

**DENNIS MUTELL, D.C.**  
832 E. Boston Street #8    Covington, LA 70433    985-875-2225

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Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Email address: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Male     Female    Marital Status: M W S D    # of children: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
How did you learn about our office? \_\_\_\_\_

Are your current complaints or injury the result of an accident?     Automobile     Work     Other

**PLEASE NOTE: If your current injury or complaint is the result of an accident, you will need to complete an accident questionnaire to ensure proper documentation and payment of your claim.**

### **PAYMENT INFORMATION**

It is our office policy that all fees for services recommended be paid on the day of service, unless insurance benefits have been verified. Please provide us with your insurance information so we may be able to verify your coverage. If we are unable to verify your insurance coverage prior to leaving today, services will be on a fee-for-services basis until we are able to verify your coverage. In case of an accident claim, please note this office does not routinely file accident claims with your medical insurance company. The cost for all services rendered in your case will be collected from the settlement of the case unless other arrangements have been made.

Any portion of your bill due today will be paid by:  
 Cash     Personal check     Major Credit Card

**I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's Signature authorizing care: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE FILL OUT ACCIDENT REPORT IF AUTOMOBILE OR JOB INJURY**

NAME \_\_\_\_\_

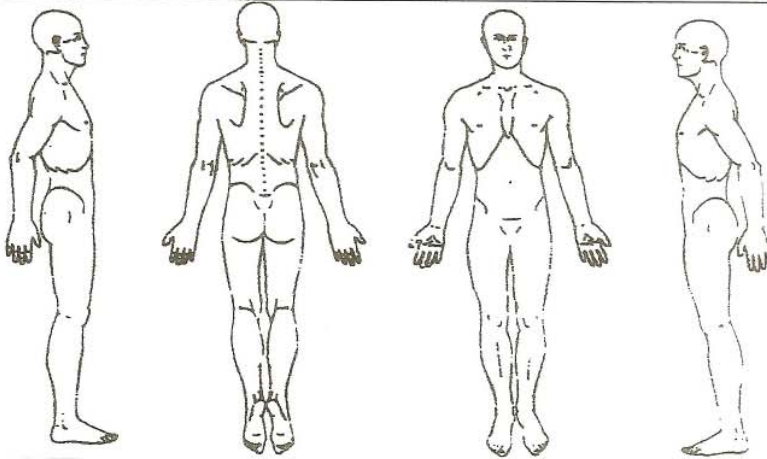
DATE \_\_\_\_\_

In the space below, please describe your major complaint.

1. Please describe your complaint: \_\_\_\_\_

- a. Description:
- Sharp Pain
  - Dull Pain
  - Ache
  - Weak
  - Throbbing
  - Numb
  - Shooting
  - Gripping
  - Burning
  - Tingling
- b. Frequency:
- Constant (76-100%)
  - Frequent (51-75%)
  - Occasional (26-50%)
  - Intermittent (25% or less)

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



- c. Indicate intensity of your pain at its lowest and highest level No Pain [0] [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] Unbearable pain
- d. Your symptoms are decreasing not changing increasing
- e. Symptoms are worse in the Morning Afternoon Night Increases during the day Same all day
2. When did your problem begin: *Specific date if possible?* \_\_\_\_\_ Describe how your problem began: \_\_\_\_\_

3. Have you been treated for this episode? Yes No Healthcare provider's Name \_\_\_\_\_
- If yes, by whom? Chiropractor MD Osteopath Physical Therapist Occupational Therapist Other \_\_\_\_\_
- Are you currently being seen? Yes No
- When and what treatment? \_\_\_\_\_

- Were any test (x-rays, MRI, blood work) performed? Yes No What and When? \_\_\_\_\_
4. In the past have you been treated for the same or a similar problem? Yes No Healthcare Provider's Name \_\_\_\_\_
- if yes, who did you see for that episode? Chiropractor MD Osteopath Physical Therapist Occupational Therapist
- When and what treatment did you receive? \_\_\_\_\_
- Were any test performed? Yes No What and when? \_\_\_\_\_

5. What makes your problem better? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity
6. What makes your problem worse? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity
7. How would you rate your general stress level? Little or No stress Minimal Stress Moderate Stress Greatly Stressed
8. General Physical Activity: No regular exercise program Light exercise program Moderate exercise program Strenuous exercise program Frequency and type of exercise \_\_\_\_\_

9. Are your complaints affecting your ability to be active?
- No effect
  - Some physical restrictions (able to perform light duty work and household tasks).
  - Need limited assistance with common everyday tasks. Need assistance often.
  - Have a significant inability to function without assistance Am totally disabled (impaired). Cannot care for self.

