101 Drake Lane, Milford, PA 18337
Phone: (570) 409-9500
Fax: (570) 409-9505

Patient Information

Full Name _____ Date:_____
First MI Last

Email* _____ * Your email will NOT be shared with any 3d parties and is used for occasional office announcements and promotions.

Address: _____ City:_____ State: _____ Zip: _____

Phone *Home* (_____)_____ *Work* (____)_____ *Cell* (_____)_____ Carrier _____

Please provide carrier for reminder text messages

Primary Contact ☐ Cell ☐ Home ☐ Work Reminder Text Message ☐ Yes ☐ No

Birth Date: _____ Age: _____ Social Security Number: _____-_____-_____ ☐ Female ☐ Male

Marital Status: _____ Spouse's Name: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Emergency Phone Number: (_____)_____

Whom may we thank for referring you? _____

Insurance or Private Pay Information

Type of Insurance: ☐ Private Ins. ☐ Medicare ☐ Auto Ins. ☐ Worker's Comp ☐ Other _____

Primary Insurance Carrier: _____ Policy # _____ Group # _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Birthdate _____ Is Patient covered by another insurance? ☐ Yes ☐ No

Secondary Insurance Carrier: _____ Policy #: _____
Policy Holder's Name: _____ Policy Holder's Birthdate: _____ Relationship to Patient _____

ASSIGNMENT/AUTHORIZATION/RELEASE

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Advanced Chiropractic of Milford 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)

Health Questionnaire

Current Complaints

Reason for your visit today?: ☐ Headache ