Dr. Cal Melton

Name:____

Address: Street:____________________________________City:_______________________________

State:__________ Zipcode:_______ _______Birth Date:_______________________________

Phone:Home:____________________Work:_________________Mobile:______________________

Email:____

Occupation:___________________________Employer:____

Emergency contact:________________________Relationship:__________________________________

Emergency contact's phone number:____

Has a doctor or health professional ever told you that you have or had one of the following conditions? Please check all that apply.

- ☐ Congenital heart defect
- ☐ Gastrointestinal issues
- ☐ Psychological
- ☐ High cholesterol
- ☐ Poor balance or Recent falls
- ☐ Severe headaches
- ☐ Epilepsy/Seizure disorders
- ☐ Liver disease
- ☐ Lung disease
- ☐ Chemical dependency
- ☐ Lyme disease
- ☐ Multiple Sclerosis
- ☐ Joint tendon or Muscular pain
- ☐ Pacemaker
- ☐ Low blood pressure
- ☐ Abdominal pain/Bloating/Gas
- ☐ Coughing/Wheezing on excretion
- ☐ Rheumatoid Arthritis
- ☐ Ulcers
- ☐ Kidney disease
- ☐ Thyroid problem
- ☐ Stroke
- ☐ Hepatitis A, B, C
- ☐ Joint replacement/repair
- ☐ Skin problem
- ☐ High/Low blood sugar
- ☐ Emphysema
- ☐ Dizziness/Vertigo/Fainting/ Blackouts
- ☐ Prostate problem
- ☐ Circulation problem or Blood clots
- ☐ Sexually Transmitted Disease or HIV/AIDS
- ☐ Allergies
- ☐ Diabetes
- ☐ Painful bowels/Loose stool/Constipation
- ☐ Heart problem/Heart disease
- ☐ Osteoporosis
- ☐ High blood pressure
- ☐ Chest Pain/Angina/Palpitations
- ☐ Shortness of breath
- ☐ Gout
- ☐ Anemia
- ☐ Depression
- ☐ Tuberculosis
- ☐ Asthma/Bronchitis/Pneumonia/Chronic cough
- ☐ Latex allergy
- ☐ Other:_________________________________

Provide details regarding condition checked above:____

____

Are you under a doctor's care: ☐ YES ☐ NO. If yes, please explain and give doctor's name:____

Dr. Cal Melton

Have you **recently** noted:

Weight loss/gain   Nausea/Vomiting   Weakness   Numbness/Tingling
Fatigue   Dizziness   Shortness of breath   Headaches
Fever/Chills/Sweats   Pain at night   Difficulty swallowing   Change of appetite

Are you pregnant? ☐ Yes ☐ No How much water do you drink in a day?____________________________

How many cigarettes do you smoke a day? ____

How much coffee or caffeinated beverages do you drink a day? (ounces)____________________________________

How many alcoholic beverages do you consume in one week?____

What forms of exercise do you practice and how often?____

Accidents, injuries, or major illnesses including motor vehicle (include date):

____

Surgeries (include date):____

____

Medications, vitamins, herbs, teas, over-the-counter medications and supplements (include dosage):___________

____

Family medical history: (Please list major illnesses in your close family such as diabetes, heart disease, high blood pressure, neurological disorders, psychological disorder, orthopedic disorders, etc.)__________________________

____

What other practitioners are you currently seeing for this condition? (Please list all with the frequency, duration, and treatment involved)____

Describe what condition you are here to be treated for and how long you have had it (date of onset):-

____

____

Have you had any prior episodes for this condition? How many?____

Have you undergone any diagnostic testing: ☐ Nerve Conditions Velocity ☐ EMG ☐ Bone Scan ☐ MRI

☐ Cardiac Stress Test ☐ CT Scan ☐ Blood Test ☐ Doppler Studies ☐ Urinalysis ☐ X-rays ☐ Other

Results from the above test:____

____

Was the onset due to: ☐ Injury at home ☐ Slow onset ☐ Chronic ☐ Work related ☐ Repetitive motion ☐ Sports ☐ Recreational ☐ Trauma ☐ Unknown ☐ Other:____

Was the onset due to : ☐ Backward bending ☐ Forward bending ☐ Twisting R or L ☐ Crushing ☐ Heavy lifting ☐ Illness ☐ Trauma ☐ Overuse ☐ Other:____

What was the onset speed of your injury ☐ Gradual ☐ Sudden

Which of the following describes your symptom trend: ☐ Improving ☐ Unchanging ☐ Worsening

