

# Downtown Chiropractic and Sports Development Center

Dr. Cal Melton, Jr.

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.

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

# Downtown Chiropractic and Sports Development Center

Dr. Cal Melton, Jr.

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? \_\_\_\_\_

Do you have any food cravings or intolerances? \_\_\_\_\_

Describe your typical meals breakfast, lunch, dinner and snacks including times: \_\_\_\_\_

How is your energy? \_\_\_\_\_ What time of day is it highest? \_\_\_\_\_ lowest? \_\_\_\_\_

How do you feel emotionally? \_\_\_\_\_

Do you have (check all that apply):  Depression  Anxiety  Panic attacks  Irritability or Short temper  Poor memory  Difficult concentration  Other: \_\_\_\_\_

Married/Stable relationship  Single      How do you feel about your relationship? \_\_\_\_\_

How do you feel about your work? \_\_\_\_\_

How are your family relationships? \_\_\_\_\_

How / Where do you hold stress? \_\_\_\_\_

How do you relax? \_\_\_\_\_

Describe your social outlets, leisure activities, and hobbies: \_\_\_\_\_

How many hours do you generally sleep per night? \_\_\_\_\_ Number of times you wake up? \_\_\_\_\_

Do you have night sweats?  Yes  No      Do you have trouble?  Falling asleep  Staying asleep  Disturbed sleep  
(Describe) \_\_\_\_\_

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.) \_\_\_\_\_

# Downtown Chiropractic and Sports Development Center

Dr. Cal Melton, Jr.

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

For the following activities check the box that applies to your current symptoms:

(Numbness=**N**, Pain=**P**, Stiffness= **S**)

**N P S**

Arm/Hand activities

Ascending stairs

Ballistic activities

Bending

Driving

Computer use

Crawling

Crouching

Descending stairs

Kneeling

Lying on L side

Lying on R side

**N P S**

Lying on back

Overhead activity

Pinching/Grasping

Quick movements of head/neck

Reaching

Sitting

Squatting

Standing

Walking

Walking on uneven ground

Work activities

Lying on stomach

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)

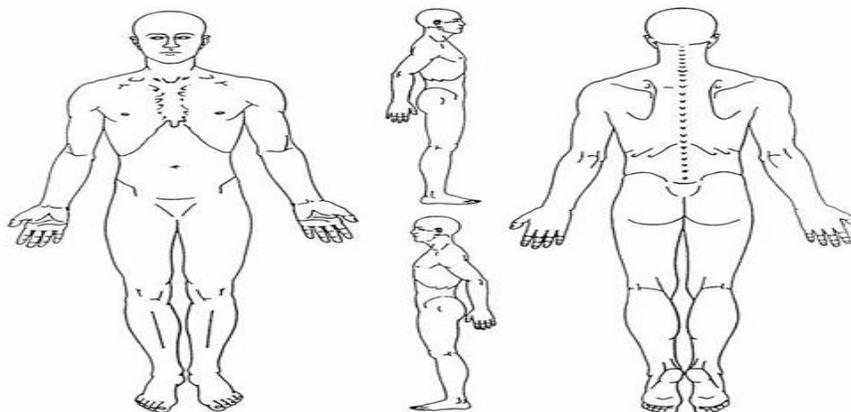
At its worst \_\_\_\_\_ At its best \_\_\_\_\_ At rest \_\_\_\_\_

At night \_\_\_\_\_ With movement (please specify movements) \_\_\_\_\_

# Downtown Chiropractic and Sports Development Center

Dr. Cal Melton, Jr.

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? \_\_\_\_\_

How many hours do you spend on the computer each day? \_\_\_\_\_

Have you ever received an ergonomic workspace evaluation? \_\_\_\_\_

What was your previous functional capacity and lifestyle before the injury or pain onset? \_\_\_\_\_

Are you seeking or planning to seek legal counsel for this condition? If yes, please provide name of attorney and details: \_\_\_\_\_

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

# Downtown Chiropractic and Sports Development Center

Dr. Cal Melton, Jr.

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 Dr. DJ Manocha, 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 \_\_\_\_\_

# Downtown Chiropractic and Sports Development Center

Dr. Cal Melton, Jr.

## 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 no 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 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 as may be required by my insurance plan. 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 allowance is made the office will charge up to *100%* of the *cash value* of the schedule appointment, *not just a co pay*. Patient *late* for appointment have the option to either using the remainder of the schedule at the full price as schedule.

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