



Mahalko Family Chiropractic
N112 W15237 Mequon Road, Suite 200
Germantown, WI 53022
Phone (262) 255-7515 Fax (262) 255-7513

CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT

Full Name _____
Name of wife, husband, or guardian _____
Address _____ City _____ State _____ ZIP _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-mail _____
Married ___ Single ___ Divorced ___ Widow(er) ___ Number of Children ___ Pregnant: ___ Due Date: _____
Date of Birth _____ Age _____
Employer _____ Employer Address _____
Spouse's Employer _____ Address _____
Whom may we thank for referring you? _____

Chiropractors you have seen before:

Name _____ City _____ State _____ When _____
Name _____ City _____ State _____ When _____

List medical doctors seen within the past year:

Name _____ City _____ State _____ When _____
Name _____ City _____ State _____ When _____

List all accidents or injuries:

Type _____ When _____ Hospitalized? _____
Type _____ When _____ Hospitalized? _____

List all surgeries:

Type _____ When _____
Type _____ When _____

List medications and/or vitamins and supplements you are taking:

Type _____ For _____ How long _____
Type _____ For _____ How long _____

Use back of sheet for any additional space needed.

PAIN DRAWING

Name: _____ Date: _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark the areas of radiating pain, and include all affected areas. You may draw on the face as well.

Pain Symbols:

Numbness

Pins & Needles

o o o o o o o o

Burning Pain

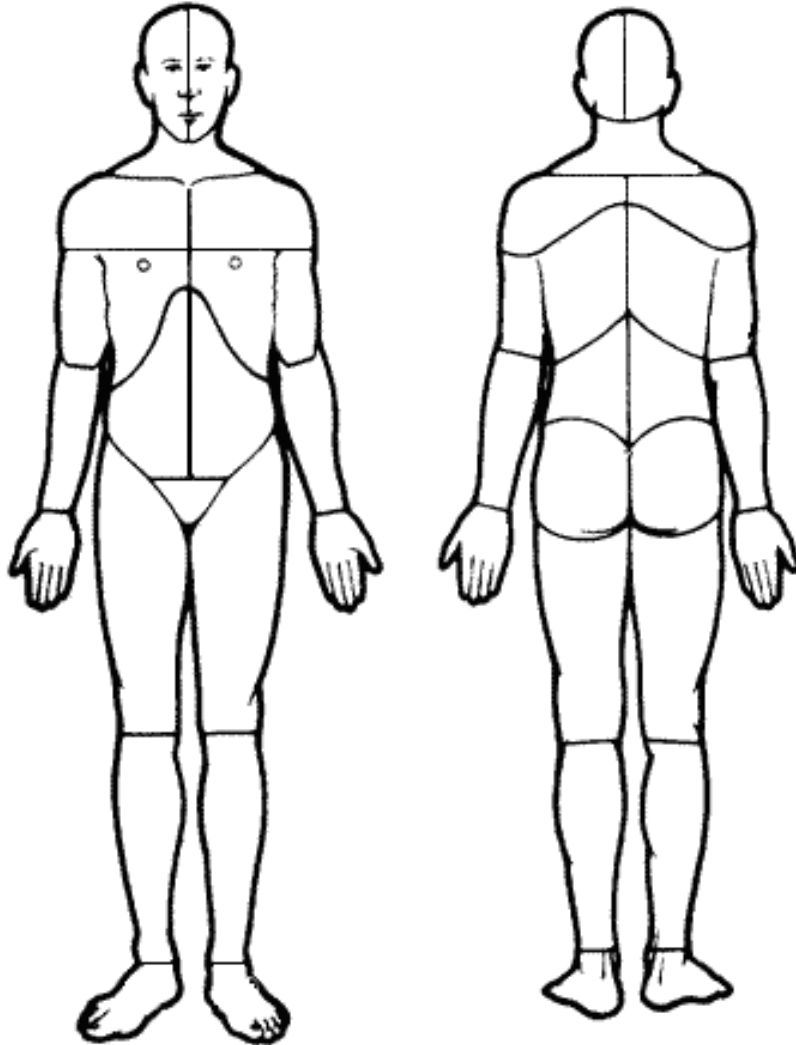
x x x x x x x x

Stabbing Pain

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Aching Pain

((((((((



Chief Complaint: _____

Patient Explanation of Incident: _____

Date of Onset: _____ Did symptoms appear gradually or suddenly?: _____

On the Job: _____ Yes _____ No Days off Work: _____

Auto Accident: _____ Yes _____ No Days off Work: _____

Past and Present Conditions – Mahalko Family Chiropractic

Patient Name _____ Date _____

Below are listed common symptoms which may suggest the presence of an ailment involving a particular body system. If you ever had a listed symptom in the past, please check that symptom in the left hand column. If you are presently troubled by a particular symptom, check that symptom in the right hand column.

