MEININGER*clinic*
MARK J. MEININGER, BS, DC, CME, CCSP®
Whiplash Case Management, Sports Injury and Spinal Care
National Registry of Certified Medical Examiners

CONFIDENTIAL HEALTH INFORMATION

550 Hampton Road - PO Box 3369
McDonough, GA 30253
Phone (770) 957-7881
Fax (770) 957-6283

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes

When?

If so, whom?

Patient Number (office use only)

Age

Gender ○ Male ○ Female

Birth Date (MM/DD/YYYY)

Race ○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American ○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White ○ Decline to answer

Ethnicity ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to specify

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name

Smoking Status (age 13 and over) ○ Never A Smoker ○ Former Smoker ○ Current Every Day Smoker ○ Current Some Day Smoker ○ Heavy Smoker ○ Light Smoker

Address

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

City **State/Province** **ZIP/Postal Code**

Preferred Language

Home Phone **Cell Phone**

Cell Phone Carrier

Spouse's Name

Email Address

Emergency Contact **Emergency Contact's Phone**

Relationship to Emergency Contact

Your Occupation

Your Employer

Work Phone

Address

May we contact you at work? ○ Yes ○ No

City **State/Province** **ZIP/Postal Code**

Preferred method of contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Email

Primary Care Provider's Name

Insurance Carrier

Policy Number and Claim Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy? ○ Self ○ Spouse ○ Parent

Insured's First Name **Insured's Middle Name (or Initial)**

Insured's Employer

Address

City **State/Province** **ZIP/Postal Code** **Employer's Phone**

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____

Rate your pain using a scale of 0 - 10
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Mild----------Moderate---------Severe

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other _____

Secondary Complaint
The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____

Rate your pain using a scale of 0 - 10
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Mild----------Moderate---------Severe

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other _____

Additional Complaint
The additional symptom that prompted me to seek care today is: _____

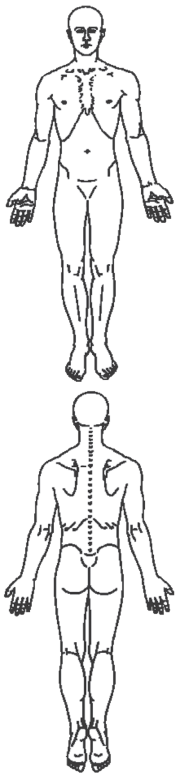
And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____

Rate your pain using a scale of 0 - 10
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Mild----------Moderate---------Severe

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other _____

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



1. What else should Dr. Meininger know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture

NONE ◯ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness

NONE ◯ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising

NONE ◯ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia

NONE ◯ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea

NONE ◯ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste

NONE ◯ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash

NONE ◯ Initials ____

Patient name _____

Patient Number
(office use only) _____

Doctor's Initials _____

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h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	Initials ____

Patient name

Patient Number
(office use only)

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

7. Allergies

Are you allergic to any medications?

Yes	No	
○	○	If Yes please list: _____

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): _____

8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

9. Family History

Some health issues are hereditary. Tell Dr. Meininger about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
_____		○	○			○	○

10. Are there any other hereditary health issues that you know about? _____

11. Social History

Tell Dr. Meininger about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much? _____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much? _____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much? _____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much? _____			

Hobbies: _____

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12. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. What is the major stressor in your life? _____

14. How much sleep do you average per night? _____ **Hours**

15. What is the type and approximate age of your mattress and pillow? _____

16. What is your preferred sleeping position? _____

17. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

20. What is your Height? _____ **What is your Weight?** _____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, unencrypted emails or personal health information to me or to an authorized recipient as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Patient (or Guardian's) signature

Date (MM/DD/YYYY)

Patient name

Patient Number
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Consultation Notes

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DR. MARK J. MEININGER, PC
MARK J. MEININGER, BS, DC, CME, CCSP®
Whiplash Case Management, Sports Injury and Spinal Care
National Registry of Certified Medical Examiners

550 HAMPTON RD.
P.O. BOX 3369
MCDONOUGH, GEORGIA 30253
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FAX (770) 957-6283

