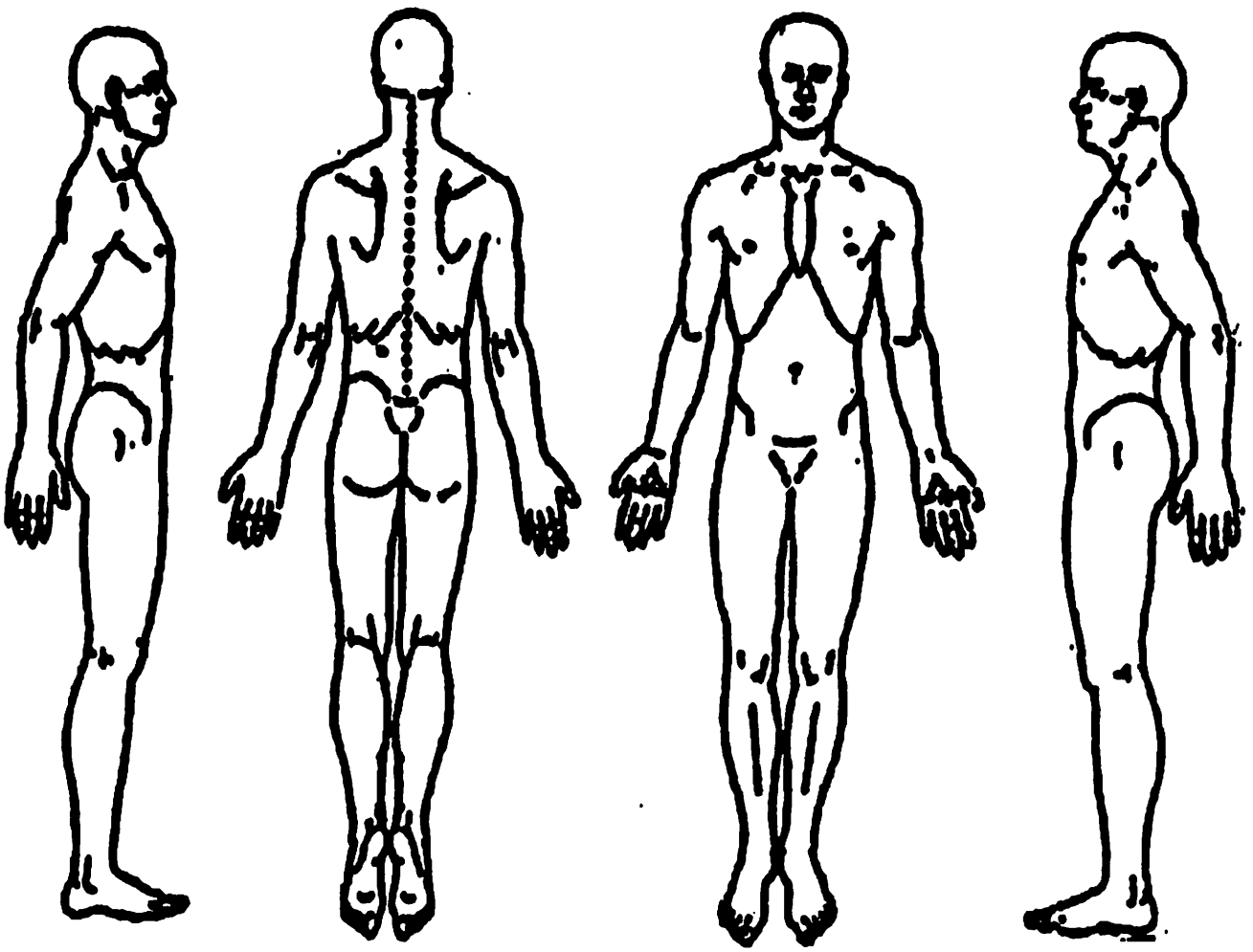
## Welcome to Mulholland Chiropractic Center, LLC

Patient Name: _____ Today's Date: _____

### *Pain Diagram*

This is a Pain Diagram. We would like you to "draw in" the pain areas you are experiencing, with arrows pointing to the affected areas. Please number them in order of severity or priority, the first problem you will be answering questions about being "1", and so on. If you have several problems to report, feel free to ask for more question sheets to report them.



