Mascoto Chiropractic

Family Wellness Center

The Power that Made the Body Heals the Body

Patient Registration

Patient Contact Information

Patient's Full Name:_____ Home Phone: ( ) _____
Home Address:_____ Work Phone: ( ) _____
City: _____ State: _____ Zip Code: _____
Email Address:_____ Cell Phone: ( ) _____

Personal Information

Social Security #: _____ Marital Status: Single Married Divorced Widowed
Age: _____Date of Birth:_____ Gender: Male Female
Names & Ages of Children: _____

Patient Employment

Employer Name:_____ Occupation: _____
Work Address: _____ City: _____ State:___ Zip: _____

Spouse Information

Spouse's Full Name: _____ Cell Phone: ( ) _____
Employer Name: _____ Work Phone: ( ) _____
Occupation: _____Date of Birth: _____

Emergency Contact

Name: _____ Home Phone: ( ) _____
Relationship: _____ Work Phone: ( ) _____

Who May We Thank for Referring You?_____

Account Information

Insurance Coverage

Primary Ins. Co. Name:_____ Group # :_____ ID#:_____
Secondary Ins. Co. Name:_____ Group #: _____ ID#:_____

Are the insured and the patient the same person? Yes__ No__ If YES, do not complete the next section.

Insured Full Name_____ Address_____
Age: ____ Date of Birth:_____ Social Security #:_____ Gender: Male __ Female __
Relationship to insured: Spouse __ Dependent __ Other _____

Insurance Information

I clearly understand that health and accident insurance policies are an arrangement between my insurance carrier and me. In addition, I understand Mascoto Chiropractic, PLLC will prepare any necessary reports and forms to aid in reimbursements from my insurance company. Any amount authorized to be paid directly to Mascoto Chiropractic, PLLC will be credited to my account upon receipt. Nevertheless, I clearly understand and agree that all my services rendered me are charged directly to me; therefore I am personally responsible for payment.

Signature _____ **Date** _____
(If under 18 years of age) Parent's Signature

Purpose of This Visit

Are you here because you were involved in a vehicle collision? ___ injured at work? ___ If so, when? _____
Purpose of this visit - Primary Complaint:_____
When did this condition begin? _____ Did it begin: Sudden ___ Gradual ___ Progressive over time ___
What makes this condition better? _____ What makes this condition worse? _____
How does this primary complaint feel? Dull/achy __ sharp __ numb __ tingling __ burn __ shooting __ throb __
How often do you experience your symptoms? Constantly ___ daily ___ weekly ___ monthly ___ yearly ___
Please rate your pain level: **best 1 2 3 4 5 6 7 8 9 10 worst** Does your pain radiate? If yes, where? _____
Does your primary complaint interfere with: work __ sleep __ hobbies __ daily routine __ Explain: _____
_____
Have you experienced this condition before? Yes ___ No ___ If yes, please explain _____
Who have you seen for this condition? _____ What did they do? _____
Did condition improve or worsen? _____

Experience with Chiropractic

Have you seen a chiropractor before this visit? Yes ___ No ___ If yes, when? _____
Name(s) of previous chiropractor(s)? _____
Reason for visit with previous chiropractor(s): _____
Do you know that posture can influence your health? Yes ___ No ___
Are you aware of any of your bad posture habits? Yes __ No __ Explain:_____
Have you noticed bad posture habits in your spouse &/or children? Yes __ No __
Explain: _____
The most common posture problem we see is **Forward Head Syndrome** (the head starting to go forward and progressively moving downward, weakening your whole body). Even if it's slight, this can have adverse affects on your overall health. Have you ever noticed or been told that you hold your head slightly forward, noticed a rounding of your shoulders, or a developing "hump" at the base of your neck? Yes __ No __

Medical History

Please mark if you have had any of these symptoms in the last year:

__ Arthritis
__ Diabetes
__ Convulsions/epilepsy
__ Skin problems
__ Cancer
__ Depressed
__ Anemia
__ Under stress
__ Eating disorder
__Trouble sleeping
__Learning disability
__Mood changes
__Pain with cough/sneeze

Have you had any surgeries? Yes __ No __ Explain: _____
Have you ever been hospitalized? Yes __ No __ Explain: _____
Have you had any major illnesses? Yes __ No __ Explain: _____
Please list any previous falls or accidents: _____

Family History

List your siblings, their age, & if they have any health problems: _____
_____
What is the health of your parents? _____

Social/Medical History

How many times in your life have you taken antibiotics? _____ Have you taken them recently? Yes __ No __
Did you or are you currently taking a probiotic (i.e. acidophilus)? Yes __ No __
Please list any medications you're currently taking and their purpose: _____
_____

