



Dr.Mukaia Mitchom Lockett LLC
 2 Eagle Center, Suite1, O'Fallon, IL. 62269, (618) 606-9119

APPLICATION FOR TREATMENT

Name _____ Date _____

Email _____ Age _____ Birthdate _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Alt Phone _____ Referred By _____

Select if you are: Married Single Widowed Divorced Separated | Gender _____

Ages of Children _____

Employer _____ Occupation _____

Emergency Contact _____ Emergency Phone _____

What is your major complaint? _____

How long? _____ How often? _____

Is there any other health problems that concerns you, besides your major complaint, that you wish you could get rid of, even if you never considered that a wellness practice or chiropractor could help? For example, do you have any **headaches, sinus problems, hormone problems, weight problems, asthma, diabetes, digestive troubles, arthritis, fatigue, mood swings, troubles with sleep, or any other problems** at all you wish you could get rid of?

Has a doctor treated you for **ANY** health conditions in the last year? Yes _____ or NO _____

If yes, please explain: _____

List **Diagnosis(es)** and types of treatment(s) _____

Who is your **Primary Care Physician?** _____

List **Medications & Supplements:** _____

List any **Surgeries** you have had **in your lifetime**

List any **Accidents** or **Injuries** you had had **in your lifetime** (i.e. slips, falls, motor vehicle, motorcycle, bicycle, sports or work related, etc.)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

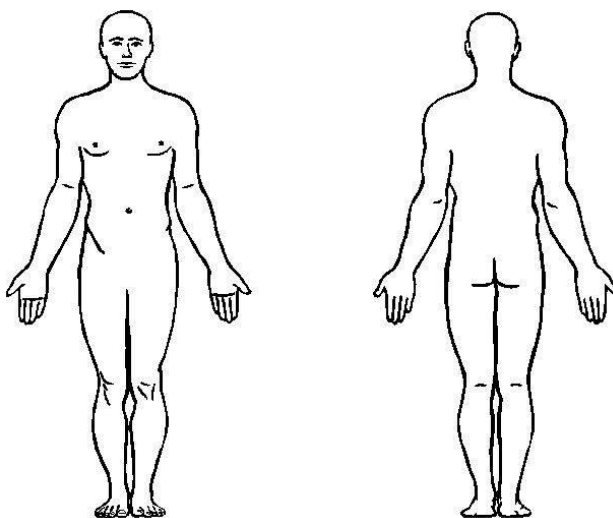
Patient Signature _____ **Date** _____

How has your pain affected your life? _____

What are some things you used to do before you had pain that you would like to do again if this was not a problem? _____

What **functions**, (sitting, walking, bending, lying down, etc, are challenging to you **(in order of severity)**)?

PLEASE MARK, On Diagram, YOUR AREAS OF PAIN AND IT'S INTENSITY.
(On a scale of **1-10**, with 10 being the worst pain).



Patient Signature _____ **Date** _____



**Dr. Mukaia Mitchom Lockett LLC
Appointment Policy**

Thank you for trusting Dr. Mukaia Mitchom Lockett LLC with your Wellness Needs. When you schedule an appointment with Dr. Mukaia Mitchom Lockett LLC, we set aside enough time to provide you with quality care. In the event that you would need to cancel or reschedule an appointment, please contact our office **as soon as possible**, and **no later than 24 hours prior to your appointment**. **This will give our office adequate time to schedule other patients who may be waiting for an appointment.**

Please see our Reschedule/Cancellation/No-Show Policy below:

- **Established patients** who fail to show or cancel/reschedule an appointment and have not contacted our office with at least **24 hour notice** will be considered a **No Show** and may be required to put a credit card on file to make another appointment and be charged a **\$35.00** fee
- Any established patient who fails to show, cancel, or reschedule an **EVENING appointment (4:00 pm or later)** without a 24 hour advance notice more than **2 times within 3 months** WILL be charged a **\$50 fee**. The evening appointments are very high in demand. **All evening appointments will be required to put a credit card on file.**
- Any **new patient** who fails to show for their initial visit will be required to **put a credit card on file to make another appointment**. Any **new patient** who fails to show for initial appointment for a second time **will not be able to reschedule**.

