Last Name:	First Name:	Middle Initial:
Preferred Name:	Date of Birth:	Sex: □ Male □ Female
Race (Please Select): □ American Indian/Alaska Native □ Asian □ Black/African American □ Hispanic/Latino □ Native Hawaiian/Pacific Islander □ White □ Decline		Language Spoken: □ English □ Spanish □_____
Marital Status: □ Never Married □ Married □ Divorced □ Separated □ Widowed □ Domestic Partners	□ Pregnant	Employment Status: □ Employed □ Unemployed □ Student □ Other □ Retired □ Child
Mailing Address		
City, State, Zip		
Primary Phone: □ Landline □ Cell	Secondary Phone: □ Landline □ Cell	
Would you like to receive text message reminders of your appointments? □ Yes □ No Can we leave you messages on your phone? □ Yes □ No		
Would you like to activate your patient portal? □ Yes □ No	If yes, please provider your email:	
Emergency Contact Name:		
Relationship to Patient:	Phone:	
Responsible Party- Other than Self- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor		
Last Name:	First Name:	Phone:
Address:		
City, State, Zip		Relationship to Patient:

Primary Insurance Company	Secondary Insurance Company
Insurance Company Name:	Insurance Company Name:
Policy Holder Name:	Policy Holder Name:
Date of Birth:	Date of Birth:

Other Family Members already registered with the practice we can link for ease of payments and scheduling:			
Name	Relationship	Name	Relationship

Referral Information-We would appreciate learning how you heard about us?

Allergies Are you allergic to: □ Shellfish □ IV Contrast Dye □ Penicillin's Reaction: _____ □ No Allergies

Please list other Food, Medication or Insect Allergies	Describe your Reaction

Medication History *Please list all the medications you are taking, including over the counter medications, herbs & vitamins*

Medication Name	Dose	Last Taken	Medication Name	Dose	Last Taken

Preferred Pharmacy and Location:

Please list your current doctor(s)

Name:	Phone:
Name:	Phone:

Family Medical History	Medical Problem	□ No History to report
Mother		□ Alive □ Deceased
Father		□ Alive □ Deceased
Other		□ Alive □ Deceased
Other		□ Alive □ Deceased

Vaccination History *Have you ever had any of the following vaccinations? (indicate the year if known)*

Influenza	□ Yes □ No		BCG	□ Yes □ No		Pneumonia	□ Yes □ No	
Varicella	□ Yes □ No		Tetanus	□ Yes □ No		HPV (Gardasil)	□ Yes □ No	

Social History

Do you now use, or have you ever used, ***Nicotine*** □ Yes □ No
If yes, how many packs _____ per day
Have you quit □ Yes □ No

Do you consume ***alcohol****?* □ Yes □ No
If yes, how many drinks_____ per □ Day □ Week □ Month □ Year

Do you now use, or have you ever used, ***drugs for recreational purposes?*** □ Yes □ No
If yes, check all that apply □ Amphetamines □ Cocaine □ Marijuana □ Heroin □ Inhalants □ LSD
Describe the method of deliver you chose □ Ingestion □ Injection □ Inhalation
Have you quit □ Yes □ No

Prior Diagnostic Tests *Have you ever had any of the following exams? (indicated the year completed)*

PAP Smear	CT "CAT" scan of chest	ECHO
Prostate Biopsy	Chest x-ray	EKG
Mammogram	Pulmonary function test	EEG
Colonoscopy	Cardiac stress test	Bone density test
EGD (Esophageal endoscopy)		

Surgical History

Surgery or Procedure	Date of Procedure	Name of Provider Performing Procedure

Female Patients Only	Age at onset of menstruation_____	Age at onset of menopause _____ □NA

Have you ever been pregnant □ Yes □ No	___# of pregnancies ___# of Live Births	___# of Miscarriages ___# of Abortions

Have you ever taken birth control pills, or used patches or implants? If yes, how long	□ Yes □ No

Review of Systems – In the last **6 months**, have you experienced any of the following symptoms?

