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

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

UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Today's Date (MM/DD/YYYY) _____

Patient Number (office use only) _____

Age _____

Gender
○ Male ○ Female

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

Birth Date (MM/DD/YYYY) _____

Your Last Name _____ **Your Social Security Number** _____

Your First Name _____ **Your Middle Name (or Initial)** _____

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** _____ **Spouse's Name** _____

Email Address _____ **Child's Name and Age** _____

Emergency Contact _____ **Emergency Contact's Phone** _____ **Child's Name and Age** _____

Your Occupation _____ **Child's Name and Age** _____

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** _____

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** _____

I certify that any changes to my personal information have been updated above for your records. _____
Signature

UPDATED CONTACT INFORMATION

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◯ **I have new contact information**

Today's Date (MM/DD/YYYY) _____

Patient Number (office use only) _____

Your Last Name _____ **Your First Name** _____ **Your Middle Name (or Initial)** _____

Please select one:

◯ **Progress evaluation** – I've been under active care and this is a periodic reevaluation. ◯ **New condition** – I've been under care and a new or returning condition has emerged.

◯ **Maintenance patient** – I'm under maintenance care with a new or returning health issue. ◯ **Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

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 _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

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 _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

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 _____

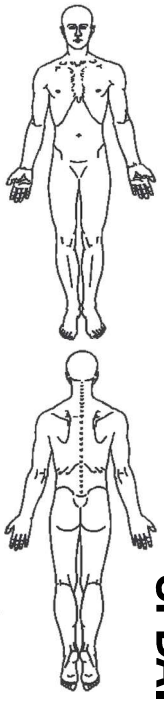
Additional Complaint
The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

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. Review of systems (Identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
a. Musculoskeletal System – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	◯	◯	◯
b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	◯	◯	◯
c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	◯	◯	◯
d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	◯	◯	◯
e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	◯	◯	◯
f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	◯	◯	◯
g. Skin System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	◯	◯	◯
h. Endocrine System– Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	◯	◯	◯
i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	◯	◯	◯
j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	◯	◯	◯

UPDATED PATIENT HISTORY

Doctor's Initials _____

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2. Illnesses, operations, injuries or treatments since your most recent evaluation with us: _____

_____

_____

3. Medications (please list all prescription and over-the-counter): _____

_____

_____

4. Social History (Tell Dr. Meininger about your health habits and stress levels.)

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: _____

5. 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	◯	◯	◯	◯

6. Is there anything else Dr. Meininger should know about your current condition, your progress or ways your current condition is affecting your life?

_____

_____ _____

Patient (or Guardian's) signature | Date (MM/DD/YYYY)

Patient name _____

Patient Number _____
(office use only)

Consultation Notes

Doctor's Initials _____

UPDATED PATIENT HISTORY

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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 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 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 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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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

HIPAA EMAIL CONSENT FORM

VERY IMPORTANT! PLEASE READ!

- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Your private health Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- If we utilize email to contact you or send your records to requested and authorized locations, it is not considered to be secured, yet many patients want us to utilize this fast, convenient method, but HIPAA requires your permission.

PLEASE SELECT ONLY ONE OF THE OPTIONS BELOW

OPTION 1 - **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to the Dr. Mark Meininger and his staff to send my personal health information via unencrypted email to authorized recipients.

_____ _____ _____

Signature (Parent or Guardian if Minor) DATE Printed Name

Print Email Address _____

OPTION 2 - **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to have private health information sent via email.

_____ _____ _____

Signature (Parent or Guardian if Minor) DATE Printed Name