Montellese Family Chiropractic & Pelvic Floor Rehabilitation

NEW PATIENT INTAKE

Patient Name:_____ Today's Date:_____ Email:_____

Address_____ City_____ State_____ Zip_____

Telephone (Cell/home)_____(work)_____ Birth Date_____ SS#_____

Occupation_____ Employer_____ Marital Status_____

Spouse/Partner's name_____ Spouse/Partner's occupation_____

Emergency Contact_____ Phone_____ Number of children_____

Insurance Company_____ Primary insured name_____ Birth Date_____

Who can we thank for referring you to our office?_____

Please describe your main problem_____

When did it begin?_____ Is it getting better, worse, or staying the same (circle one)

Did it start as a result of: (Circle) Auto Accident, Workers Comp, Other _____

Describe activities that you cannot do because of the problem? _____

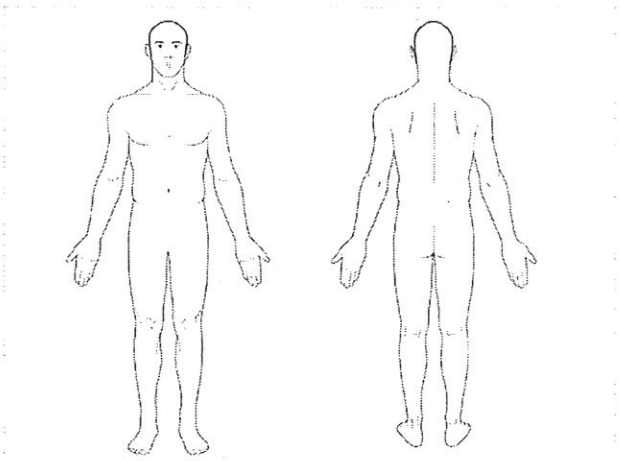
What makes it worse?_____ What relieves your problem?_____

Do your symptoms interfere with normal daily activities? Y / N Does it wake you at night? Y / N

How do you feel today (Circle): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (0 = No pain, 10 = Unbearable pain)

Circle and Label where your symptoms are located:

A=Ache, B=Burning, N=Numbness, P=Pins & Needles, S=Stabbing, O=Other



List all practitioners seen for this injury (MD, Chiropractor, Physical Therapy, etc.)_____

Have you ever experienced this condition before? Y / N When? _____

Have you had **SURGERY** for ***any*** condition in the past? Describe_____

Have you been **HOSPITALIZED** for ***any*** condition in the past? Describe_____

Do you have a **PACEMAKER**? _____ If so when was your surgery? _____

Last Xray or MRI: Of what body region _____

Have you seen: A Chiropractor for *any other* conditions? Y / N A Physical Therapist for *any other* conditions? Y / N

If yes, please explain _____

Have you ever had:(circle)	Broken bones	Ear Aches	Numbness
Hospitalized_____	Cancer _____	Allergies	Pacemaker
Been in an Auto Accident	Chest pain	Shoulder Pain	Jaw pain
Diabetes	High blood pressure	Rib Pain	Constipation
Been struck unconscious	Stroke	Digestive problems	Bladder/bowel control
Loss of balance/Dizziness	Vertigo	Loss of taste	Pelvic / Groin pain
Surgeries_____	Swelling of _____ _____	Headaches	Incontinence (leakage)
Other_____	Fever	Hernia	Diastasis Recti

Is there a chance that you are pregnant? Y / N If yes, do you have an OB or Midwife_____

Are you seeking care for a Pelvic Floor Dysfunction? Y / N If yes, please describe_____

Please Read the DETAILED Laminated Forms attached with this packet. Sign and Date each line after reading.

Appointment and Cancellation Policy. I, _____, have read and agree to the "No Show and Late Cancellation" policy at this office. I agree and understand this office policy that I may be charged $75.00 if I do not give 24 hours notice to cancel or reschedule. I may request a copy of this agreement to take home with me.

_____ _____

Patient Signature / Guardian Signature Date

Financial Policy. I, _____, have read and agree to the "Financial Policy" at this office. I agree and understand this office policy for Non-Insured, Medical Insurance, Medicare or Auto Insurance. I agree that I will be responsible for paying my bill if my insurance does not cover my treatments. I may request a copy of this agreement to take home with me.

_____ _____

Patient Signature / Guardian Signature Date

Notice of Privacy Practices. I, _____, have read and agree to the Privacy Notice and understand my rights contained in this notice. By my way of signature, I provide my Doctor with my authorization and consent to disclose my protected health care information for purposes of treatment, payment and healthcare operation as described in the Privacy Notice. I may request a copy of this agreement to take home with me.

_____ _____

Patient Signature / Guardian Signature Date

MONTELLESE FAMILY CHIROPRACTIC, INC.

Dr. Christopher G. Montellese, D.C.

Dr. Kristina E. Montellese, D.C.

Dr. Dustin Nagai, D.C.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the Doctor of Chiropractic listed above and/or with other office or clinic personnel.

I further understand and am informed that, as in all health care, in the practice of Chiropractic, there are risks to treatment, including, but not limited to the following:

*While rare, some patients have experienced rib fractures or muscle and ligament sprain or strains following spinal adjustments;

*There have been reported cases of injury to vertebral artery following cervical spinal adjustments. Vertebral artery injury have been known to cause stroke, sometimes with serious neurological impairment and may on rare occasion result in serious injury. The possibility of injuries resulting from cervical spinal adjustment is extremely remote;

*There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment;

I do not expect the Doctor to be able to anticipate and explain all risks and complications and I wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based upon the facts then known, and is in my best interest. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care contributes to your overall wellbeing.

The risk of injuries or complications from Chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of Chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the Chiropractic treatment offered or recommended to me by my Chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future Chiropractic care.

Date this _____ day of _____, 20___.

_____ _____

Patient's Signature (or Parent/Guardian) Minor's Name

_____

Print Name

Montellese Family Chiropractic, Inc.
550 Camino El Estero, Suite 103
Monterey, CA 93940

Electronic Health Records Intake Form

Patient Name:_____ **Gender:** Male / Female **Date of Birth:** _____

Preferred method of communication (Circle one): Email / Phone / Mail **Preferred language**: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Are you currently taking any Supplements or Homeopathy?	
Supplement Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **Check here if you DO NOT want this form emailed to you after each visit. I choose to decline receipt of my clinical summary after every visit.**

Patient Signature: _____ Date: _____

For office use only Height: _____ Weight:_____ Blood Pressure:_____/_____

Montellese
Chiropractic & Pelvic Rehab Clinic

Dr. Christopher Montellese, D.C. ~ Dr. Kristina Montellese, D.C. ~ Dr. Dustin Nagai, D.C.
550 Camino El Estero, Ste 103 - Monterey, Ca 93940
(P) 831-655-3255 (F) 831-655-3443

No Show / Late Cancellation Policy

Definition of a "No Show"

* **Does not arrive to scheduled appointment.**
* **Cancels with less than 24 hours (1 business day) notice.**
* **Arrives more than 15 minutes late and is unable to be seen.**

Results of a "No Show"

1. First "No Show" will be waived as a courtesy.
2. Second "No Show" patient will be charged **$75** fee, and for each additional "No Show."
3. If you miss 3 or more scheduled appointments within 1 year, you may be dismissed from our practice. Patient dismissal is at the discretion of your provider.

I have read and understood the office "No Show / Late Cancellation Policy" and my responsibility to notify the office appropriately if I have difficulty keeping my scheduled appointment.

_____ _____

Patient Name (Please Print) Date

_____ _____

Patient Signature or Parent/Guardian ID# (Office only)