PATIENT RESPONSIBILITY FOR PAYMENT

As a service to our patients, Dr. Mark J. Meininger PC will submit charges for chiropractic treatment to the patient's insurance company. I, hereby, authorize Dr. Mark J. Meininger, PC and/or Meininger Clinic to furnish information to my insurance carriers concerning my illness and/or treatment. I, hereby, assign to Dr. Mark J. Meininger, PC and/or Meininger Clinic all payments for chiropractic/medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Dr. Mark J. Meininger, PC and/or Meininger Clinic and the staff may attempt to verify in advance that the patient's insurance company will pay for specific chiropractic procedures. Occasionally, even though coverage was verified and an authorization may have been obtained before the chiropractic services were provided, the insurance company denies the claim. If the insurance company denies payment or will only pay a portion of the chiropractic bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible in addition to whatever amounts the insurance company does not pay.

I understand that if I obtain services from the chiropractor without a referral (HMO or POS) from my primary care physicians that I will be responsible for the amount that the insurance states is the responsibility of the patient. I agree to pay all chiropractic/ medical expenses within 30 days of the date that I am billed for those expenses, unless other arrangements have been made with Dr. Mark J. Meininger PC.

I understand that if my insurance company forwards the check to me that I will be responsible to endorse the check to Dr. Mark J. Meininger, PC and/or Meininger Clinic immediately for services rendered at the office of Dr. Mark J. Meininger, PC and/or Meininger Clinic.

CONTRACTUAL AGREEMENT TO PAY CHIROPRACTIC EXPENSES

I agree to pay all **COPAYS, COINSURANCE AND DEDUCTIBLES** at the time of service, unless other arrangements have been made with Dr. Mark J. Meininger PC. I understand that if my account is not paid and is turned over to Dr. Mark J. Meininger, PC's collection agency that I will be responsible for the full amount owed, plus any legal fees, collection fees and attorney fees to Dr. Mark J. Meininger, PC.

_____ _____
Date **Patient or Patient's Guardian Signature**

_____
Patient's Printed Name

_____
Date _____
Dr. Mark J. Meininger PC

Current Employer: _____ Current Insurer: _____

Address_____ Address: _____

_____ _____

Employer Phone: _____ Current Insurer Phone:_____

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Whiplash Case Management, Certified Sport's Injury and Spinal Care

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McDonough, Georgia 30253
(770) 957-7881
Fax (770) 957-6283

Informed Consent

Chiropractic, along with other types of healthcare, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment in remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in contesting to treatment

Specific Risk Possibilities Associated with Chiropractic Care:

Stroke: Stroke is the most serious complication of Chiropractic Treatment, and the rarest. According to the journal of CCA, vol. 37, no. 2, June 1993, recent studies estimate the risk of this type of stroke is 1 in every 3 million upper cervical adjustments. Vertebral arteries, which supply the brain with blood, are located within the bones of the upper spine. Therefore, cervical treatment poses a small risk for a stroke, which could result in temporary or permanent brain dysfunction, with some extreme cases resulting in death.

Soreness: Chiropractic adjustments are sometimes accompanied with post treatment soreness. This is normal, but be sure to inform your doctor of Chiropractic of the soreness.

Soft Tissue Injury: Occasionally Chiropractic treatment may aggravate a disc injury, or cause a minor joint, ligament, tendon or other soft tissue injury.

Rib Injury: Manual adjustments to the thoracic spine could cause a rib injury or fracture. Keep in mind that this is very uncommon, and treatment is performed very carefully to minimize such risk. Precautions such as pre-adjustment X-rays are taken and thoroughly analyzed in cases that are considered at risk of such injury.

Physical Therapy Burns: Heat generated by physical therapy modalities can cause minor burns to the skin. Burns that are serious are very unlikely, but should be reported, as well, as other side effects you may be experiencing.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptoms, condition or disease. An attempt to provide the best Chiropractic care is our goal, and if the results are not successful, we will kindly refer you to another health care provider. If you have any questions, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have Chiropractic treatment administered.

_____ _____
Patient's Printed Name **Today's Date**

_____ _____
Patient's Signature **Parent or Guardian**
Signature if Minor