The fee is **charged to the patient, not the insurance company or any third party**, and is due prior to the patient's next visit.

As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, **the above policy will still remain in effect.**

If a patient is **more than 10 minutes late** for their appointment, they **may be rescheduled to the next available appointment that day** or if necessary, **another day altogether**.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office. You may contact Dr. Mukaia Mitchom Lockett LLC at the number below. Should it be after regular business hours Monday through Friday, or a weekend, **you may leave a voice message and/or text message.**

**Dr. Mukaia Mitchom Lockett LLC
618-606-9119**

I have read and understand the Appointment policy at Dr. Mukaia Mitchom Lockett LLC and **I do agree to it.**

Print: _____

Sign: _____

Date _____



Dr. Mukaia Mitchom Lockett, LLC
 "We Are Transforming Lives To Better Health Naturally"
 2 Eagle Center, Suite 1, O'Fallon, IL. 62269, (618) 606-9119

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering service at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members **and their phone numbers** that are allowed:

This consent was signed by: _____
 (PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____



Dr. Mukaia Mitchom Lockett, LLC
2 Eagle Center, Suite 1, O'Fallon, IL. 62269, (618) 606-9119

Patient Consent Authorization

Consent for Treatment. I voluntarily consent to the rendering of care, for myself or my child including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

Assignment of Benefits. I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

Release of Information. The physician(s) may disclose all or part of the patient's record to any persons or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patients for all part or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Subsequent rejection of a claim as a result of having non covered out of network benefits will constitute responsibility for payment of claim on my part.

MEDICARE AND MEDICAID PATIENT CERTIFICATION - PATIENTS CERTIFICATION **AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:**

I certify that the information given by me in applying for payment under Title XVIII and / or Title XI of the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid Claim. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Patient's Printed Name

Date:

Patient's Signature/Authorized Signature

If not the patient - print name & relationship

Witness

Please initial that you have read the Notice of Privacy Practices statement_____

Health Satisfaction Score (HSS)

Name: _____

Date: _____

Email Address: _____

Please answer the questions on a scale of 1 to 10, 1 representing that you don't agree (NOT TRUE) with the statement and 10 representing (TRUE) that there is no doubt in your mind or heart that you agree with the statement.

1 - Absolutely **Disagree** NOT TRUE FOR ME [2] [3] [4] [5] [6] [7] [8] [9] **10** - Absolutely **Agree** TRUE FOR ME

Section 1 - Physical Health

1. I am a physically fit person and formally exercise on a regular basis.

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

2. I have a physically attractive body that I am proud to look at in the mirror.

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

3. I have not had many traumas in my life (auto accident, broken bones, bad falls).

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

4. I get at least 7 hours of sleep, 7 days at week.

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

5. I have gotten regular Chiropractic care within the past 5 years.

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 1 total _____

Section 2 - Emotional/Mental Health

6. I am a calm, peaceful person. I can shut my mind off and focus my mind at will.

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

7. I practice some form of mental relaxation (meditation, yoga, breathing exercises, prayer, etc.) on a regular basis.

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

8. Most of the time, I am truly happy and feel a sense of purpose in my life.

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

9. I have healthy relationships and a rich social network of friends and activities.

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

10. I am organized, have time for myself, and can prioritize the important tasks in my life.

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 2 total _____

Section 3 - Chemical/Nutritional Health

11. I eat 4-6 small meals daily and properly combine my protein, carbs, and fats.

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

12. I supplement everyday with good supplements such as a vitamin/mineral complex, antioxidants, and good fatty acids (fish oil, flax seeds).

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

13. I do not take medications for chronic medical problems such as digestive disorders; cardiovascular problems; headaches; chronic pain; blood sugar problems; chronic fatigue; immune problems or chronic infections; or any other chronic conditions.

