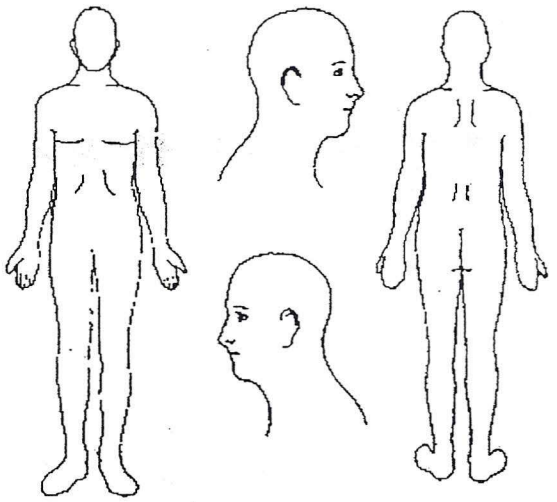
Date of Visit: ___/___/___ Patient: _____ Age: _____

What brought you here today? _____

_____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES



PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Describe your past health history:

Prior Illness: _____

_____

Past Hospitalizations: _____

_____

Surgeries: _____

_____

Medications: _____

Patient Signature: X _____

(DO NOT WRITE BELOW THIS LINE)

EXAMINATION

Range of Motion

Cervical	Normal		Pain
Flexion	50		
Extension	60		
Left Lat Flex	45		
Right Lat Flex	45		
Left Rotation	80		
Right Rotation	80		
Lumbar	**Normal**		**Pain**
Flexion	60		
Extension	25		
Left Lat Flex	25		
Right Lat Flex	25		
Left Rotation	30		
Right Rotation	30		

Health HX Notes:

_____

_____

_____

_____

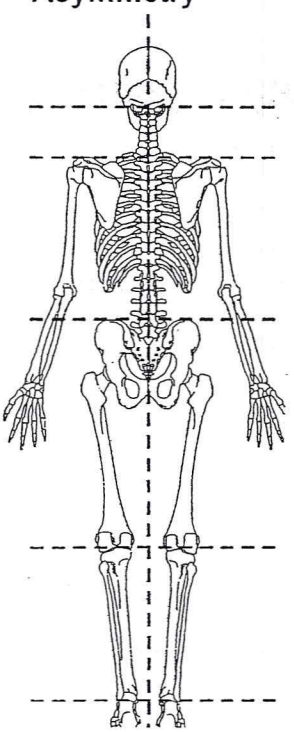
_____

_____

Asymmetry

C0
C1
C2
C3
C4
C5
C6
C7

L1
L2
L3
L4
L5
SAC
L-IL
R-IL

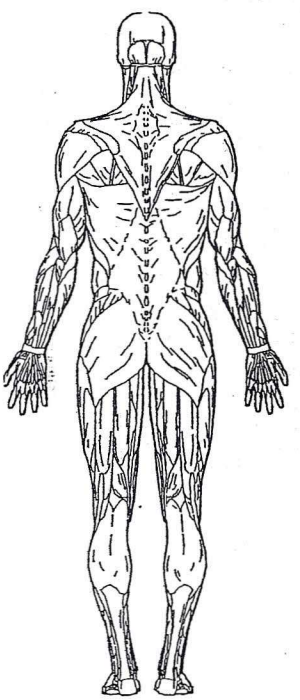


Using arrows (↑ ↓ → ←) mark the misaligned vertebrae

T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

Using arrows (↑↓), mark postural asymmetry

Tissue



Mark tissue abnormalities
TP, LG, TN, SK, FS

TP=Trigger Points; LG=Ligaments (swollen or tender)
TN=Tendons; SK=Skin; FS=Fascial Restrictions

MountainHealth

Chiropractic *and Natural Rehabilitation*

Welcome, and thank you for choosing our practice for your chiropractic needs. If you have any questions or concerns, do not hesitate to discuss them with us. We will be happy to help you. Please print your answers legibly.