Constitutional
- □ Chills
- □ Fatigue
- □ Fever
- □ Weakness
- □ Weight Gain
- □ Weight Loss

Head
- □ Dizziness
- □ Fainting
- □ Head Injury
- □ Headaches
- □ Pain
- □ Sweats

Eyes
- □ Blurry Vision
- □ Cataracts
- □ Discharge
- □ Double vision
- □ Vision Loss
- □ Excessive Tearing
- □ Eye Pain
- □ Eyeglass use
- □ Pain with light

Nose
- □ Discharge
- □ Hay fever
- □ Nasal Obstruction
- □ Nosebleeds

Mouth
- □ Bleeding gums
- □ Change in Dentition
- □ Tongue Burning

Ears
- □ Hearing Aid
- □ Hearing Impairment
- □ Pain
- □ Ringing in Ears

Throat & Neck
- □ Frequent Sore Throats
- □ Lumps
- □ Tenderness

Respiratory
- □ Asthma
- □ Bronchitis
- □ Cough
- □ Pain
- □ Pleurisy
- □ Shortness of Breath
- □ Tuberculosis
- □ Wheezing

Cardiovascular
- □ Chest Pain
- □ Extremity(s) Cold
- □ Extremity(s) Discolored
- □ Heart Murmur
- □ High Blood Pressure
- □ History of Heart Attack
- □ Palpitations
- □ Rheumatic Fever
- □ Short of Breath-Exertion-Lying Flat-Sleeping
- □ Swelling of Legs
- □ Ulcers on Legs
- □ Varicose Veins

Gastrointestinal
- □ Abdominal Pain
- □ Black Tarry Stools
- □ Change in Frequency of BM
- □ Change in Stool Color
- □ Change in Stool Consistency
- □ Constipation
- □ Decreased Appetite
- □ Diarrhea
- □ Excessive Hunger
- □ Excessive Thirst
- □ Gallbladder
- □ Heartburn
- □ Hepatitis
- □ Jaundice
- □ Liver Disease
- □ Nausea
- □ Rectal Bleeding
- □ Rectal Pain
- □ Swallowing Problem
- □ Vomiting

Musculoskeletal
- □ Arthritis
- □ Deformities
- □ Gout
- □ Joint Pain
- □ Paralysis
- □ Restricted Motion

Psychiatric
- □ Depression
- □ Disorientation
- □ Disturbing Thoughts
- □ Hallucinations
- □ Mood Changes
- □ Nervousness

Breasts
- □ Discharge
- □ Lumps
- □ Pain
- □ Tenderness

Skin
- □ Easy Bruisability
- □ Eczema
- □ Hives
- □ Itching
- □ Lumps
- □ Mole Increased Size
- □ Nail Appearance
- □ Nail Texture Change
- □ Rashes

Neurological
- □ Blackouts
- □ Burning
- □ Head Injury
- □ Headaches
- □ Loss of Consciousness
- □ Paralysis
- □ Speech Disorders
- □ Strokes
- □ Tingling
- □ Tremors
- □ Unsteady Gait

Endocrine
- □ Excessive Urination
- □ Goiter
- □ Increased thirst
- □ Sweats
- □ Thyroid Trouble
- □ Weakness
- □ Weight Gain
- □ Weight Loss

Hematologic/Lymph
- □ Anemia
- □ Blood Clots
- □ Easy Bruisability
- □ Transfusion

Allergic/Immunologic
- □ Hives
- □ Itchy Eyes
- □ Itchy Nose
- □ Sneezing
- □ Stuffy Nose
- □ Watery Eyes

Men's Health
- □ Prostate problems
- □ Sexual Problems

Urinary
- □ Awaking to Urinate
- □ Bed-Wetting
- □ Blood in Urine
- □ Burning
- □ Difficulty Starting Stream
- □ Excessive Urination
- □ Incontinence
- □ Infections
- □ Pain on Urination
- □ Retention
- □ Stones
- □ Urgency

Women's Health
- □ Birth Control
- □ Bleeding between Periods
- □ Discharge
- □ Fertility Problems
- □ Itching
- □ Menopause
- □ Menstrual Pain
- □ Pain on Intercourse
- □ Postmenopausal Bleeding
- □ Sexual Problems
- □ Venereal Disease