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

14. I do not smoke cigarettes.

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

15. I drink water as my primary beverage and consume at least 30 ounces per day.

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 3 total _____

Grand total of all three sections: _____

PATIENT HEALTH QUESTIONNAIRE

Name _____

Date _____

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently having a particular symptom, check that symptom in the Present column. **CORRECTLY ANSWERING THE CONDITIONS CAN INFLUENCE TREATMENT CHOICES AND OUTCOME OF CARE.**

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain Loss	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Muscular In-coordination
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip
<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain _____	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/irregular bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke (Date) _____
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Swelling, Stiffness of Joint(s)
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises)
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders)	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	Have You or Your Family Had:		
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (R _____ L _____)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Headache _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (date)	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Back Problems
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Headaches
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon	<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain			
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)	Do you have a permanent disability rating? Yes ___ No		
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	Location _____		
<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gallbladder problems	Date rating received ? Rating Percentage _____		
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			

Present Weight _____ **Pounds** **Height** _____ **Feet** _____ **Inches**

Please check any of the following that apply to you

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy # births _____	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco ___ packs/day
<input type="checkbox"/>	<input type="checkbox"/>	Birth control pills, Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol ___ drinks/day/week/month
<input type="checkbox"/>	<input type="checkbox"/>	Medication (list if not listed elsewhere)	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
		_____	<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffeinated Soft drinks
		_____	<input type="checkbox"/>	<input type="checkbox"/>	_____ cups/cans per day
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations/Surgical Procedures (List if not described elsewhere)			

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this Doctor immediately whenever I have changes in my health condition

Signature

Date

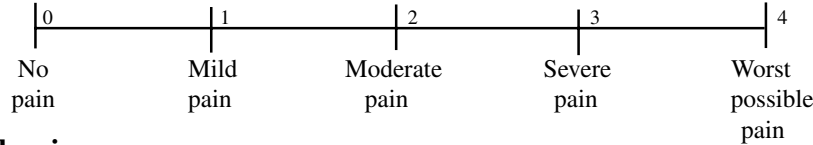
Functional Rating Index

For use with Neck and/or Back Problems only.

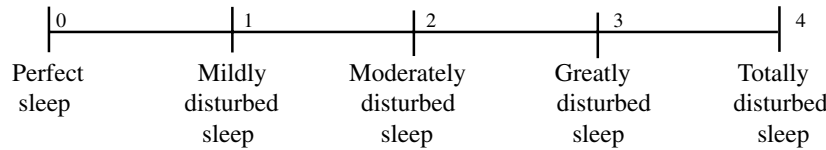
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please click on the number which most closely describes your condition right now.

Bowel/Elimination Habits: How frequent? _____ time per _____

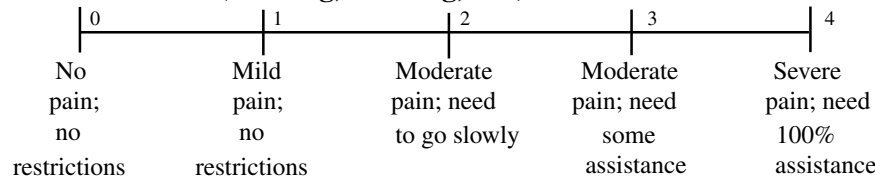
1. Pain Intensity



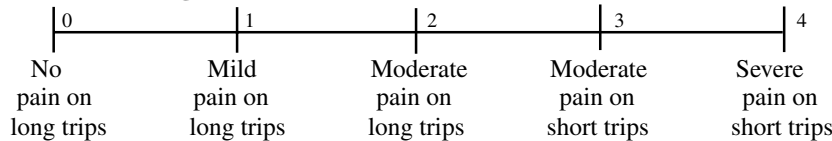
2. Sleeping



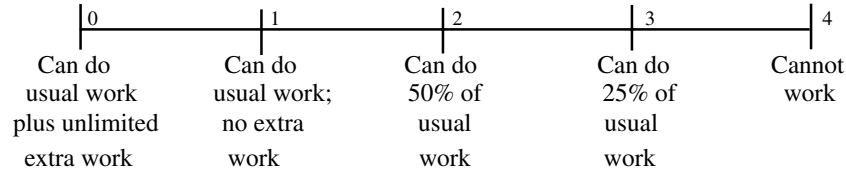
3. Personal Care (washing, dressing, etc.)