Personal Registration Information

Name_____ Date_____
First Middle Last

Address _____
Street City State Zip Code

Phones: Home: _____ Work:_____ Cell _____

Do you prefer to receive calls at: Home ☐ Work ☐ Cell ☐ Male ☐ Female ☐ **Birthdate** _____

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Children's ages:_____ Occupation: _____

Employer_____ Email: _____ How did you hear about our office _____

Name/Address/Phone of Primary Care Physician _____

Emergency Contact_____Phone _____ Relationship:_____

Financial Responsibility (This includes the Policyholder of any insurance you wish to use)

Financially responsible person if not patient: _____ Relationship_____

Full address *if* different than patient: _____

Birthdate_____Employer _____ Work Phone _____

If you intend to use insurance to help pay for services, we will need additional forms signed.

Family Health Profile

Please list any blood-related family member who has had: Diabetes, Heart Disease, Cancer, or Stroke:

_____

_____

Daily Habits

Exercise: None ☐ Monthly ☐ Weekly ☐ Type: _____

Work habits: Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Computer Work ☐ Other ☐ _____

Vitamins: No ☐ Yes ☐ Other Nutritional Supplements: No ☐ Yes ☐_____

Smoke: No ☐ Yes ☐ Type_____How much_____ Alcohol: No ☐ Yes ☐ How much _____

How much caffeine do you consume daily from soft drinks, coffee or other source? _____

On a scale of 1 (none) to 10 (extreme) describe your stress level: Personal _____ Work _____

On a Scale of Poor, Good, or Excellent describe your: Diet _____ Sleep _____ Health_____

Please list ***all*** medications you are currently taking, and what for: _____

_____

_____

Are you currently wearing: Heal Lift _____ Arch Support _____ Brace of any kind? _____

Patient Health History Have you ever had:

☐ AIDS/HIV	☐ Chemical Dependency	☐ Kidney Disease	☐ Rheumatoid Arthritis
☐ Alcoholism	☐ Depression	☐ Knee Problems	☐ Rheumatic Fever
☐ Allergy Shots	☐ Diabetes	☐ Liver Disease	☐ Scarlet Fever
☐ Anemia	☐ Emphysema	☐ Migraine Headaches	☐ Sciatica
☐ Anorexia	☐ Epilepsy	☐ Miscarriage	☐ Scoliosis
☐ Appendicitis	☐ Glaucoma	☐ Mononucleosis	☐ Stroke (minor or major)
☐ Arthritis	☐ Goiter	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Gout	☐ Osteoporosis	☐ Tonsillitis
☐ Breast Lump	☐ Heart Disease/Arteriosclerosis	☐ Pacemaker	☐ Tuberculosis
☐ Bronchitis	☐ Hepatitis	☐ Parkinson's	☐ Typhoid Fever
☐ Bulimia	☐ Hernia	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Herniated Disc	☐ Polio	☐ Vaginal Infections
☐ Carpal Tunnel Syndrome	☐ High Blood Pressure	☐ Prostate Problems	☐ Whiplash injury
☐ Cataracts	☐ High Cholesterol	☐ Psychiatric Care	☐ Whooping cough

☐ Any other medical condition(s) not listed above:_____

Please list any: Broken bones_____

Surgeries_____

Allergies to Medications: _____Other allergies: _____

Have you ever had: Chronic ear infections_____ Prolonged use of antibiotics_____ Inhaler_____Asthma_____

Females:

Are you pregnant? No ☐ Yes ☐ Nursing? No ☐ Yes ☐ Birth Control Pills? No ☐ Yes ☐ When_____ Brand_____

Date of last cycle:_____ Was it: Normal ☐ Painful ☐ Heavy ☐ Light ☐ Cramps ☐ N/A ☐

Addressing The Issues That Brought You to Our Office

Where is the problem(s) located?_____

When did you first notice the symptoms?_____

Type of pain:	☐ Sharp	☐ Throbbing	☐ Numbness	☐ Aching	☐ Shooting	☐ Dull
	☐ Burning	☐ Tingling	☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other

Rate the severity of your pain: (1 = mild/discomfort to 10 = severe): 1 2 3 4 5 6 7 8 9 10

Is the condition getting: Better ☐ Worse ☐ Is the pain: Constant ☐ Comes and Goes ☐

Doctors who have treated you for this condition, and when did you see them? _____

_____

Have you received for your condition: Medication ☐_____ Surgery ☐ Physical Therapy ☐ Other ☐

Please check all symptoms you have had in the last 6 months, even if they do not seem related to your current condition