Thank you so much for choosing our office for your chiropractic care. By filling out this paperwork, you're allowing us to get to know you a little bit better and quite a bit faster, therefore making your first experience at our office that much more pleasant. We appreciate your patience, and if you have any questions or concerns about any of our following questions, please feel free to bring them up with us when you come to the office. Again, thank you for your attention in filling out these forms. We are looking forward to meeting you!

**Demographics** Today's Date: _____

1. Patient name: (first/middle/last) _____
2. Address: Physical _____
   Mailing _____
3. Phone number Home _____ Work _____ Cell _____
4. E-mail _____
5. Date of birth _____/_____/_____ Age _____
6. Gender ◻ male ◻ female
7. Employment ◻ Employed ◻ Unemployed ◻ Retired ◻ Homemaker ◻ On Disability ◻ Other: Please complete the sentence:

"I am _____."

If Employed, complete the sentence: "I'm employed at _____ as a _____."

8. Marital Status ◻ Married ◻ Unmarried If married,

   Spouse name: (first/middle/last) _____

   E-mail _____
9. Guardian name (first/middle/last) _____

   Number _____
10. Emergency contact name (first/middle/last) _____

    Number _____
11. How did you hear about us? _____
12. Type of claim ◻ Workers Compensation ◻ Personal injury ◻ Commercial insurance ◻ Medicare ◻ Medicaid

    ◻ Denali Kid Kare ◻ Managed care ◻ VA ◻ Self-pay ◻ Other: _____
13. Insurance information Patient Social Security number _____/_____/_____

- Primary insurance co. _____ Insured Name _____

  Policy #. _____ Group #. _____

  Phone number (on the back of your card) _____
- Second insurance co. _____ Insured Name _____

  Policy #. _____ Group #. _____

  Phone number (on the back of your card) _____
- Third insurance co. _____ Insured Name _____

  Policy #. _____ Group #. _____

  Phone number (on the back of your card) _____

14. If Workers Comp or Personal Injury, do you have a claim pending? □ Yes □ No

If Yes: Insurance co. _____ Claim Number _____

Adjuster _____ Phone no. _____

15. Do you have an attorney involved? □ Yes □ No

If yes, Attorney name _____ Phone no. _____

16. Have you read and do you accept our Privacy Practices? □ Yes □ No

17. Have you read the Authorization and Consent Form and do you agree to its terms? □ Yes □ No

18. Medicare only. Have you filled out the ABN form? □ Yes □ No

**History of Present Illness**

1. Chief Complaint/Reason for visit? _____

When did this problem start? _____

2. How did this start? (Please check one) □ abruptly (all at once) or □ gradually (over a period of time)? Describe: _____

_____

3. What caused this problem? □ A work accident □ A motor vehicle accident □ Other: "This happened as a result of _____

_____

4. Which of the following symptoms are constant? □ none, □ dull, □ achy, □ burning, □ tingling, □ stiff, □ sharp, □ numb, □ shooting, □ electric, □ stabbing, □ diffuse, □ other: If "other" is checked, please complete the following sentence. "This pain is best described as _____."

Which of the following symptoms are intermittent? (Please check all that apply)

□ none, □ dull, □ achy, □ burning, □ tingling, □ stiff, □ sharp, □ numb, □ shooting, □ electric, □ stabbing, □ diffuse, □ other: If "other" is checked, please complete the following sentence. "This pain is best described as _____."

What percentage of the time are you having these intermittent symptoms? (please circle one)

10% 20% 30% 40% 50% 60% 70% 80% 90%

5. How would you grade the intensity of this pain at its worst on a 1-10 scale, with 1 being the least amount of pain and 10 being the worst, most unbearable pain?

