Old Mill Chiropractic
Daniel L. Coogan, D.C.

235 Jungermann Rd., Suite 209, St. Peters, MO 63376
Phone: (636) 928-7387 Fax (636) 928-1269

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Appointment Date: _____
Name: _____Date of Birth: _____
Address: _____ City: _____ State: ____Zip:_____
Home Phone: _____Work Phone: _____
Cell Phone: _____Email: _____
Social Security #:_____ Age: _____ ❑ Male ❑ Female
Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other _____
Number of children: _____ Ages of children: _____, _____, _____, _____, _____, _____
Name of Spouse or Nearest Relative: _____ Phone: _____
Your Occupation_____ Your Employer: _____
Referred to this Office by: _____
Payment for Services will be by: ❑Cash ❑Check ❑Credit Card ❑Health Insurance
❑Automobile Insurance ❑Worker's Compensation
Name of Insurance Co.:_____ Insured's Name: _____
Insured's Social Security #:_____ Insured's Date of Birth: _____
Are you covered by more than one insurance company? ❑Yes ❑No Name _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

Please indicate which conditions have been experienced by marking appropriate boxes.

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No
Describe Condition_____ Date of Last Physical Exam: _____
Habits: Nicotine/Tobacco usage per day: _____ Alcohol/Drinks per week: _____Coffee/Cups per day: _____
Vitamins/Herbs (list all being taken):_____
Exercise: _☐_None _☐_Moderate _☐_Daily
SURGICAL HISTORY:
1._____ Date: _____
2._____ Date: _____
3._____ Date: _____

Have you ever had a metal implant? ❑Yes ❑No Have you ever been gunshot? ❑Yes ❑No

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other 1. _____Date:_____
❑Job ❑Auto ❑Other 2._____Date:_____
❑Job ❑Auto ❑Other 3._____Date:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your Symptoms (1-10, with 10 being the worst)

1) Symptom: _____ Rating: _____

2) Symptom: _____ Rating: _____

3) Symptom: _____ Rating: _____

4) Symptom: _____ Rating: _____

5) Symptom: _____ Rating: _____

6) Symptom: _____ Rating: _____

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT
WHEN AND HOW OCCURRED? _____
_____
SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT
❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED: _____ _____
SYMPTOMS HAVE PERSISTED FOR: ____HOUR(S) ____DAY(S) ___WEEK(S) ___MONTH(S) ___YEAR(S)
SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT
HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN? _____
IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?
_____ _____
NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):
_____
_____
ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑NO ❑YES WHAT KIND? _____
ARE YOU TAKING ANY MEDICATIONS? ❑NO ❑YES WHAT KIND? _____
ARE YOU PREGNANT? ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion
❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever
❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Old Mill Chiropractic or Daniel Coogan, D.C. I authorize Old Mill Chiropractic to release all information necessary to communicate with personal physicians and other healthcare providers and insurance companies and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

The patient understands and agrees to allow Old Mill Chiropractic to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