10. Physical activity at work: Sitting more than 50% of workday Light manual labor Manual labor Heavy manual labor Repeated motion

11. Occupation: \_\_\_\_\_ FT PT Has your work status changed because of this complaint? Yes No

12. Present Weight \_\_\_\_\_ lbs. Has this changed by more than 10 lbs in the past 3 months? Yes No Height \_\_\_\_\_

## PATIENT HEALTH QUESTIONNAIRE

If you have ever had a listed condition in the past, please check it *In the Past column*. If you are presently troubled by a particular condition, check it *In the Present column*. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

| PAST                     | PRESENT                  |   | PAST   | PRESENT                  |                                    |
|--------------------------|--------------------------|---|--|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain   | <input type="checkbox"/>   | <input type="checkbox"/> | Aortic Aneurysm                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain   | <input type="checkbox"/>   | <input type="checkbox"/> | High Blood Pressure                |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in the Upper Arm or Elbow  | <input type="checkbox"/>   | <input type="checkbox"/> | Angina                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain   | <input type="checkbox"/>   | <input type="checkbox"/> | Heart Attack                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain  | <input type="checkbox"/>   | <input type="checkbox"/> | Stroke                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain   | <input type="checkbox"/>   | <input type="checkbox"/> | Asthma                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Leg or Hip  | <input type="checkbox"/>   | <input type="checkbox"/> | Cancer                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Lower Leg or Knee   | <input type="checkbox"/>   | <input type="checkbox"/> | Tumors                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in ankle or foot   | <input type="checkbox"/>   | <input type="checkbox"/> | Prostate Problems                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm / Hand / Leg / Foot numbness  | <input type="checkbox"/>   | <input type="checkbox"/> | Blood Disorder                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain  | <input type="checkbox"/>   | <input type="checkbox"/> | Emphysema (chronic lung disorders) |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling / Stiffness of Joint(s)  | <input type="checkbox"/>   | <input type="checkbox"/> | Arthritis                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting  | <input type="checkbox"/>   | <input type="checkbox"/> | Rheumatoid Arthritis               |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual disturbances   | <input type="checkbox"/>   | <input type="checkbox"/> | Diabetes                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions   | <input type="checkbox"/>   | <input type="checkbox"/> | Epilepsy                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness   | <input type="checkbox"/>   | <input type="checkbox"/> | Ulcer                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache  | <input type="checkbox"/>   | <input type="checkbox"/> | Liver / Gallbladder problems       |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination   | <input type="checkbox"/>   | <input type="checkbox"/> | Kidney Stones                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (Ear Noises)   | <input type="checkbox"/>   | <input type="checkbox"/> | Hepatitis                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid Hear Beat   | <input type="checkbox"/>   | <input type="checkbox"/> | Bladder Infection                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains   | <input type="checkbox"/>   | <input type="checkbox"/> | Kidney Disorders (by condition)    |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite  | <input type="checkbox"/>   | <input type="checkbox"/> | Colitis                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia  | <input type="checkbox"/>   | <input type="checkbox"/> | Irritable Colon                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss | <input type="checkbox"/>   | <input type="checkbox"/> | HIV / AIDS                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst  | <input type="checkbox"/>   | <input type="checkbox"/> | Systemic Lupus                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough   | <input type="checkbox"/>   | <input type="checkbox"/> | Other _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis   |  |                          |                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue   |  |                          |                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control   |  |                          |                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination   | <input type="checkbox"/>   | <input type="checkbox"/> | <b>FEMALES ONLY</b>                |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination  | <input type="checkbox"/>   | <input type="checkbox"/> | Irregular Menstrual Flow           |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain  | <input type="checkbox"/>   | <input type="checkbox"/> | Profuse Menstrual Flow             |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation / irregular bowel habits                                       | <input type="checkbox"/>   | <input type="checkbox"/> | Breast Soreness / Lumps            |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in Swallowing  | <input type="checkbox"/>   | <input type="checkbox"/> | Endometriosis                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn / Indigestion   | <input type="checkbox"/>   | <input type="checkbox"/> | PMS                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis / Eczema / Rash  | <input type="checkbox"/>   | <input type="checkbox"/> | Birth Control Type _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression  | <input type="checkbox"/>   | <input type="checkbox"/> | Hormone / Estrogen Replacement     |
| <input type="checkbox"/> | <input type="checkbox"/> | Low-back Pain   | Are you currently Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |                                    |
|                          |                          |   | Date of your last period? _____  |                          |                                    |

If a family member has had any of the following, please Mark the appropriate box:

- |   |  |
|---|--|
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Epilepsy              |
| <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Chronic Back Problems |
| <input type="checkbox"/> Lung Problems        | <input type="checkbox"/> Chronic headaches     |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Lupus                 |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Other Condition _____ |

Please check any of the following that apply.

- | Past                     | Present                  |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco  |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol  |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or alcohol Dependence   |
| <input type="checkbox"/> | <input type="checkbox"/> | Coffee / Tea / Caffeinated Soft Drinks:<br>cups/cans per day _____ |

Yes  No Do you have allergies to any medications or general allergies? Please List: \_\_\_\_\_

Primary Care Doctor's Name: \_\_\_\_\_ Date last seen by him/her: \_\_\_\_\_

Reason for your last visit to him/her: \_\_\_\_\_

Have you seen any medical specialist within the last year?  Yes  No Doctor's Name: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Hospitalization / Surgical procedure (Please include dates): \_\_\_\_\_

Medications / Vitamins / Herbs currently taking: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_