(Please circle one) 1 2 3 4 5 6 7 8 9 10

6. Does this pain radiate to other areas? (please check one) □ Yes □ No If "yes" was checked, please complete the sentence: "This pain radiates to the _____."

7. What makes this condition worse? (Please check all that apply)

□ work, □ lifting, □ sitting, □ coughing, □ sneezing, □ bending, □ standing, □ walking, □ sleeping, □ reaching, □ other: If other is checked, please complete the following sentence: "This condition is aggravated by _____."

8. What makes this condition better? (Please check all that apply)

□ nothing, □ prescription medications, □ over-the-counter medications, □ stretching, □ exercising, □ massage, □ walking, □ rest, □ heat, □ ice, □ analgesic cream, □ other: If other is checked, please complete the following sentence: "This condition is relieved by _____."

9. Who else have you seen anyone else for this condition? (please check all that apply)

□ No one, □ a family doctor, □ an orthopedist, □ an internist, □ a primary care physician, □ an emergency room physician, □ a massage therapist,

□ a physical therapist, □ an acupuncturist, □ a chiropractor, □ other: If other is checked, please complete the following sentence: "I have also seen

_____ for this." Have any of these been helpful? □ Yes □ No

**Review of Systems**

We now have some questions that may seem like they're unrelated, but they may be important in understanding your overall health. Please check any of the other systems below with which you are currently having difficulty. Your doctor will have more specific questions about them during your consultation. Please check all that apply.

□ 1. Constitutional. *This would be symptoms like unexplained weight loss, night sweats, unexpected fatigue, reduced appetite, or fever.*

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□ 2. Eyes. *This would include symptoms like visual changes, headache when you read, eye pain, double vision, blind spots, pressure in your eyes, "floaters", or unexpected colors or shadows.*

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□ 3. Ears, nose, mouth, and throat (ENT). *This would include symptoms like runny nose, pain in the nose, frequent nosebleeds, sinus pain, stuffy ears, pain in the ears, discharges from the nose or ears, pain in the teeth or mouth, ringing in the ears, bleeding gums, sore throat, or pain to swallow?*

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□ 4. Cardiovascular. *This would include symptoms like chest pain, palpitations, shortness of breath, difficulty exercising, difficulty breathing, burning in your chest/throat, lightheadedness with exertion, lightheadedness or dizziness with changes in position, or pain or swelling in the legs or feet.*

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□ 5. Respiratory. *This would include symptoms like cough, coughing up sputum, coughing up blood, wheezing in your lungs, shortness of breath, or difficulty exercising.*

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□ 6. Gastrointestinal. *This would include symptoms like abdominal pain, unintentional weight loss, bloating or cramping, weight loss, difficulty swallowing, indigestion, nausea/vomiting, diarrhea/constipation, vomiting blood, blood in the stools, black tarry stools, foul smelling stools, or excessive gas.*

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□ 7. Genitourinary. *This would include symptoms like burning/painful or smelly urine, dark/cloudy urine, blood in the urine, difficulty starting urine flow, dribbling after urination, discharges, difficulty urinating, increased frequency, bed wetting, increased frequency at night, decreased force of stream, discharges, changes in menstral cycles, difficult pregnancies, changes in erections, difficulty in climax, changes in semen, or lumps.*

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□ 8. Musculoskeletal. *This would include things like joint pain unrelieved by rest, pain that wakes you at night, pain that lasts all day, pain uncontrolled by mediations, pain that moves from joint to joint, grinding in the joints, or hypermobile joints.*

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□ 9. Skin. *This would include symptoms like rashes, red streaks, excessive scarring, excessive bruising, significant scars, problem tattoos, problem piercings, new warts/moles, unusual discolorations, lesions or nodules, changes in skin sensitivities, or excessive dry skin?*

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□ 10. Neurological. *This would include symptoms like headaches, migraines, changes in sight, smell, hearing, or taste, fainting spells, seizures, fainting spells, tremors, balance or speech problems, tremors in the arms/legs, tingling in the arms/legs, changes in speech, changes in memory or managing difficult tasks or changes in bowel or bladder control.*

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□ 11. Psychiatric. *This would include symptoms such as depression, anxiety, difficulty with relationships, fears, or aggression, significant sleep changes, thoughts of harming yourself, or changes in your personality?*

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□ 12. Endocrine. *This would include symptoms like difficulty tolerating heat or cold, sweating, weight loss or gain, palpitations, thinning of your hair, changes in urination, changes in blood pressure, headaches, changes in balance or lightheadedness, mood swings, significant changes in hunger or thirst, menstrual changes, or difficulty with sexual function?*

_____

□ 13. Hematologic/lymphatic. *This would include symptoms such as anemia, varicose veins, bruising easily, excessive bleeding after brushing your teeth or with injuries, history of bleeding disorders, or refused for blood donation?*

_____

□ 14. Allergic/immunologic. *This would include symptoms such as difficulty with breathing after exposure to certain foods, smells or animals, swelling or pain in the groin, armpit, or along the front of the neck, runny nose or itchy eyes after exposure to anything, hives, etc.*

_____

**General, Past, Family and Social History**

1. Do you personally have a history of any of the following conditions? (Please check all that apply)

□ cancer, □ seizures, □ migraines, □ shingles, □ tumors, □ osteoporosis, □ herpes, □ diabetes, □ depression/anxiety, □ neuropathy, □ high blood pressure, □ high cholesterol, □ intestinal problems □ HIV/AIDS, □ none, □ other: If other is checked, please complete the following sentence: "I have a history of _____."

2. Do you have a history of prior surgeries? (Please check all that apply)

Organ: □ gallbladder, □ appendix, □ hysterectomy, □ thyroid, □ gastric/stomach, □ diverticulitis/crohn's, □ heart valves, □ bypass, □ stents, □ ulcers, □ eyes, □ nose, □ sinuses, □ prostate, □ carpal tunnel syndrome, □ wisdom teeth, □ other: If other is checked, please complete the following sentence: "I've had surgery for my _____."

Bone/joint: □ neck, □ mid back, □ low back, □ right shoulder, □ right elbow, □ right wrist/hand, □ right hip, □ right knee, right ankle/foot, □ left shoulder, □ left elbow, □ left wrist/hand, □ left hip, □ left knee, □ left ankle/foot, □ TMJ, □ other: If other is checked, please complete the following sentence: "I've had surgery on my_____."

3. Do you use any supportive devices? (Please check all that apply)

□ back brace, □ neck collar, □ knee brace, □ ankle brace, □ wrist brace, □ orthotics, □ shoulder sling, □ glasses/contacts, □ hearing aids, □ C-PAP, □ mouth guard, □ crutches, □ cane, □ wheelchair, □ walker, □ portable oxygen, □ magnets, □ other: If other is checked, please complete the following sentence: " I use_____."

4. Do you have a history of significant trauma? (This means prior motor vehicle accidents, prior work injuries, prior sports injuries that required or probably should have been treated, significant slips and falls that required treatment or probably should have been treated, etc.?). Please check all that apply.

□ past motor vehicle accident, □ past work accident, □ past sports injury, □ past slip and fall, □ past lifting injury, □ other: If other is checked, please complete the following sentence: "My past trauma history also includes suffering from _____."

5. Do you take prescription medications? (Please check all conditions for which this would apply)

□ no medications □ inflammation, □ pain, □ hormone replacement, □ osteoporosis, □ muscle spasms, □ asthma, □ high blood pressure, □ migraines, □ high cholesterol, □ diabetes, □ thyroid, □ stomach/intestines, □ arthritis/joint pain, □ depression, □ anxiety, □ cancer, □ blood thinners, □ water pills, □ eyes, □ other: If other is checked, please complete the following sentence: "I take prescription medications for _____."