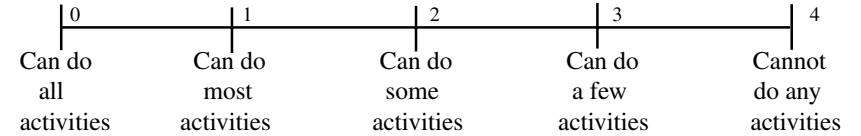
4. Travel (driving, etc.)



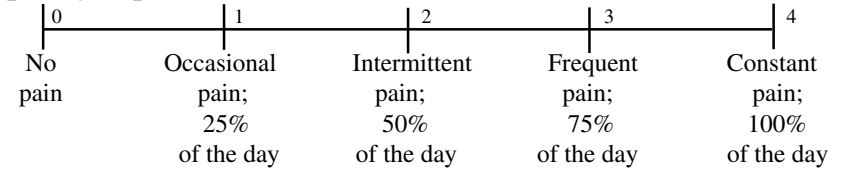
5. Work



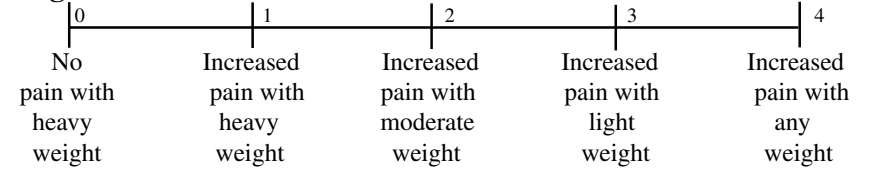
6. Recreation



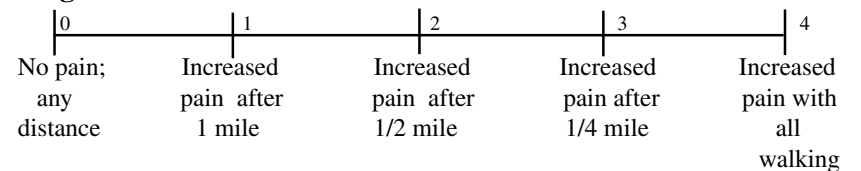
7. Frequency of pain



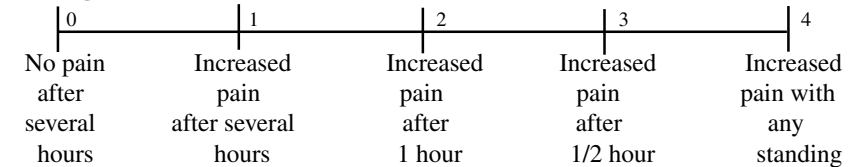
8. Lifting



9. Walking



10. Standing



Name _____

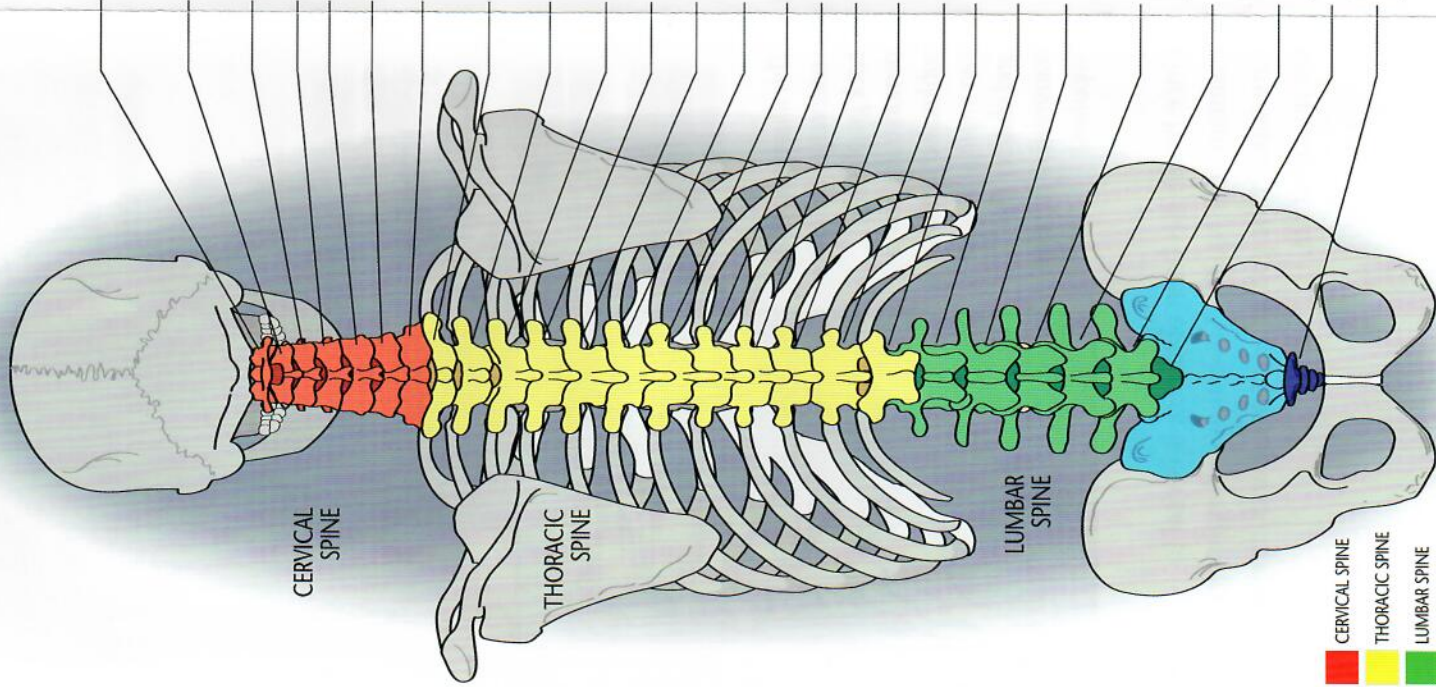
PRINTED

Signature

Total Score _____ /40

Date

"The nervous system controls and coordinates all organs and structures of the human body." (Gray's Anatomy, 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nervous system and affect the structures, organs, and functions which may result in the conditions shown below.



WHAT IS CHIROPRACTIC?



CHIROPRACTIC & YOU

Areas Controlled By Nerves*	Possible Effects if Malfunction
Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system	headaches, nervousness, insomnia, head colds, high blood pressure, migraine headaches, nervous breakdowns, amnesia, chronic tiredness, dizziness
Eyes, optic nerves, auditory nerves, sinus, mastoid bones, tongue, forehead	sinus trouble, allergies, crossed eyes, deafness, eye troubles, earache, fainting spells, vision difficulties
Cheeks, outer ear, face bones, teeth, trifacial nerve	neuralgia, neuritis, acne or pimples, eczema
Nose, lips, mouth, eustachian tube	hay fever, hearing loss, adenoids
Vocal cords, neck glands, pharynx	laryngitis, hoarseness, sore throats, quincy
Neck muscles, shoulders, tonsils	stiff neck, pain in upper arm, tonsillitis, whooping cough, croup
Thyroid gland, bursae in the shoulder, elbows	bursitis, colds, thyroid conditions
Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea	asthma, cough, difficult breathing, shortness of breath, pain in lower arm, pain in hands
Heart, including its valves and covering; coronary arteries	functional heart conditions, chest conditions
Lungs, bronchial tubes, pleura, chest, breast	bronchitis, pleurisy, pneumonia, congestion, influenza
Gall bladder, common duct	gall bladder conditions, jaundice, shingles
Liver, solar plexus, blood	liver conditions, fevers, low blood pressure, anemia, poor circulation, arthritis
Stomach	stomach troubles, nervous stomach, indigestion, heartburn, dyspepsia
Pancreas, duodenum	ulcers, gastritis
Spleen	low resistance to colds and disease
Adrenal and supra renal glands	allergies, hives
Kidneys	kidney troubles, hardening of the arteries, chronic tiredness, nephritis, pyelitis
Kidneys, ureters	acne, pimples, eczema, boils
Small intestines, lymph circulation	rheumatism, gas pains, sterility
Large intestines, inguinal rings	constipation, colitis, dysentery, diarrhea, ruptures, hernias
Appendix, abdomen, upper leg	cramps, difficult breathing, acidosis, varicose veins
Sex organs, uterus, bladder, knees	bladder troubles, menstrual troubles such as painful or irregular periods, miscarriages, bed wetting, impotency, change of life symptoms, knee pains
Prostate gland, muscles of the lower back, sciatic nerve	sciatica, lumbago, difficult, painful, or too frequent urination, backaches
Lower legs, ankles, feet	poor circulation in the legs, swollen ankles, weak ankles and arches, cold feet, weakness in the legs, leg cramps
Hip bones, buttocks	low back pain, spinal curvature
Rectum, anus	hemorrhoids (piles), pruritus (itching), pain at end of spine on sitting