☐ Headaches	☐ Pins/Needles in Legs	☐ Fainting	☐ Ringing in Ears	☐ Mood Swings
☐ Dizziness	☐ Pins/Needles in Arms	☐ Cold Feet	☐ Buzzing in Ears	☐ Menstrual Pain
☐ Neck Pain	☐ Numbness in Fingers	☐ Cold Hands	☐ Depression	☐ Menstrual Irregularity
☐ Stiff Neck	☐ Numbness in Toes	☐ Diarrhea	☐ Fatigue	☐ Hot flashes
☐ Back Pain	☐ Sleeping Problems	☐ Constipation	☐ Heartburn	☐ Problem Urinating

I certify that I have read and understand the above information to the best of my knowledge. The new patient questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractic doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me - or my child - during the period of such chiropractic care to third party payers and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____

Signature of patient (or guardian if patient is a minor) **Date**

Mountain Health Chiropractic, LLC
1108 W Parker Rd #102
Plano, TX 75075

K. Andrew Shepherd, DC CCN

Phone: 972-398-0440
Fax: 972-398-9069

Consent to X-ray

I hereby authorize Mountain Health Chiropractic, LLC, the doctors named above, and/or qualified assistant(s) to take x-rays of myself (or said minor).

Date_____

_____ _____
Printed Name of Patient **Signature** of Patient

_____ _____
Printed Name of Guardian (If a minor) **Signature** of Guardian

Pregnancy Release

To the best of my knowledge I am not pregnant. I understand that if I am pregnant and have x-rays taken which will expose my lower torso, it is possible to injure the fetus.

I have been advised that the 10 day period from the start of my menstrual cycle is usually considered to be not pregnant and a safe time to have an x-ray exam.

With full understanding of the above, and believing I am not currently at risk, I hereby release Mountain Health Chiropractic, LLC, the doctors named above, and his/her assistant(s) from any and all liability.

Date_____

_____ _____
Printed Name of Patient **Signature** of Patient

_____ _____
Printed Name of Guardian (If a minor) **Signature** of Guardian

Mountain Health
Chiropractic and Natural Rehabilitation

1108 W. Parker Rd #102
Plano, TX 75075

(972) 398-0440

Informed Consent To Chiropractic Adjustments And Care

I hereby request and consent to the performance of chiropractic adjustments and other Chiropractic procedures, including various modes of therapy and diagnostic tests, on me (or the patient below, for whom I am legally responsible) by the doctors of chiropractic at Mountain Health Chiropractic and/or his/her assistants who now, or in the future, treat me while affiliated at the office listed above.

I have had an opportunity to discuss with the doctor of chiropractic, adjustments and other procedures. I understand that results are not guaranteed.

I have been informed and understand that as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including but not limited to fractures, disc injury, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure that the doctor feels at the time, based upon all factors then known, is in my best interest.

I have read, or have had read to me, the above consent. I also have had the opportunity to ask questions about its content; and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I request treatment.

I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____
Date

_____ _____
(**Print** Patient's Name) (Patient's Signature)

_____ _____
(**Print** Guardian's Name if Patient is a Minor) (Guardian's Signature)

MountainHealth
Chiropractic and Natural Rehabilitation

1108 W Parker Rd #102
Plano, TX 75075
(972) 398-0440
Fax: (972) 398-9069

Authorization
Assignment of Benefits

I authorize _____ insurance company to pay ***M*ountain Health Chiropractic** all insurance benefits due to me for services rendered.

I authorize the use of this signature on all insurance submissions, **including** all insurance submissions for family members for whom I am the insured party.

I authorize ***M*ountain Health Chiropractic** to release any information necessary to my insurance company in order to secure the payment of benefits.

I understand that I am financially responsible for all charges incurred in this office, whether or not covered by my insurance company.

_____ _____
PRINT Patient Name Date

_____ _____
PATIENT Signature (or legal Guardian) Relationship if Guardian

NOTE

On occasion, insurance companies will send payment to the patient instead of the doctor.

Should this happen, I agree to NOT cash the check, contact the office, and bring all paperwork with the check to the office.

I understand that I am liable for any monies erroneously sent to me by the insurance company.

_____ _____
PATIENT Signature (or Legal Guardian) Date