated by another healthcare provider. If you wish to discontinue any medications previously prescribed- you must discuss this with the prescribing physician. Understand our relationship will be considered a "partnership," and it is your responsibility to disclose prior medical conditions, supplements or substances you are allergic to, changes in your condition, symptoms, contact information, or treatments between visits. Treatment with Dr. Mason is not a replacement for regular primary care, or specialized form of medicine such as a Gastrointestinal specialist. Health-related questions are encouraged, and the treatment protocol may encourage you to make dietary or lifestyle changes to achieve the desired results.

While undergoing a Functional Medicine program the most common issues that arise are from changes in how your body responds to diet change and being more physically active—especially if it has been awhile since someone has exercised regularly. Dr. Mason will always take this process slowly and recommend changes he thinks your body is ready for. He also recommends at times that your ongoing care coincide with regular check ups or lab testing with your primary care doctor or specialists. Additional but rare risks are a reaction to supplements given, or a supplement/medicine reaction, that may involve serious complications and may require additional medical care including the emergency room. Dr. Mason thoroughly investigates any supplement/drug interactions prior to putting his patients on natural substances, but he can not fully anticipate which patients will encounter such a reaction, as everyone responds differently to supplements whether they are on medication at the time or not. Most natural supplements are well tolerated by patients, but if you think you are having a reaction to supplements given at the office you are to call him on his cell phone 317-517-1093 immediately, or contact your primary care provider, or go to the emergency room as soon as possible.

Dr. Mason may as a part of your care send lab kits out of this office for analysis of saliva, stool, or home blood finger prick samples to get at the root of your issues.

The patient and doctor both enter this relationship on a voluntary basis. Both/either doctor or patient can terminate the relationship at any time without consequence.
Patients are expected to follow instructions and guidance outlined by Dr. Mason and to maintain an honest, open line of communication. Patient understands that Dr. Mason cannot guarantee results from nutritional/dietary/lifestyle therapies; and if said course of action is not meeting treatment goals, you will be referred to your primary care doctor, a specialist, or another natural practitioner to further evaluate and treat.

If any changes to this agreement need to be made the document will be updated and sent to the patient for agreement.

INFORMED CONSENT

I understand and agree to the information contained and explained in this Consent document. I, as the patient, agree that I am accepting or rejecting this care of my own free will and choice. I, the patient, am not an agent of any private, local, county, state or federal agency attempting to gather information without so stating my intentions. I, the patient, have read and/or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I understand the above. I intend this consent form to cover the entire course of my treatment for my present condition and for any future conditions for which I seek treatment with Dr. Mason. I further understand that Dr. Mason can not guarantee results during your treatment program, and you may be referred out to other practitioners if treatment goals are not met, or if your condition worsens for further evaluation and management.

_____
Printed name of patient or guardian of minor

_____
Signature of patient or guardian of minor

_____/_____/_____
Date

MASON FAMILY CHRIOPRACTIC & 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 rescheduled the appointment.

In the event that 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.

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. The terms of this Agreement shall be construed under the law of the state of Indiana, and proper venue shall be in Hamilton County, Indiana.

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/ Guardian (if minor)

_____
Printed Name of Witness

_____
Signature of Witness