Mashike Chiropractic Family Wellness Center
APPLICATION FOR HEALTH CARE

Date of Application________________ Case # ______________________

Chiropractic Care is a system of Natural Health Care that uses the powerful healing ability of your body, allowing you to regain your health. Only by correcting the CAUSE of your condition can that condition be permanently corrected.

There are 3 conditions which must be met in order to accept your case;

1. That we are able to determine the CAUSE of your condition.
2. That we are reasonably sure we can produce favorable results.
3. That you will attend periodic workshops concerning your condition and how you can help yourself accelerate the healing process.

We will inquire as to your insurance benefits and notify you as soon as we obtain any information. You must also check to verify the same coverage.

Name ____________________________________ Birthdate________________________ Age __________

Address __________________________________ City ________________________ State ____________

Zip code ______________ Home Phone ______________________ Cell Phone ________________________

Male/ Female __________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Name of Spouse _______________ Children & Ages ______________________________________

S.S. Number ______________________ Drivers License Number ______________________________

Employer ____________________________________ Phone Number __________________________

Occupation __________________________________ Health Insurance _________________________

Primary Insured Name_______________ Birthdate _____ Insured S.S. Number ____________________

Insured Employer ___________________________ Referred by ______________________________

Please indicate if you are here because of ☐ Work Injury ☐ Auto Accident ☐ Date of Injury

The following questions are important to your care.

Current Health Complaint/ Reason for consulting our office: ________________________________

____

Has this occurred before ? ☐ Yes ☐ No

When was the very first time that this occurred, even if it may have been minor or for only a short period of time: __________

What caused this condition? ____

Have you seen a Chiropractor before? ☐ Yes ☐ No Name of Chiropractor _________________________

Last visit date: ________________________ For what condition? __________________________

Have you had treatment for **THIS** condition? ☐ Yes ☐ No When? __________ Results ___________________

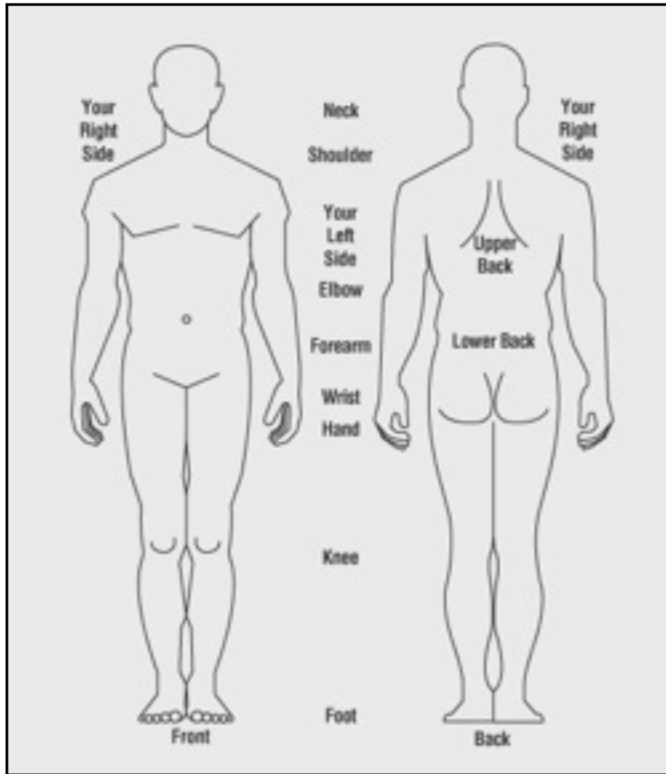
Name of Doctor seen ______________________ Diagnosis _______________________________

Are you now under the care for any condition? ☐ Yes ☐ No Explain ______________________________

Have you had any Fractures?_________ Spinal Tap? ________ Operations?_______ If Yes, Please explain __________

____

Please outline areas of complaint below.



List areas of concern: ____________________________________

____

____

What medications are you taking? ___________________________

____

____

Please indicate any additional information important to you not covered that you feel we should know about.

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____

Have you had a Breast Augmentation? ☐ Yes ☐ No

Check the areas below ONLY if you have or have had difficulty with the following:

1. HEAD: Headaches_______ (How Often?) _____________________ Dizziness ________ Sinus ________

2. EYES: Glasses ________ Pain ________ Inflammation ________

3. EARS: Hearing ________ Ringing ________ Pain ________

4. NOSE: Allergies ________ Smell ________ Hayfever ________ Head Colds ________ Obstruction ________

5. THROAT: Speech ________ Pain ________ Thyroid ________ Tonsils ________

6. NECK: Stiffness ________ Pain ________ Grating ________ Tension ________ Decreased Movement ________

7. SHOULDERS: Pain ________ Stiffness ________ Bursitis ________ Left Shoulder ________ Right Shoulder ________

8. PAIN: Arms ________ Left or Right Elbow ________ Left or Right Wrist ________ Left or Right Carpel Tunnel _________

9. HEART: Attack ________ When? ____________________ Pain ________ Spasms ________ Palpitations ________

10. BLOOD PRESSURE: High ________ Low ________

11. LUNGS: TB ________ Chest Pain ________ Rib Pain ________

12.Condition of ABDOMEN: Stomach Ulcers________ Gall Bladder ________ Kidney ________ Hemorrhoids ________

13: FEMALE: Menstrual Pain ________ Cramping ________ Are you Pregnant? ________

14. What areas of the spine do you have pain? Upper Back ________ Middle Back ________ Lower Back ________

15. What areas do you have numbness? ____

What areas do you have cramps? ____

What areas do you have swelling ? ____

What areas do you have painful joints ____

What areas do you have arthritis? ____

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AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize Dr. Mashike to disclose to my Insurance Company or lawyer and all necessary information, which he may have acquired by examination or other means of my physical or mental condition, and I release him of any consequences thereof.

ASSIGNMENT OF PAYMENT

My attorney and or Insurance Company are hereby requested and authorized to pay direct to Dr. Mashike any moneys due him on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Dr. Mashike the difference between the total amount of his charges and the amount paid by the attorney and or the Insurance Company. It is further understood that I. the undersigned, agree to pay Dr. Mashike, the full amount of his charges, should my condition be such that is not covered by my policy or if for any reason the insurance company refuses to pay the full amount of my claim.

X-RAYS

Under the laws of the State of Michigan, x-rays are the property of this office. The amount paid by you or the Insurance company are for interpretation and x-rays will remain the property of this office. X-rays are not loaned, however we will have copies made which can be purchased for $35.00.

Signature of Applicant (or Agent) ____

Relation to Patient if signed by Agent ____

Date ________________________________