Past DIAGNOISED Medical History -Please circle and put the name of the provider who diagnosed you □ **No History**		
Please write the estimated year of diagnosis		
Acne	Esophageal Dysfunction	Polycystic Ovarian Syndrome
Adrenal Dysfunction	Fibromyalgia	Psoriasis
Alzheimer	Gallstones	Pulmonary Artery Hypertension
Amyotrophic Lateral Sclerosis	Gastritis or Gastric Ulcers	Pulmonary fibrosis
Anorexia or Bulimia	GERD (reflux problems)	Radiation Therapy, if yes explain
Anxiety Disorder	Glaucoma	Recurrent Infections
Arteriovenous Malformations (AVMs)	Heart or Valve Defects	Restless Leg Syndrome
Arthritis	Heart Attack	Sarcoidosis
Asthma	Hemochromatosis	Schizophrenia
Autoimmune Disease	Hemorrhoids	Scleroderma
Bipolar Disorder	Hepatitis	Scoliosis
Bleeding Disorder	HIV or AIDS	Seizure Disorder
Cataracts	Hypertension	Sickle Cell
Celiac Disease	Irritable Bowel Syndrome	Sjogren
Chemotherapy If yes, state when	Irregular Heart Rhythm	Skin Disorders-other
Crohn's Disease	Kyphosis	Stroke
Claudication	Liver Dysfunction	Thalassemia
Clotting Disorder	Kidney Failure, or Dysfunction	Thrombocytopenia
Congenital Heart Defects	Malignancy If yes, describe	Thrombophilia
Coronary Artery Disease	Mania	Thyroid Disease
COPD	Muscular Dystrophy	Transfusions
Cystic Fibrosis	Narcolepsy	Tuberculosis If yes, have you been treated?
Depression	Obstructive Sleep Apnea	Ulcerative Colitis
Diabetes	Organ Transplant If yes, describe	Urinary retention or urgency
Dialysis	Osteoporosis	Urinary urgency
Eclampsia or Pre-eclampsia	Pancreatitis	Vasculitis
Endocarditis	Periodic Limb Movement Disorder	Visual defects
Endometriosis	Peripheral Artery Disease	Vocal cord dysfunction/paralysis
End Stage Renal Disease	Personality Disorder	Other:
Erectile Dysfunction	Pituitary Dysfunction	
Work History *Please list your occupation(s). (Include military experience)*		
Exercise History *Do you exercise? □ Yes □ No If yes, describe how long and how often you exercise on average each week*		

Consent for Treatment

Name _____ Date of Birth _____

Medical Consent: I request and authorize Magic Valley Medicine ("MVM"), its employees, and any physician as are necessary to provider emergency, outpatient, and/or general treatment and care. Further, I authorize MVM and the physicians involved in my care to permit the presence of observers in my treatment as deemed necessary. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me as a patient.

I understand and acknowledge that from time to time, medical students, nursing students, or students of other healthcare disciplines may be undergoing clinical education at MVM. I herby authorize and permit such students of any such health profession to participate in my care insofar as they are properly supervised always by a licensed and credentialed healthcare practitioner in that field of expertise. I acknowledge that I have a right to ask questions of any physician or nurse regarding the use of students in my care at any time.

Chiropractic Consent: I request and consent to the performance of chiropractic adjustments by the chiropractic physician. I request and consent to the performance of chiropractic therapies by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

_____**(Initial) We can only bill for chiropractic visits when they are only adjustments**. Anything more, such as new prescriptions, medication refills or other medical questions will be billed out as a medical visit or may need to be rescheduled. **When you are scheduling appointments, inform the staff of all your concerns so we can schedule appropriately.**

All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

_____**(Initial)** We reserve special times for you that other patients could be seen at. If you need to cancel or reschedule and appointment, you need to do so 24 hours in advance so that time can be taken by someone who needs it. Otherwise you will be charged with a **Missed Appointment Fee of $25.00.**

We accept assignment with your insurance company as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If an over-payment exists after all insurance billing has been done, we will issue an over-payment check to you- it will not come from your insurance company. All insurance payments regardless of which company issues a check first, are applied to your account if any balance is due.

Any service not covered or coverage reductions by your insurance will be your responsibility.

This office will resubmit a claim ONE TIME. We will not enter any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

Payment is due in full at time of service unless other arrangements are made. A fee of $25 will apply to all returned checks.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intent this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

I have been given the opportunity to review the "HIPAA PRIVACY POLICY" Act. *If you would like a copy to take with you please see the front desk*

Signature of Patient or Representative: _____ Date: _____

Name and Relationship to patient if not self: _____