MVMT

CHIROPRACTIC

Dr. John David Mason, D.C.

3420 West Dallas
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(832) 391-8077

PERSONAL HISTORY

Name: _____ Today's Date _____

Address: _____ Business Employer: _____

City: _____ Type of Work: _____

State: _____ Zip/Postal Code: _____ Work Phone: _____

Home Phone Number: _____ Cell:_____

Date of Birth: _____ Age: __ Sex: □ M □ F Circle One: Single Married Widowed Divorced Separated

Email Address:_____ Name Of Spouse (If applicable): _____

Name of Individual you authorize us to share your health information/appointment scheduling/financial information: _____

Referred To This Office By: _____ Phone Number of Emergency Contact: _____

Who is Responsible For Your Bill, You and □ Spouse □ Workers' Comp □ Auto Insurance □ Medicare

□ Personal Health Insurance Co.: _____ □ Health Card Number: _____

Insured Person's Name:_____ Insured Person's Date of Birth: _____

Name of Primary Care Physician (PCP):_____

PCP Address: _____

CURRENT HEALTH CONDITION

Reason for Visit: _____

When Did This Condition Begin?_____ Has the Condition Occurred Before? □ Yes □ No

Is this condition getting worse? □ Yes □ No Rate the severity of the pain 1 (least pain) to 10 (severe pain) _____

Type of Pain: □ Sharp □ Dull □ Throbbing □ Numb □ Stiff □ Burning □ Aching □ Shooting □ Tingling □ Cramping _____

How often do you have this condition: _____ Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful to perform: □ Sitting □ Standing □ Lifting □ Walking □ Lying Down

Other Doctors Seen For This Condition: □ Yes □ No If Yes Who? _____

Type of Treatment: _____ Results: _____

Is Condition: □ Job Related □ Auto Accident □ Home Injury □ Fall □ Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report Of Your Accident To Your Employer/Insurance Company: □ Yes □ No

Drugs You Take Now: □ Nerve Pills □ Pain Killers/Muscle Relaxers □ Blood Pressure Medicine □ Insulin □ Other

_____

Vitamins/Herbs/Minerals You are taking: _____

_____

Do You Suffer From Any Other Condition Other Than That Which You Are Now Consulting Us? _____

_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gall Bladder □ Hernia □ Back Surgery □ Broken Bones

□ Other (please list details)_____

Major Accidents Or Falls: _____

Hospitalization (Other Than Above): _____
Previous Chiropractic Care: □ None □ Doctor's Name & Approximate Date of Last Visit: _____
Date of Last: Spinal X-ray _____ MRI _____ (region:_____) Physical Exam _____

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect you overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES or SYMPTOMS YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer (type: _____)
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

Have you tested HIV Positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Gas/Bloating After Meals
- ☐ Heartburn/Reflux
- ☐ Black/Bloody Stool
- ☐ Irritable Bowel/Colitis/Chron's

NERVOUS SYSTEM

- ☐ Weakness in arms/legs/body
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Cold or discolored extremities
- ☐ Fainting
- ☐ Convulsions or Seizures
- ☐ Tingling Extremities

GENERAL CODE

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine
- ☐ Kidney Stones

C-V-R

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems or congenital defect
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches or Infection
- ☐ Hearing Difficulty
- ☐ Stuffed Nose or Sinus Infection
- ☐ Ringing in the ears

MALE/FEMALE

- ☐ Menstrual Irregularity

FEMALES ONLY

When was your last period?

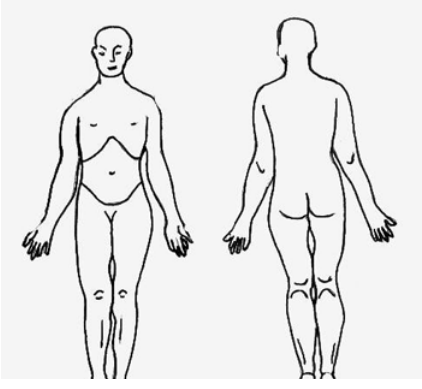
_____

Are you Pregnant?
☐ Yes ☐ No

MENTAL/EMOTIONAL

- ☐ Anxiety
- ☐ Psychotic episodes
- ☐ Attempted suicide in lifetime
- ☐ Anger/aggression
- ☐ Attention Deficit
- ☐ Depression

Please outline on the diagram the area of your discomfort



- ☐ Fatigue
- ☐ Allergies (List: _____)
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems

PAST HEALTH HISTORY (cont)

GASTRO-INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

FAMILY HISTORY

List family members with the following illnesses:

- ☐ Heart Disease _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Stroke _____
- ☐ Neurological Disorder _____
- ☐ Other _____

Height_____

Weight_____

EXERCISE

- ☐ **None**
- ☐ **Mild 1-2x/wk**
- ☐ **Moderate 3x/wk**
- ☐ **Daily**
- ☐ **Heavy (daily and intense)**

HABITS

- ☐ **Smoking (Pack/day)_____**
- ☐ **Alcohol (Drinks/wk) _____**
- ☐ **Coffee/Caffeine (Cups/day) ___**
- ☐ **Water Ounces/day _____**
- ☐ **High Stress Level**
  Reason _____
- ☐ **Things you do to handle stress**

  _____

  _____

Sign_____ Date_____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc.on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative (if patient is minor or handicapped) Date

x_____ _____
Witness to Patients' Signature Date

Doctor:_____

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Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits (4 for amex) located on the back of the credit card)

Billing Zip _____

Cardholder – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____