Please list all of your medications:

_____

_____

6. Do you currently take vitamins/nutrients? (Please check all conditions for which you take supplements)

□ no nutrients, □ inflammation, □ pain, □ hormone replacement, □ osteoporosis, □ muscle spasms, □ asthma, □ high blood pressure, □ migraines, □ high cholesterol, □ diabetes, □ thyroid, □ stomach/intestines, □ arthritis/joint pain, □ depression, □ anxiety, □ cancer, □ blood thinners, □ water pills, □ eyes, □ other: "I take vitamins/nutrients for _____"

Please list all of your vitamins/nutrients: _____

_____

7. Do you have allergies to any medications? □ Yes □ No (no known medication allergies)

If yes, please complete the sentence: "I'm allergic or sensitive to _____."

8. Do you have other allergies, such as to foods, animals, or plants/pollen? □ Yes □ No known food, animal, or environmental allergies

If yes, please complete the sentence: "I'm allergic to _____."

9. Are you currently seeing any other health care providers for other reasons? (Please check all that apply)

□ no one, □ a family doctor, □ an orthopedist, □ an internist, □ a nurse practitioner, □ a nutritionist, □ a massage therapist, □ a physical therapist, □ an acupuncturist, □ a naturopath, □ a chiropractor, □ other: If other is checked, please complete the following sentence. "I am also seeing _____."

Please describe: _____

_____

**Family History**

1. Does anyone in your immediate family have a history of the following disorders before the age of 60? (This means your mother, father, brothers or sisters). Check all that apply.

□ bone or joint problems, □ arthritis, □ significant allergies (which would have required treatment), □ similar symptoms that I currently have, □ diabetes, □ cancer, □ benign tumors, □ high blood pressure, □ heart disease, □ depression, □ seizures, □ other: If other is checked, please complete the following sentence: "I have a family history of _____."

**Social History**

1. Do you use tobacco in any form at this time? (Check which ever would apply)

□ Never used tobacco □ Used to use tobacco, but quit □ Occasionally (less than 1 pack/can per day)

□ Moderately (1 pack/can per day) □ Heavily (more than 1 pack/can per day)

2. Do you consume alcohol at this time? (Please check which ever would apply)

□ Never used alcohol □ Used to use alcohol, but quit □ Occasionally (less than 1 drink per day)

□ Moderately (1-2 drinks per day) □ Heavily (3 or more drinks per day)

3. If employed, have you lost time from work because of this condition? □ Yes □ No If Yes, how much? _____

**Disability Questionnaire**

This survey asks you to grade how your problem affects your function in everyday activities. This information will help you and your doctor know where your level of function is now and will help us measure your improvement with treatment.

Please answer every question by circling the number that shows how much your condition has affected you. (from having no problems at all, to having the most severe problems you can imagine).

**Be sure to answer all questions. Circle only one number for each question.**

1. How does this condition interfere with your ability to work in or around the home?

0 1 2 3 4 5 6 7 8 9 10
Work normally — Unable to work at all

2. How does this condition interfere with personal care (such as washing, dressing, etc.)?

0 1 2 3 4 5 6 7 8 9 10
Take care of myself completely — Need help with all my personal care

3. How does this condition interfere with your ability to travel?

0 1 2 3 4 5 6 7 8 9 10
Travel anywhere I like — Only travel to see doctors

4. How does this condition affect your ability to sit or stand?

0 1 2 3 4 5 6 7 8 9 10
No problems — Cannot sit/stand at all

5. How does this condition affect your ability to lift overhead, grasp objects, or reach for things?

0 1 2 3 4 5 6 7 8 9 10
No problems — Cannot do at all

6. How does this condition affect your ability to lift objects off the floor bend, stoop, or squat?

0 1 2 3 4 5 6 7 8 9 10
No problems — Cannot do at all

7. How does this condition affect your ability to walk or run?

0 1 2 3 4 5 6 7 8 9 10
No problems — Cannot walk/run at all

8. Has your income declined as a result of this condition?

0 1 2 3 4 5 6 7 8 9 10
No decline — Lost all income

9. Do you have to take pain medication every day to control this condition?

0 1 2 3 4 5 6 7 8 9 10
No medication needed — On pain medication throughout the day

10. Does this condition force you to see doctors much more often than before your pain began?

0 1 2 3 4 5 6 7 8 9 10
Never see doctors — See doctors all the time

11. How does this condition interfere with your ability to see the people who are important to you as much as you would like?