CAPITAL CHIROPRACTIC CENTER

Dr. Cal Melton

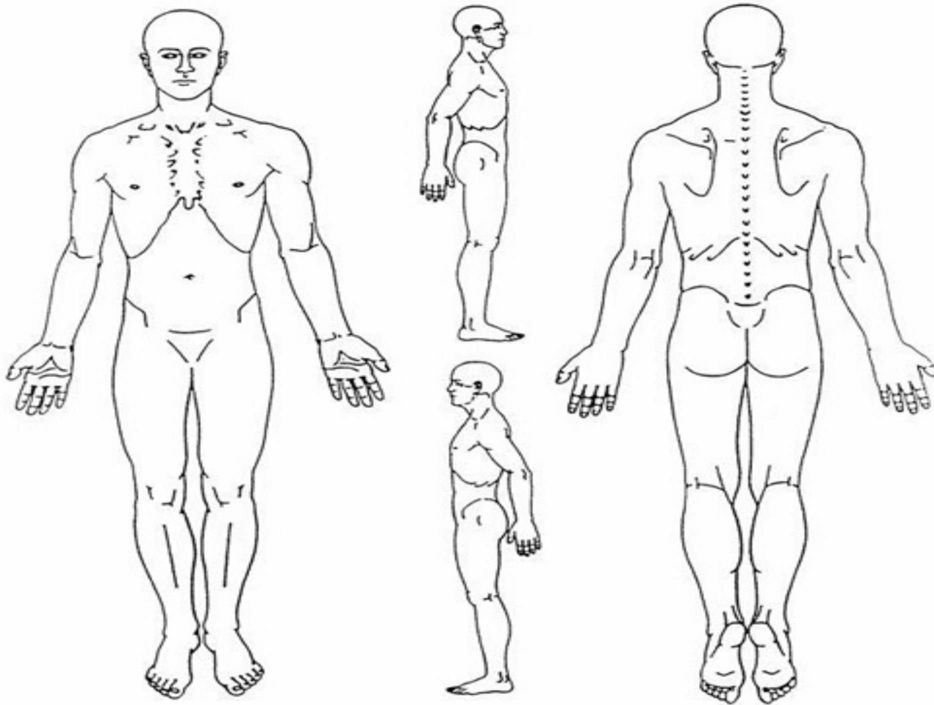
What is the frequency of your pain? ☐ Constant ☐ Intermittent/Daily ☐ Occasional (less than daily)
☐ Sporadic (less than weekly) ☐More specifically____

What is your pain intensity on average? (0= no pain, 10= worst imaginable)

At its worst_______________ At its best_______________________ At rest_______________________________

At night ___________________With movement (please specify movements)______________________________

Please indicate where your pain or symptoms are by shading areas below



What specific remedies or movement decrease your pain?____

Does it radiate and if so where?____

Does your pain change morning to noon to evening? Describe:____

____

What is the quality of your pain? ☐ Sharp ☐ Dull ☐ Achy ☐ Stabbing ☐ Throbbing ☐ Pulsating ☐ Deep ☐ Boring ☐ Shooting ☐ Searing ☐ Radiating ☐ Tearing ☐ Gripping ☐ Other:_______________________________

Do you have: ☐ Pin and needless ☐ Numbness ☐ Tingling ☐ Loss of sensation ☐ Hypersensitivity ☐ Strength loss If so where?____

Dr. Cal Melton

I certify that the above information is correct to the best of my knowledge. I have disclosed all medical condition that I am aware of and will inform the practitioner of any changes in my health status. I understand that these service are a health aid and not a substitute for a doctor's care.

Signature:____Date:___________________________________

MY PRIVACY

I have received a copy of the **Notice of Privacy Practices**. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to; conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing treatment; Obtain payment from third-party payer; Conduct normal healthcare operations such as quality assessments and accreditation.

____ ____________________________________

Signature of patient or person acting on patient's behalf Date

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and electrical stimulation to include ARP program therapy, on me (or on the patient named below, for whom I am legally responsible) by Dr. Cal Melton, D.C. and/or other licensed doctors of chiropractic and/or registered chiropractic assistants who now or in the future work at the clinic or office listed below or any other office or clinic.

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. I understand that results are not guaranteed.

I understand and am 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an 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 seek treatment.

Patient Signature_________________________ Date _________________

Witness Signature ________________________________ Date_____________

Dr. Cal Melton

INSURANCE INFORMATION

Patient Last name:	First Name:	Middle

Insurance: We need a copy of your card(s) for our records.

Insurance Company____

Insured's Name____DOB ___________________________________

Social Security# ____

ID/Policy # ____

Insurance phone #____

Responsibility Party: Complete this section if you are not the patient but are responsible for the payments.

Name:____

Relationship to Pateint:____

Home Address____Apt#______________________

City____State_____________________Zip______________

Home Phone#_____________________Work Phone#_______________________ Mobile Phone#________________

MY FINANCIAL RESPONSIBILITY

I certify that the above information is correct. I understand that I am **personally responsible** for all the services not paid for by my insurance. I am also responsible for any annual deductibles applicable, co-payments, or non-covered services that may be required by my insurance plan. If I am a PIP patient, depending on my auto coverage plan, I may be responsible for 20% of each visit. I further understand that the office charges a $25 fee for returned checks.

The **office reserves** the right to charge for appointments canceled without 24 hours notice. One "*no-show*" is allowed for every patient per six months of care. After that the office will charge up to *100%* of the *cash value* of the scheduled appointment, *not just a co pay*. A patient that is *late* for an appointment will have the option to use the remainder of the scheduled appointment at full price.

I authorize the **release** of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X____ __________________________________

Patient/Legal guardian Signature Date