Mankey Family Chiropractic
Dr. Graham V. Mankey, D.C.
Dr. Allison Mankey, D.C.

Patient Information Intake Form

Personal Info:

Last Name:_____ First Name:_____ Middle Initial:_____

DOB:_____ Gender: M / F

Weight:_____ Height:_____ Name Suffix: Jr. / Sr.

Marital Status: M / S / W / D Employer:_____ Title:_____

Preferred Language: ❑ Eng ❑ Span Smoker? ❑ Never ❑ Former ❑ Current Frequency:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Fax:_____ Preferred Phone: ❑ Cell ❑ Home

Email:_____ Reminder: ❑ Email ❑ Text

How did you hear about us?_____ ❑ Voice (Cell) ❑ Voice (Home)

If referred by friend, can we tell them thank you? ❑ Yes ❑ No Cell Carrier: ❑ Verizon ❑ At&t ❑ Other__

Emergency Contact Info:

Contact Name:_____ Relationship to Patient:_____

Phone #:_____ ❑ Home ❑ Cell

Accident/Injury:

Was this injury/illness caused by: ❑ Work Accident? ❑ Auto Accident? Date of Accident_____

Are you receiving any litigation for your injury/illness? ❑ Yes ❑ No

Are you receiving any litigation for any other injuries/illnesses? ❑ Yes ❑ No

Previous Chiropractic Care? ❑ Yes ❑ No Date of last Appt:_____

For Office Use Only: ❑ G ❑ CP ❑ MC ❑ Informed Consent
Medicare: ❑ ABN (2) ❑ Insurance Card

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Prenatal Patient Health Information

Patient Name:_____ Date:_____

Reason for your visit: ☐ Well-Mama Pre-Natal Chiropractic Care ☐ Baby Breech Presentation
☐ Headache ☐ Backache of Pregnancy ☐ Trauma ☐ Chronic Condition ☐ Other:_____

Prenatal History:

Week of gestation: _____ Due Date: _____ Sex of Baby (if known): ☐ Male ☐ Female

First Pregnancy? ☐ YES ☐ NO Number of Pregnancies: _____ Live births: _____

How many babies are you having? ☐ One ☐ Twins ☐ Multiple: _____

Where are you planning to deliver? ☐ Hospital ☐ Birth Center ☐ Home

Name of Hospital/Birth Center: _____ Name of OB/Midwife: _____

Can we contact your OB/Midwife to co-manage you if needed? ☐ YES ☐ NO

Type of Birth: ☐ Vaginal ☐ VBAC ☐ Planned Cesarean Section

How many ultrasounds have you had so far? _____

Any abnormal findings? ☐ YES ☐ NO If Yes, list findings: _____

Any complications with this pregnancy? _____

What is your biggest fear with this birth? _____

Previous Birth History:

Names & Ages of children:	Weeks of Gestation:	Birth Weight/Length:	Labor time:	Pushing time:
_____	_____	Lbs oz in	_____	_____
_____	_____	Lbs oz in	_____	_____
_____	_____	Lbs oz in	_____	_____
_____	_____	Lbs oz in	_____	_____

Previous Birthing Providers/Delivery Methods:

Place of birth: ☐ Hospital ☐ Birth Center ☐ Home

Delivering Practitioner: ☐ OB/GYN ☐ Midwife Name of OBs/Midwives: _____

What delivery method(s) did you experience? ☐ Vaginal ☐ VBAC ☐ Cesarean Section

Any Interventions? (check all that apply) ☐ Induction ☐ Epidural ☐ Membranes Stripped

Patient Health History

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Patient Name:_____ Date:_____

LIST EACH SYMPTOM/CONDITION THAT BROUGHT YOU INTO OUR OFFICE:

❑ No Complaint/Wellness Care

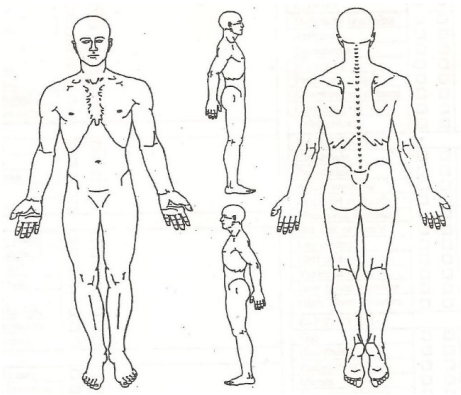
#1:_____

#2:_____

#3:_____

Others:_____

_____



Using the symbols below, mark on the pictures where you have symptoms:

Numbness	= = =
Dull Ache	OOO
Sharp/Stabbing	/ / / /
Pins, Needles	+ + +
Other _____	^ ^ ^

History of EACH Complaint: (Please answer each of the following questions for EACH symptom/condition)

Symptom #1:_____

Date symptom began: _____ Is it: ☐ Constant ☐ Intermittent ☐ Activity-related

What caused this condition/pain? _____ Is it getting: ☐ Better ☐ Worse ☐ Same

What aggravates this condition/pain? _____ Rating: (best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

What lessens this condition/pain? _____ % of Day: ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Does this pain shoot/radiate/travel? Y / N Where?_____ Frequency? ☐ Daily ☐ Weekly ☐ Monthly

Is there numbness/tingling? Y / N Where?_____ Duration? ☐ Secs ☐ Mins ☐ Hours ☐ Days

Other Doctors seen for this condition: _____ Worse during: ☐ Morning ☐ Afternoon ☐ Night

Any home remedies? _____ Interfere with: ☐ Work ☐ Sleep ☐ Routine

Symptom #2:_____

Date symptom began: _____ Is it: ☐ Constant ☐ Intermittent ☐ Activity-related

What caused this condition/pain? _____ Is it getting: ☐ Better ☐ Worse ☐ Same

What aggravates this condition/pain? _____ Rating: (best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

What lessens this condition/pain? _____ % of Day: ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Does this pain shoot/radiate/travel? Y / N Where?_____ Frequency? ☐ Daily ☐ Weekly ☐ Monthly

Is there numbness/tingling? Y / N Where?_____ Duration? ☐ Secs ☐ Mins ☐ Hours ☐ Days

Other Doctors seen for this condition: _____ Worse during: ☐ Morning ☐ Afternoon ☐ Night

Any home remedies? _____ Interfere with: ☐ Work ☐ Sleep ☐ Routine

Symptom #3:_____

Date symptom began: _____ Is it: ☐ Constant ☐ Intermittent ☐ Activity-related

What caused this condition/pain? _____ Is it getting: ☐ Better ☐ Worse ☐ Same

What aggravates this condition/pain? _____ Rating: (best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

What lessens this condition/pain? _____ % of Day: ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Does this pain shoot/radiate/travel? Y / N Where?_____ Frequency? ☐ Daily ☐ Weekly ☐ Monthly

Is there numbness/tingling? Y / N Where?_____ Duration? ☐ Secs ☐ Mins ☐ Hours ☐ Days

Other Doctors seen for this condition: _____ Worse during: ☐ Morning ☐ Afternoon ☐ Night

Any home remedies? _____ Interfere with: ☐ Work ☐ Sleep ☐ Routine

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Patient Name:_____ Date:_____

Do you have any previous imaging? ☐ **X-ray** ☐ **MRI** ☐ **CT** ☐ **Other**_____

Place of Service_____

I authorize Mankey Family Chiropractic to online access of all images, reports and any other information relating to my condition. Please Sign_____

Please mark any of the following conditions/symptoms that you have now or have experienced:

☐ Headaches	☐ Recurring Fevers	☐ Double Vision
☐ Migraines	☐ Painful Urination	☐ Dizziness
☐ Lights Bother Eyes	☐ High Blood Pressure	☐ Drop Attacks
☐ Pain in Hands or Arms	☐ Chest Pains	☐ Difficulty Speaking
☐ Pain in Legs or Feet	☐ Heart Attack	☐ Difficulty Swallowing
☐ Loss of Consciousness	☐ Stroke	☐ Loss of Balance
☐ Loss of Memory	☐ Unexplained Weight Loss	☐ Nausea
☐ Loss of Smell or Taste	☐ Cancer	☐ Numbness
☐ Shortness of Breath	☐ Pain waking you up at night	☐ Nystagmus
☐ Fainting Spells	☐ Difficulty breathing at night	

☐ **NONE OF THE ABOVE APPLY**

Current Health Habits:

Do you drink water? ☐ Yes ☐ No How much & how often?_____
Do you eat a healthy diet? ☐ Yes ☐ No Special Diet?_____
Exercise regularly? ☐ Yes ☐ No Type?_____
Did/do you smoke? ☐ Yes ☐ No How much & how often?_____
Did/do you drink alcohol? ☐ Yes ☐ No How much & how often?_____
Did/do you drink caffeine? ☐ Yes ☐ No How much & how often?_____
Daily time spent driving? _____
Physical stress? ☐ Yes ☐ No Explain?_____
Emotional/Mental stress? ☐ Yes ☐ No Explain?_____
Occupational stress? ☐ Yes ☐ No Explain?_____
Do you sleep well? ☐ Yes ☐ No Hours?_____
Sleeping posture: ☐ Side ☐ Stomach ☐ Back ☐ All of the above

Past History:

Any accidents/trauma? ☐ Yes ☐ No List:_____
Any previous fractures? ☐ Yes ☐ No List:_____
Any hobbies/sports injuries? ☐ Yes ☐ No List:_____
Any major Illnesses? ☐ Yes ☐ No List:_____
Any previous surgeries? ☐ Yes ☐ No List & Date:_____
Any previous hospitalizations? ☐ Yes ☐ No List:_____
Any medications? ☐ Yes ☐ No List:_____
Any allergies? ☐ Yes ☐ No List:_____

Family History:

Is there a family history of: ☐ **No family history of the conditions listed below**

	Arthritis	Heart/Blood Disease	Cancer	Diabetes	Other_____	Unknown
Father's side	☐	☐	☐	☐	☐	☐
Mother's side	☐	☐	☐	☐	☐	☐

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature_____ Date_____

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

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Informed Consent for Chiropractic Treatment of your Pain

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*

Other options for the treatment of pain include: *do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery*. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

Patient Name	**Signature**	**Date**
Witness Name	**Signature**	**Date**

FINANCIAL POLICY

Mankey Family Chiropractic
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Payment is expected at the time of service. We accept cash, check, or charge (Visa, Discover or Master Card). We do not accept AMEX. Our Cash Price is discounted and is to be paid at time of service. The discount is forfeited if services are not paid in full at time of service. If we have to send a bill, the charge will reflect our usual (non-discounted) fees. We encourage you to take advantage of time-of-service discount.

There will be an additional $25 fee for checks submitted with insufficient funds. Balances over 60 days will incur an interest charge of 1.5% per month and after 90 days, an additional $5.00 rebilling fee per statement will be charged

MISSED/CANCELLED APPOINTMENTS:
We ask for a 24-hour notice for appointment cancellations. There will be a cancellation fee (the cost of your visit) for each missed appointment and/or cancellation with less than 24 hours notice.

We understand that sometimes last-minute cancellations are unavoidable. Individual circumstances may be discussed with the office manager and/or the doctor.

INSURANCE:
We are a out of network provider with all health insurances. Our financial relationship is with you, not your insurance company. As a courtesy to our patients, our office will complete a superbill to help you collect from your insurance company. **You are responsible for payment of our services at the time of service.** If your insurance company pays any amount directly to our office, we will credit it back to your account or give you a refund.

As a courtesy to our patients, we can check your insurance benefits for you. Verification of benefits or eligibility is not a guarantee of payment. Payment can only be made after the claim has been received and reviewed in regards to eligibility, benefits, medical necessity, and other limitations and/or exclusions. Your insurance is an agreement between you and your insurance company and you are responsible to know and understand your insurance benefits.

IT IS IMPORTANT THAT YOU UNDERSTAND YOUR HEALTH OR ACCIDENT INSURANCE.

I HAVE READ AND UNDERSTAND MY RESPONSIBILITY CONCERNING THE PAYMENT OF SERVICES.

SIGNATURE: _____ **Date:** _____

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Health Insurance Portability and Accountability Act Form (HIPAA)

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, “I” and “my” refer to the patient, and “Chiropractor” refers to Dr. Mankey or Mankey Family Chiropractic.

I consent to the use or disclosure of my protected health information by the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of the Chiropractor.
I understand that analysis, diagnosis or treatment of me by the Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Chiropractor is not required to agree to the restrictions that I may request. However, if the Chiropractor agrees to a restriction that I request, the restriction is binding on the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except that the Chiropractor has taken action in reliance on this Consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have a right to review the Notice of Privacy Practices prior to signing this document. This page is a modified version of our Notice of Privacy Practices. A full copy can be obtained upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Chiropractor.

The Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and requesting a revised copy be sent in the mail, email, or asking for one at the time of my next appointment.

Patient Signature: _____ **Date:**_____