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:

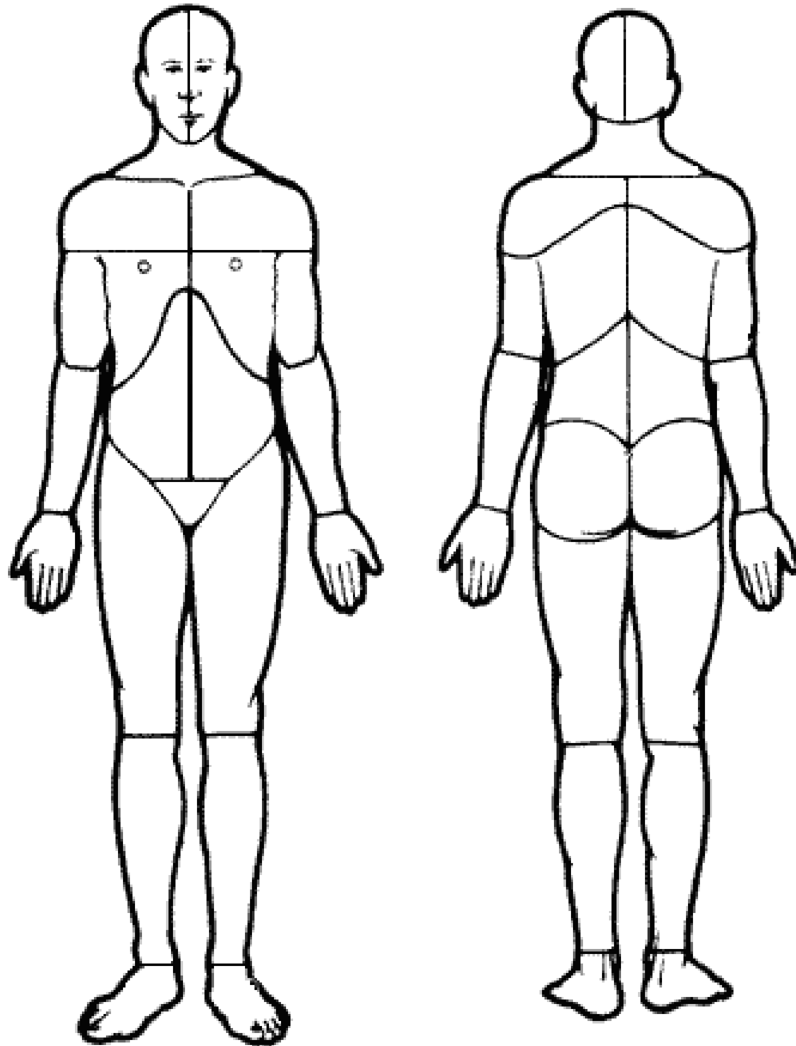
Numbness
- - - - - - - - - -

Pins & Needles
o o o o o o o o o

Burning Pain
x x x x x x x x x

Stabbing Pain
/ / / / / / / / / / /

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
[ ]	Neck pain	[ ]
[ ]	Shoulder pain	[ ]
[ ]	Pain in upper arm or elbow	[ ]
[ ]	Hand pain	[ ]
[ ]	Upper back pain	[ ]
[ ]	Low back pain	[ ]
[ ]	Pain in upper leg or hip	[ ]
[ ]	Pain in lower leg or knee	[ ]
[ ]	Pain in ankle or foot	[ ]
[ ]	Jaw pain	[ ]
[ ]	Swelling in joints (list joints)	[ ]
[ ]	Stiffness of joints (list joints)	[ ]

Past	**Nervous System**	Present
[ ]	Depression	[ ]
[ ]	Insomnia	[ ]
[ ]	Bedwetting	[ ]
[ ]	Fainting	[ ]
[ ]	Convulsions	[ ]
[ ]	Dizziness	[ ]
[ ]	Headache	[ ]
[ ]	Muscular incoordination	[ ]
[ ]	Hearing loss	[ ]
[ ]	Tinnitus (ear noises)	[ ]
[ ]	Ear pain	[ ]
[ ]	Impaired vision	[ ]
[ ]	Eye pain	[ ]
[ ]	Paralysis	[ ]

Past	**Cardiovascular**	Present
[ ]	Rapid heart beat	[ ]
[ ]	Chest pains	[ ]

Past	**Endocrine**	Present
[ ]	Loss of appetite	[ ]
[ ]	Abnormal weight gain	[ ]
[ ]	Abnormal weight loss	[ ]

Past	**Respiratory**	Present
[ ]	Shortness of breath	[ ]
[ ]	Chronic pain	[ ]
[ ]	Chronic cough	[ ]
[ ]	Chronic sinusitis	[ ]

Past	**Gynecologic**	Present
[ ]	Pain during menstruation	[ ]
[ ]	Irregular menstrual flow	[ ]
[ ]	Spotting	[ ]
[ ]	Menopausal symptoms	[ ]

Past	**Genito-Urinary**	Present
[ ]	Painful urination	[ ]
[ ]	Loss of bladder control	[ ]
[ ]	Frequent urination	[ ]
[ ]	Urethral discharge	[ ]

Past	**GI Tract**	Present
[ ]	Abdominal pain	[ ]
[ ]	Difficult swallowing	[ ]
[ ]	Heartburn/indigestion	[ ]
[ ]	Constipation	[ ]
[ ]	Diarrhea	[ ]

Past	**Skin**	Present
[ ]	Rash	[ ]
[ ]	Dermatitis or eczema	[ ]
[ ]	Persistent itching	[ ]

Please check any of the following that apply to you.

[ ] Tobacco
[ ] Alcohol
[ ] Tranquilizers/Sedatives
[ ] Laxatives
[ ] Coffee, cups/day_____________
[ ] Regular soda, cans/day________
[ ] Diet soda, cans/day___________
[ ] 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
[ ]	Hemorrhoids	[ ]
[ ]	Rheumatic heart disease	[ ]
[ ]	High blood pressure	[ ]
[ ]	Angina	[ ]
[ ]	Heart attack	[ ]
[ ]	Stroke	[ ]
[ ]	Asthma	[ ]
[ ]	Gallbladder	[ ]
[ ]	Cancer	[ ]
[ ]	HIV positive/AIDS	[ ]

Past	**Condition**	Present
[ ]	Emphysema	[ ]
[ ]	Arthritis	[ ]
[ ]	Drug or alcohol dependency	[ ]
[ ]	Diabetes	[ ]
[ ]	Ulcer	[ ]
[ ]	Kidney stones	[ ]
[ ]	Bladder infection	[ ]
[ ]	Other___________________	[ ]
[ ]	Other___________________	[ ]
[ ]	Other___________________	[ ]

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

__________ 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