WHAT IS CHIROPRACTIC

DEFINITIONS:

gland: any organ or group of cells that produces secretions (insulin) or excretions (urine).

alignment: arrangement in a straight line.

vertebra: any of the single bones or segments of the spinal column.

Chiropractic is a system of health care based upon helping to eliminate pain and improve body function by working to remove irritation to the nerves in the body. Your nerves control all the functions in the body from breathing and digestion to movement, circulation, and touch. Nerves also inform the body when injury occurs by producing pain.

When nerves of pain are irritated, you feel pain. When nerves of function are irritated, there is no pain. However, you lose some, if not all, the functions controlled by those nerves.

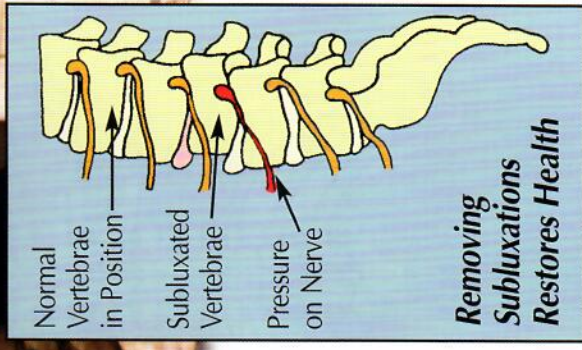
Almost all nerves travel from the brain through the spine to reach every organ, gland, and tissue in the body. When the spine, through trauma, injury, falls, poor posture, and muscle weakness, loses its normal alignment, bones of the spine can cause pressure or irritation to the delicate nerves that exit between them.

This condition is called subluxation; a minor misalignment of the spine, causing pressure on nerves. A subluxated vertebra can occur when someone is very young from falls or later in life from an auto accident. Whenever it occurs the body tries to stop further injury by tightening the muscle around it. Over time calcium deposits may occur to prevent further movement that would damage the nerves.

Although pain can sometimes occur immediately with a subluxation, more often than not, health problems, including pain, can occur slowly over time.

Chiropractors get a doctorate degree with four years of graduate study focusing on the sciences studied by other physicians. They also study techniques to eliminate pain and restore normal function without using medications or surgery.

Our goal is to help our patients get free of the symptoms with which they suffer, but even more important to help them correct the cause of those problems. Symptomatic treatment that leaves the cause of the problem un-handled is incomplete because it leaves the source of the problem there to cause future problems.



This illustration of the vertebrae of the lower back graphically demonstrates how a subluxated vertebra can impinge a nerve and obstruct the transmission of nerve impulses.

Once health has been obtained, it is vital to maintain your health. Prevention and maintenance care support the goal of prolonging and improving the quality of life.

