

WELCOME

PERSONAL INFORMATION

PLEASE PRINT

First Name: [] M.I. [] Last Name: [] Preferred Name: []
Address: [] City: [] State: [] Zip: []
Birthdate: []/ []/ [] Age: [] Gender: Male Female Unspecified SSN: [] [] []
Primary Phone: [] Cell Phone: [] Work Phone: []
Home Email: [] Work Email: []

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email would you like us to use to communicate with you? (check one) Home Work

Contact Method: (check one) Primary Phone Cell Phone Work Phone Home Email Work Email

Status: (check one) Single Married Divorced Widowed Separated Children?: Yes No How Many: []

Spouse's Name: []

Race: White Black/African American Hispanic/Latino Asian Native American Other: [] I choose not to specify

Ethnicity: Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language: English Spanish French Japanese Chinese German Other: [] I choose not to specify

Occupation: [] Employer: []

Emergency Contact: (Name, Relationship, Phone #) [] [] []

Family Physician Name: [] City: []

How were you referred to Preferred Health? Patient [] Physician []

Yellow Pages Internet Radio Newspaper Sign Other []

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to receptionist.

Type of Insurance: Private Ins. Medicare Auto Ins. Worker's Comp Other []

Primary Insurance Carrier: [] Phone: []

Policy# [] Group # [] Claim# []

Name of Policy Holder: [] Relationship to Patient: []

Policy Holder's Birthdate: []/ []/ [] Policy Holder's SSN: [] [] [] Employer: []

Is patient covered by another insurance? Yes No

Secondary Insurance Carrier: [] Policy #: []

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Preferred Health of Marshall, PA all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

Private Pay/Cash: By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account: []

(X) []

DATE: []

Signature of Patient, Parent or Legal Guardian (if minor)

[]

REASON FOR VISIT

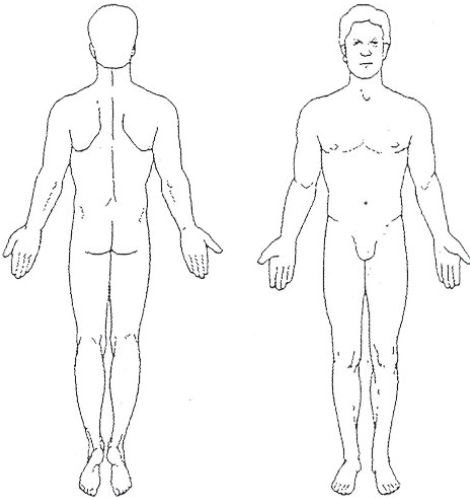
What is the reason for your visit today? Headache Neck Pain Mid-Back Pain Low Back Pain Other _____

What caused this complaint(s)? _____

When did this complaint begin? ____/____/____ **Is it getting worse?** Yes No Constant Comes and goes

Have you had this or similar complaint in the past? Yes No If "Yes", when? _____

What does your complaint (s) feel like? **Circle all that apply:** Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other _____



← Please **Circle** or make an "X" on the body diagram to the left where you have pain or other symptoms.

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain

Moderate Pain

Worst

Possible Pain

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|----|

What area(s) does the pain radiate, shoot, or travel to? (if applicable)? _____

What aggravates this complaint? **Circle all that apply:** Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other: _____

What relieves this complaint? **Circle all that apply:** Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Acupuncture / Nothing / Other: _____

Are you interested in learning more about acupuncture? Yes No

How often do you experience your symptoms? 25% of the day 50% of the day 75% of the day 100% of the day

Timing of complaint: **Check appropriate box:** Morning As day progresses Afternoon Evening While sleeping

During activities After activities Symptoms are constant and do not change Other: _____

With time are your symptoms: Improving Worsening Not changing

Have you seen other doctors for this complaint? Yes No If "Yes", please provide the following information:

Doctor's name: _____ Date consulted: _____ Diagnosis _____

Is this condition interfering with your: **Circle all that apply** Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other: _____

Is your complaint interfering with your daily activities? Not at all A little bit Moderately Quite a bit Extremely