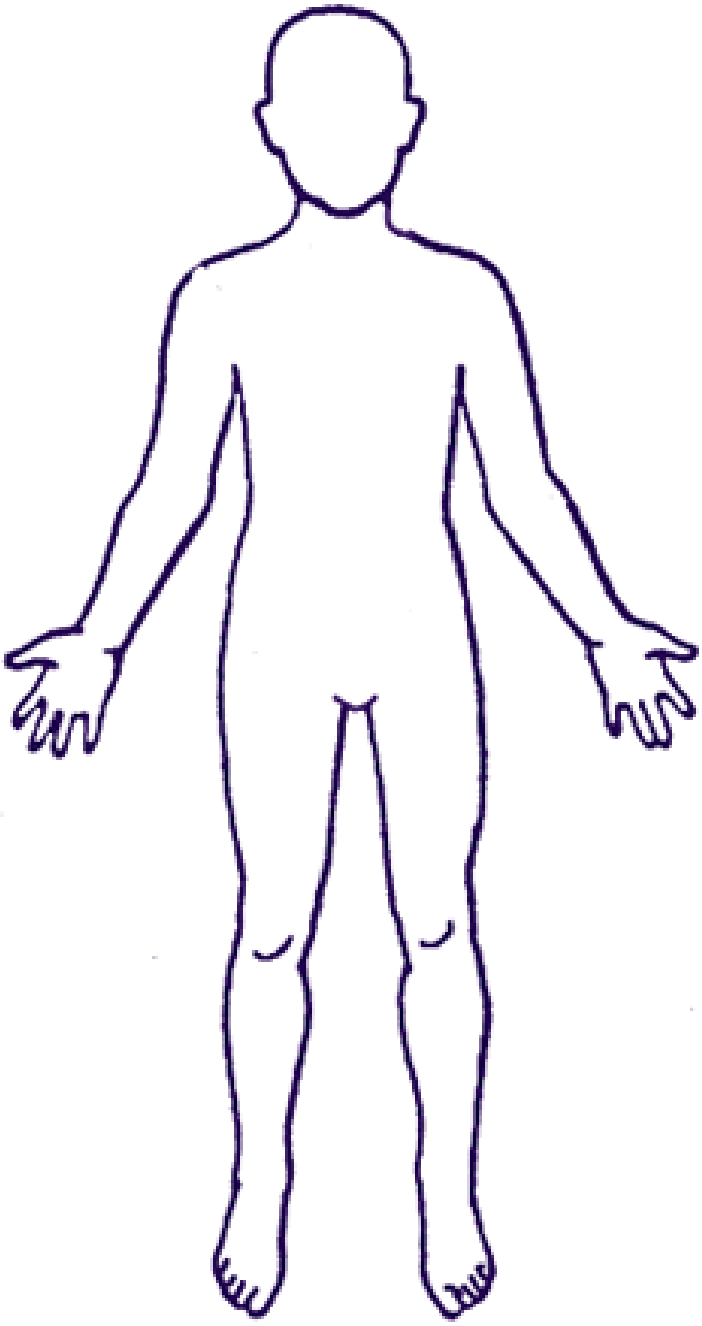
Date: _____Signature:_____

Patient Name: _____ Appointment Date: _____

These are front and back views of the human body. Please use a highlighter or marker and color anywhere you are experiencing pain, tingling, numbness, or having ANY problems.

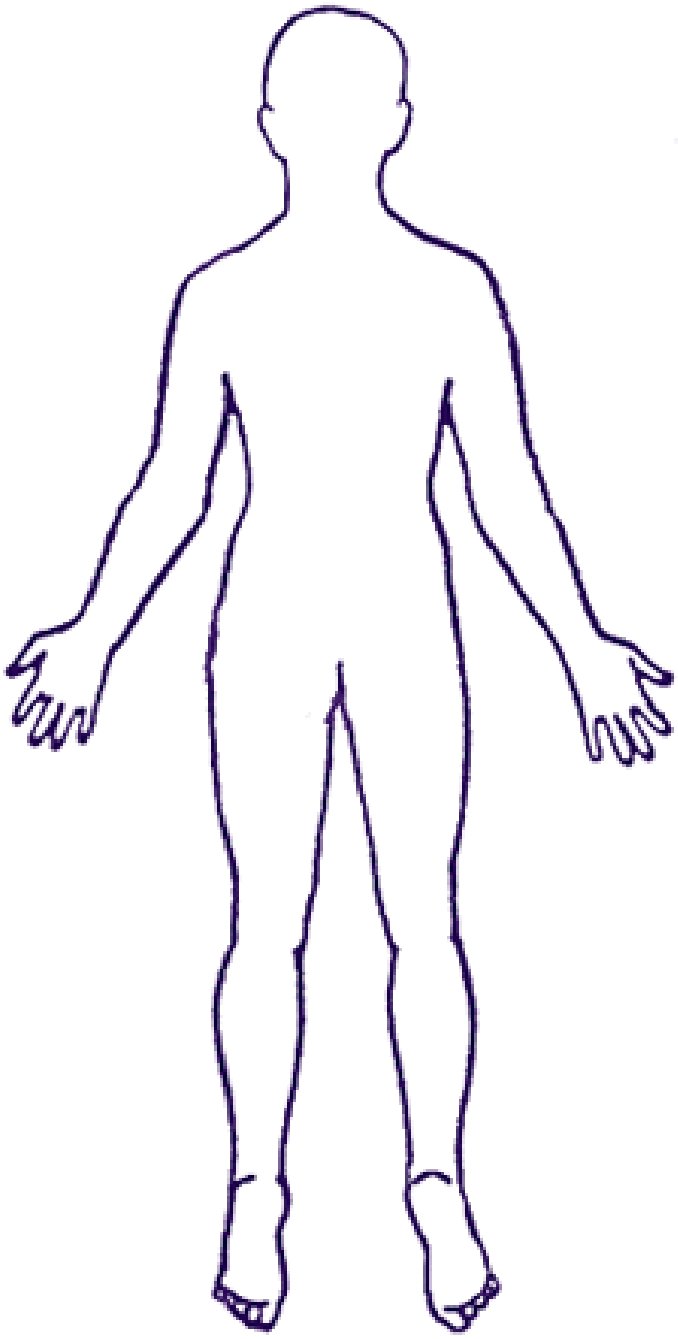
Front

Right **Left**



Back

Left **Right**



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Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Old Mill Chiropractic to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Old Mill Chiropractic to submit requested **PHI** to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all **PHI** to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at ay time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their **PHI**. Old Mill Chiropractic is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient at Old Mill Chiropractic.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures at Old Mill Chiropractic. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Dr. Daniel Coogan, D. C. has the right to refuse to give care.
8. The patient agrees that Old Mill Chiropractic can use **PHI** for in house projects (referral board, patient of the month, newsletter, etc….).

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____
Patient Signature Date

_____
Print Name of Patient

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INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays on me (or on the patient named below, for whom I legally responsible) by the doctor,
Daniel L. Coogan, D.C. or his associates, affiliated with Old Mill Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, factures, disc injuries, dislocations and sprains. I do not expect Dr. Coogan to be able to anticipate and explain all risks and complications. I wish to rely on Dr. Coogan to exercise judgment during the course of the procedure which Dr. Coogan feels at the time, based on the facts then known, and is in my best interest.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the Dr. Coogan or his associates, affiliated with Old Mill Chiropractic to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____
Print Name of Patient Date

_____
Patient or Guardian Signature

For Women Only - Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and Dr. Coogan and/or his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:

_____

_____ _____
Signature Date