Health & Lifestyle

Do you exercise? Yes __ No __ How often per week? 1X 2X 3X 4X 5X other: _____
What type of exercise? Weight training Running/Jogging Yoga Pilates Swimming Other: _____
Do you drink alcohol? Yes __ No __ How much per week? _____
Do you smoke? Yes __ No __ How much? _____
Do you drink coffee or any other caffeinated drinks? Yes __ No __ How much/day? _____
Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

Bad posture habits are the result of stress or trauma to the body that have caused the misalignment of the vertebrae in your spine. When these vertebrae are misaligned from their normal position, they will cause stress to the spinal cord and nerves that exit between the vertebrae. We call these misalignments **Subluxations**. It has been significantly documented that subluxations will weaken and alter the overall structure of your spine. This results from bad posture habits.
Please check any health condition you may be experiencing now or in the past.

Cervical Spine (Neck):

Postural alterations from subluxations (causing Forward Head Syndrome) in your neck will cause weakness of the nerves into your head, shoulders, arms, and hands. Do you have any of the following?

__ Neck pain
__ Pain into shoulders/arms/hands
__ Numbness/tingling in arms/hands
__ Weakness in grip
__ Hearing disturbances
__ Ear infections
__ Headaches
__ Dizziness
__ Visual Disturbances
__ Coldness in hands
__ Thyroid conditions
__ Sinus problems
__ Allergies
__ Recurrent Colds/Flu
__ Fatigue/Low Energy Levels
__ TMJ/Pain/Clicking

Thoracic Spine (Upper Back):

Postural alterations from subluxations (causing Forward Head Syndrome) in your upper back will weaken the nerves to the lungs and heart. Do you have any of the following?

__ Upper Back Pain
__ Asthma/Wheezing
__ Shortness of Breath
__ Pain on Deep Inspiration/Expiration
__ Recurrent Lung Infections/Bronchitis
__ Heart Palpitations
__ Heart Murmurs
__ Heart Attacks/Angina
__ Tachycardia (increase heart rate)

Thoracic Spine (Mid Back):

Postural alterations from subluxations (causing Forward Head Syndrome) in your mid back will weaken the nerves to the ribs/chest & upper digestive tract including your liver, gallbladder, and kidneys. Do you have any of the following?

__ Mid Back Pain
__ Pain Into Ribs/Chest
__ Indigestion/Heartburn
__ Reflux
__ Nausea
__ Gastritis
__ Hypoglycemia
__ Ulcers
__ Digestive problems
__ Liver problems
__ Gallbladder problems
__ Kidney problems

Lumbar Spine (Low Back):

Postural alterations from subluxations (causing Forward Head Syndrome) in your low back will weaken the nerves to the pelvic organs, hips, legs, and feet. Do you have any of the following?

__ Low back pain
__ Numbness/Tingling in Legs/Feet
__ Coldness in Legs/Feet
__ Muscle Cramps in Legs/Feet
__ Weakness/Injuries in Hips/Knees/Ankles
__ Constipation/Diarrhea
__ Hemorrhoids
__ Recurrent Bladder Infections
__ Frequent/Difficulty Urinating
__ Sexual Dysfunction
__ Prostate Problems
__ Menstrual Problems (PMS)
__ Pregnant *(NOW)*
__ Hip Pain

Terms of Agreement

When a person is seeking chiropractic and wellness care, it is very important for both parties (doctor and patient) to work toward the same goal. As a Chiropractic and Family Wellness Center, our main goal is to detect and correct/reduce the Vertebral Subluxation Complex. Here are some terms to better understand the method we use to attain this goal:

Wellness: A healthy balance of the mind, body, and spirit that results in an overall feeling of well-being & it's also more than just being disease or pain free.

Vertebral Subluxation: A misalignment of one or more of vertebrae in the spinal column which causes nerve alterations and interference of mental impulses, resulting in dysfunction of the body's God give ability to express its maximum health potential.

Adjustment: A specific force applied to assist the body's correction of vertebral subluxation. The subluxations adjusted in this office are detected during the initial exam and the beginning of each visit.

We do not offer to diagnose or treat a disease or condition other that vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. We also do not offer advice regarding treatment prescribed by other health care professionals. Our only objective in our office is to eliminate the nerve interference to the expression of our body's God given ability to heal from the inside out. The method used in this office to correct vertebral or extremity subluxation is specific spinal or extremity adjustments along with rehabilitation procedures.

Consent to Care

I do hereby authorize the doctor of Mascoto Chiropractic, PLLC to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments, and other chiropractic procedures, including various modes of physical therapy or other procedures that are advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and was informed 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 injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, 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 seek treatment.

Signature:_____ Date:_____
(Parent's Signature if under age 18)