0 1 2 3 4 5 6 7 8 9 10
No problem — Never see them

12. How does this condition interfere with recreational activities and hobbies that are important to you?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Normal activity | | | | | | | | | | No recreation/hobbies at all |

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of this condition?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Never need help | | | | | | | | | | Need help all the time |

14. Do you now feel more depressed, tense, or anxious than before this condition began?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No depression/tension | | | | | | | | | | Severe depression/tension |

15. Are there emotional problems caused by this condition that interfere with your family, social, or work activities?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No problems | | | | | | | | | | Severe problems |

Scoring: Total: _____

*Mulholland Chiropractic Center, LLC*
Independence Park Professional Center
2020 Abbott Road, Suite 2
Anchorage, Alaska 99507
Phone: (907)770-5700 Fax: (907)770-5701

## Consent to Treat

I _____ give Mulholland Chiropractic Center, LLC permission to treat.

Mulholland Chiropractic Center shall have the authority to:

-evaluate me and provide chiropractic treatments, medical advice, as well as use ancillary therapies such as ultrasound, electrical stimulation, traction, exercises, and other therapies as needed.

-take x-rays and/or order tests as needed.

This grant of authority shall begin on the date signed, and shall remain effective until terminated with written notice.

_____ _____
Signature Date

## Consent to Treat a Minor

I _____ as a parent or guardian give Mulholland Chiropractic Center, LLC permission to treat the following child(ren):

_____
_____
_____
_____

Mulholland Chiropractic Center shall have the authority to:

- evaluate the child and provide chiropractic treatments, medical advice, as well as use ancillary therapies such as ultrasound, electrical stimulation, traction, exercises, and other therapies as needed.

-take x-rays and/or order tests as needed.

This grant of authority shall begin on the date signed, and shall remain effective until terminated with written notice.

_____ _____
Parent/Guardian Signature Date

# *David J. Mulholland, DC, LLC*

**2020 Abbott Rd., Suite2**
**Anchorage, Alaska 99507**


## *Financial Information for our Valued Patients*

### Regular Insurance

Many insurance companies now provide coverage for chiropractic services, and hopefully yours is one of them. As a courtesy to our patients, we will bill your insurance company, provided we receive a completed claim form and verify that your policy provides for your coverage. If you haven't done so already, you can assist us by providing the name and phone number of your insurance company, as well as your policy number and subscriber number. Remember however that insurance coverage usually has a deductible amount that must be met, as well as a percentage "co-pay" that is your responsibility. This must be paid by you as services are rendered. If these present a hardship to you, we can make arrangements for affordable payments which can be made concurrent with your care. Also, remember that your insurance policy is a contract between you and the insurance company, and we are not a party to that contract. Questions about coverage, benefits, deductibles or others should be addressed by you directly with your insurance company. We cannot negotiate for you, but we will gladly assist you by providing all necessary paperwork to process your claim.

### Workers Compensation and Personal Injuries

These cases are handled differently than others because they either have special laws that apply, have additional people that must be informed, or have unique reporting requirements for the doctor, patient, or employer. We gladly accept these cases, and will do everything we can to comply with these special requirements, but it is important that you do your part as well. We cannot accept your case as a WC/PI case until an appropriate accident report is filled out and submitted to us, a claim number is provided and coverage is verified. Since there are typically other parties involved or responsible, it is also very important that you, the patient, do everything in your power to comply with your treatment recommendations from your doctor. Any patient that does not comply with the doctor's recommendations for care will be dismissed from being a WC/PI account, and will be responsible for their balance. In that case, we can certainly make arrangements to bill your regular insurance, or set up an affordable monthly payment plan for you.