Past	Musculoskeletal	Present	Past	Respiratory	Present
[]	Neck pain	[]	[]	Shortness of breath	[]
[]	Shoulder pain	[]	[]	Chronic pain	[]
[]	Pain in upper arm or elbow	[]	[]	Chronic cough	[]
[]	Hand pain	[]	[]	Chronic sinusitis	[]
[]	Upper back pain	[]			
[]	Low back pain	[]	Past	Gynecologic	Present
[]	Pain in upper leg or hip	[]	[]	Pain during menstruation	[]
[]	Pain in lower leg or knee	[]	[]	Irregular menstrual flow	[]
[]	Pain in ankle or foot	[]	[]	Spotting	[]
[]	Jaw pain	[]	[]	Menopausal symptoms	[]
[]	Swelling in joints (list joints)	[]			
[]	Stiffness of joints (list joints)	[]	Past	Genito-Urinary	Present
			[]	Painful urination	[]
			[]	Loss of bladder control	[]
			[]	Frequent urination	[]
			[]	Urethral discharge	[]
Past	Nervous System	Present	Past	GI Tract	Present
[]	Depression	[]	[]	Abdominal pain	[]
[]	Insomnia	[]	[]	Difficult swallowing	[]
[]	Bedwetting	[]	[]	Heartburn/indigestion	[]
[]	Fainting	[]	[]	Constipation	[]
[]	Convulsions	[]	[]	Diarrhea	[]
[]	Dizziness	[]			
[]	Headache	[]	Past	Skin	Present
[]	Muscular incoordination	[]	[]	Rash	[]
[]	Hearing loss	[]	[]	Dermatitis or eczema	[]
[]	Tinnitus (ear noises)	[]	[]	Persistent itching	[]
[]	Ear pain	[]			
[]	Impaired vision	[]			
[]	Eye pain	[]			
[]	Paralysis	[]			
Past	Cardiovascular	Present	Please check any of the following that apply to you.		
[]	Rapid heart beat	[]	[]	Tobacco	
[]	Chest pains	[]	[]	Alcohol	
			[]	Tranquilizers/Sedatives	
			[]	Laxatives	
Past	Endocrine	Present	[]	Coffee, cups/day _____	
[]	Loss of appetite	[]	[]	Regular soda, cans/day _____	
[]	Abnormal weight gain	[]	[]	Diet soda, cans/day _____	
[]	Abnormal weight loss	[]	[]	Water _____	

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or presently troubled by a listed disorder.

Past	Condition	Present	Past	Condition	Present
[]	Hemorrhoids	[]	[]	Emphysema	[]
[]	Rheumatic heart disease	[]	[]	Arthritis	[]
[]	High blood pressure	[]	[]	Drug or alcohol dependency	[]
[]	Angina	[]	[]	Diabetes	[]
[]	Heart attack	[]	[]	Ulcer	[]
[]	Stroke	[]	[]	Kidney stones	[]
[]	Asthma	[]	[]	Bladder infection	[]
[]	Gallbladder	[]	[]	Other _____	[]
[]	Cancer	[]	[]	Other _____	[]
[]	HIV positive/AIDS	[]	[]	Other _____	[]

MAHALKO FAMILY CHIROPRACTIC HAS MY PERMISSION TO SEND ME APPOINTMENT REMINDERS.

_____ YES - BY PHONE

_____ YES - BY TEXT MESSAGE

_____ NO

MAHALKO FAMILY CHIROPRACTIC HAS MY PERMISSION TO LEAVE A PHONE MESSAGE OR VERBAL MESSAGE WITH WHOEVER ANSWERS THE PHONE REGARDING APPOINTMENT INFORMATION OR CONCERNS REGARDING MY CARE.

_____ YES

_____ NO

MAHALKO FAMILY CHIROPRACTIC HAS MY PERMISSION TO SEND NEWSLETTERS OR OTHER PRINTED MATERIAL TO ME VIA US MAIL OR OTHER SIMILAR METHODS.

_____ YES

_____ NO

ELECTRONIC NEWSLETTERS OR OTHER ELECTRONIC MATERIAL MAY BE SENT TO MY E-MAIL ADDRESS(S).

_____ YES

_____ NO

MAHALKO FAMILY CHIROPRACTIC WILL PREPARE INSURANCE FORMS AND REPORTS IF YOU WISH TO FILE WITH INSURANCE. CASH PAYMENTS AND INSURANCE COPAYS ARE DUE AT THE TIME SERVICE IS PROVIDED.

BY SIGNING BELOW, I AGREE TO THE INFORMATION ABOVE, SERVICES TO BE RENDERED, AND RESPONSIBILITY OF CHARGES INCURRED AT THIS OFFICE. IF INSURANCE DOES NOT COVER FILED CHARGES, I UNDERSTAND THAT I WILL BE FULLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES PROVIDED.

Printed Patient Name

Signature (guardian if minor)

Date

Mahalko Family Chiropractic

INFORMED CONSENT TO CHIROPRACTIC CARE

THE NATURE OF CHIROPRACTIC TREATMENT: The doctor will use his/her hands to move your joints. You will typically feel and hear the movement of the joints similar to popping your knuckles. Therapeutic ice may be used.

POSSIBLE RISKS: You may feel tired after your first adjustment. You may feel sore like you “used muscles you didn’t know you had” like after your first workout at a gym. A very small percentage of people may feel pain, tingling, numbness, cramps or tightness in their extremities. There is a one in one million to one in ten million chance of stroke associated with certain types of cervical (neck) manipulation. We do not employ that type of procedure in our office. The risks of complications due to chiropractic care have been described as “rare”.

OTHER TREATMENT OPTIONS: Other treatment options which could be considered may include the following:

-Over-the-counter analgesics: The risks of these medications include irritation to the stomach, bleeding ulcers, liver and kidney damage, heart attacks, and other side effects in a significant number of cases.

-Medical Care: including prescribed anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

-Hospitalization: in conjunction with medical care adds risk of exposure to virulent communicable disease occurs in a significant number of cases.

-Surgery: in conjunction with medical care adds risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risk of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and include chronic pain cycles.

By signing below, I agree to the following: I have read the explanation above. I will have had the opportunity to have any questions answered to my satisfaction before beginning treatment. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo treatment, and hereby give my full consent to treatment.

Printed Patient Name

Signature (guardian if minor)

Date