NAME: _____ DATE: _____

HEALTH HISTORY

| Please check ALL of the health conditions below that apply to you currently or in the past. | | Family History | | Relationship: |
|---|---|---|--|---------------|
| | | Mark ALL conditions that run in your family (Father, Mother, Sister, Brother) | | |
| <input type="checkbox"/> Osteoarthritis/Degenerative Joint Disease | <input type="checkbox"/> Whiplash Injury <i>Date of injury:</i> | <input type="checkbox"/> Cancer <i>Type:</i> | | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Anemia | | |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure | <input type="checkbox"/> Joint Pain (<u>Circle</u> location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other: _____ | <input type="checkbox"/> Diabetes (check one) <input type="checkbox"/> Type I <input type="checkbox"/> Type II | | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Migraines | <input type="checkbox"/> Heart Problems / Stroke | | |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Osteoporosis /Osteopenia | <input type="checkbox"/> High Blood Pressure | | |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Genetic Disorders | | |
| <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Fibromyalgia / Chronic Fatigue | <input type="checkbox"/> Rheumatoid Arthritis | | |
| <input type="checkbox"/> Disc Herniation | <input type="checkbox"/> Genetic Disorders | <input type="checkbox"/> Other (List): | | |
| <input type="checkbox"/> High Blood Pressure /Hypertension | <input type="checkbox"/> Please list any other medical conditions: | | | |
| <input type="checkbox"/> Heart Disease / Stroke | | | | |

WOMEN ONLY: Currently Pregnant? Yes No Painful /Abnormal Menstrual Cycle? Yes No Menopause? Yes No Miscarriage? Yes No Do you have children? Yes No If "Yes", type of birth? (Circle) Vaginal or C-Section

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

SURGERIES and/or HOSPITALIZATIONS (List and Date):

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? Yes No

List current prescription medications, including frequency and dosage if known. If there are NO current medications, check here

| Name of prescription medication | Dosage/Start date | 4. | |
|---------------------------------|-------------------|----|--|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |

List any known allergies you have had to prescription medications. If NO medication allergies are known, check here

1. _____ 2. _____

SOCIAL HISTORY

| |
|---|
| Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Times per week? Intensity? <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous Type? |
| Do you currently smoke tobacco of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> Former smoker <input type="checkbox"/> Never been a smoker If "Yes", how often do you smoke: <input type="checkbox"/> Current every day smoker <input type="checkbox"/> Current sometimes smoker <u>Circle</u> level below ↓: If "Yes", what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) 0 1 2 3 4 5 6 7 8 9 10 |
| Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How many drinks per week? For how many years? |
| Do you drink caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No How many drinks per day? What type? <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soft Drinks <input type="checkbox"/> Energy Drinks |
| Do you take pain killers? <input type="checkbox"/> Yes <input type="checkbox"/> No How often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely What type? <input type="checkbox"/> Aspirin <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Tylenol <input type="checkbox"/> Other _____ |
| What do your work duties include? <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor <input type="checkbox"/> Other: |
| Please describe your overall health right now? <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| What is your current stress level? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> High |
| Have you seen a chiropractor in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| What are your hobbies? |

NAME: _____ DATE: _____

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use, as a Doctor of Chiropractic, is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> spinal manipulative therapy | <input type="checkbox"/> palpation | <input type="checkbox"/> vital signs | <input type="checkbox"/> range of motion testing |
| <input type="checkbox"/> orthopedic testing | <input type="checkbox"/> basic neurological testing | <input type="checkbox"/> muscle strength testing | <input type="checkbox"/> postural analysis |
| <input type="checkbox"/> EMS | <input type="checkbox"/> ultrasound | <input type="checkbox"/> hot/cold therapy | <input type="checkbox"/> radiographic studies |
| <input type="checkbox"/> Other (please explain) _____ | | | |

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- 1-Self-administered, over-the-counter analgesics and rest
- 2-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- 3-Hospitalization
- 4-Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE "BOX" AND SIGN BELOW:

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor of Chiropractic at Preferred Health of Marshall, PA and have had my questions answered to my satisfaction. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Preferred Health of Marshall, PA responsible for any errors or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient's Name (Please print)

Doctor's Name (Please print)

(X)

Signature of Patient, Parent or Legal Guardian (if a minor)

Doctor's Signature