### Medicare / Medicaid / Managed Care

These are corporate or government sponsored programs and have special requirements both for qualifications and record keeping, as well as payment. Not all doctors participate in these programs, so if you think you are covered under one of these programs, you must discuss this with the billing staff as well as your doctor before we can accept you as a Medicare/Medicaid/Managed Care patient.

### Special Arrangements

Not everyone has the benefit of insurance or other assistance programs, and even if you do, the deductibles and co-pay portions can be substantial. We understand that these can be a hardship for you. To whatever extent possible, we don't want financial considerations to be a barrier to your getting the chiropractic care you need. Our billing staff will gladly explain these to you at your convenience.

David J. Mulholland, D.C., LLC
Independence Park Professional Center
2020 Abbott Rodad, Suite 2
Anchorage, Alaska 99507

# Notice of Use of Private Healthcare Information

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

## Your Healthcare Information is Private

We understand that information we collect about you and your health is personal. Keeping your healthcare information private is one of our most important responsibilities. The law says:
1. We must keep your healthcare information from others who do not need it.
2. You may ask us not to share certain healthcare information, even though sometimes we may not be able to agree to your request.
We are committed to protecting your healthcare information and following all laws regarding the use of that information. You have the right to discuss with your privacy officer any concerns you may have about how your healthcare information is shared.

## Who Sees and Shares My Health Information?

Your healthcare givers, such as nurses, doctors, and others may see, use and share your healthcare information to determine your plan of care. This use may cover healthcare services you had before now or may have later. We may review your healthcare information and bills (claims) to make sure that you get quality care and that all laws about providing and paying for your healthcare and being followed. We may also use your information to remind you about appointments or to tell you about treatment alternativies.

## How Does This Affect Payment Programs?

We may share your healthcare information with health plans, insurance companies, or government programs which may help you get your benefits or may assist you in paying for your healthcare services.

## May I See My Health Information?

In most cases, you may see your healthcare information. There may be legal reasons of safety concerns that may limit the amount of information that you may see. If you think some of your healthcare information is wrong, you may ask in writing that we correct or

add to it. You may ask that the corrected or new information be sent to others who have received your healthcare information from us. You may ask us for a list of where we sent your healthcare information.

**What If My Healthcare Information Needs to Go Somewhere Else?**

You may ask to have your healthcare information sent to others. You will be asked to sign a separate form, called an authorization form, permitting your healthcare information to go to them. The authorization form tells us what, where, and to whom the information must be sent. You can stop or limit the amount of information sent at any time by letting us know in writing. We may charge a small amout for copying costs. Note: if you are younger than 18 years old and, by law, you are able to consent for your own healthcare, then your healthcare information is kept private from others unless you sign an authorization form.

**Could My Health Information Be Released without My Authorization?**

We follow laws that tell us when we have to share healthcare information, even if you do not sign an authorization form. We always report:
1. Reportable infectious diseases and birth defects;
2. Reactions or problems with medications or defective medical equipment;
3. To the police when required by law;
4. When the court orders us to;
5. To the government to review how our programs are working;
6. To the provider or other insurance company who need to know if you are enrolled in one of our programs;
7. Birth, death and immunization information;
8. To the federal government when they are investigating something important to protect our country;
9. Abuse, neglect and domestic violence, if related to child protection or vulneralble adults;
10. To workers compensation for work-related injuries;
11. We may also share healthcare information for permitted research purposes and serious threats to public health or saftey.

**May I Have a Copy of This Notice?**

This notice is yours, and you may ask for another copy at any time. If there are important changes to this notice we will get a new copy to you on your next visit.

**Questions or Complaints?**

If you have questions or feel your privacy rights have been violated, you can contact your privacy officer, which is Dr. Pairmore, by writing to him at the address above. Your healthcare services will not be affected by any concerns brought to him.