Dr. Mitchel V. Mondo
1310 E. Highway 96 #206
White Bear Lake, MN 55110
651-429-0101

Patient Information

Last Name:		First Name:		Middle Initial:	
Home Address:		City:		State:	Zip:
Home Phone #:	Birthdate:			SS #:	
Cell Phone #:		Referred By (Name):			
Email Address:	Work Status: □Employed □Full-time Student □Part-time Student □Other				
Employer:	Work Phone #:			Occupation:	
Employer's Address:		City:		State:	Zip:

Family Information

Marital Status: □Single □Married □Divorced □Separated □Widowed					
Spouse's Name:					
Names of Children:	Age:	Names of Children:		Age:	
Please Note: This section to be filled out only if patient is a child or student.					
Parent's Name:	Birthdate:			SS #:	
Parent's Employer:				Work Phone #:	
Employer's Address:		City:		State:	Zip:

Health Insurance

Insurance Company:		Group or Policy #:	
Name of Insured:	Birthdate:		SS #:
Insured's Employer:	Patient's Relationship to Insured:		
Secondary Insurance:			
Person Ultimately Responsible for this Account:			

Auto Insurance/ Workman's Compensation

Date of Accident:	Claim #:		
Insurance Company:		Phone #:	
Address:	City:	State:	Zip:
Agent's Name or Employer Contact:		Phone #:	
Name of Insured:			

General Health Overview

Have you ever been treated by a Chiropractor before: □Yes □No	If so, was your experience favorable? □Yes □No	When was your last visit?
Are you involved in a regular exercise routine? □Yes □No	Do you take vitamins or nutritional supplements? □Yes □No Is this supervised by a healthcare professional? □Yes □No	

Which of the following medications do you take?

□Antacids	□Heart medication	□Laxatives	□Sleeping aids
□Antibiotics	□High blood pressure	□Muscle relaxant	□Thyroid medication
□Antidepressants	□Hormones	□Pain reliever	□Other___________
□Anti-inflammatory	□Insulin	□Oral contraceptive	

Check the health conditions that apply:

Digestive	**Cardiovascular**	**Urological**	**Neurological**	**Miscellaneous**
□Bloated feeling	□Heart problems	□Urinary	□Headache	□Weight Issues
□Abdominal gas	□High/low blood pressure	□Bladder infections	□Migraine	□Skin (hives, rashes, acne, psoriasis)
□Belching or burping	□Circulatory problems	□Kidney	□Dizziness	□Depression
□Diarrhea	□High Cholesterol	□Prostate		□Sleep disturbance
□Constipation			**Endocrine**	□Chronic fatigue
□Abdominal pain	**Respiratory/Immune**	**Musculoskeletal**	□Diabetes	□Cancer
□Heartburn	□Asthma	□Joint problems	□Thyroid	
□Ulcers	□Chronic Bronchitis	□Muscle spasms	□Pancreas	□Other______________
□Food Allergies	□Sinus Infection	□Stiffness		□Other______________
□Gall bladder	□Allergies/Hay Fever	□Chronic pain	**Reproductive**	□Other______________
□Liver	□Ear Infections	□TMJ	□Infertility	
	□Chronic colds, cough, or sore throats	□Arthritis	□Menstrual Problems	
		□Fibromyalgia	□Menopausal Difficulties	

Reason for Visit

If not accident or workman's compensation related, please describe the reason for your visit.

Auto Related Accident

Date of Accident:________/________/________ Time:__________ □AM □PM	Name of the location/street on which you were traveling?
Were any traffic violations issued? □Yes □No	If Yes, to whom?
How many people were in the vehicle?	Were you the: □Driver □Front Passenger □Rear Passenger
Which direction did the impact to your vehicle come from? □Front □Rear □Right Side □Left Side □Other:__________	
During Impact, which way were you facing? □Right □Left □Forward	
Did any part of your body strike anything in the vehicle? □Yes □No	If yes, Please describe:
Please describe the accident:	

Work Related Accident

Date of Accident: ________/________/________ Time:__________ □AM □PM	Was your accident directly related to your work? □Yes □No
Did you report your accident to your employer? □Yes □No	Have you changed jobs in the last year? □Yes □No
Please describe your accident:	

* The information on this form is complete and correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes.

Signature:____ Date:__________/__________/__________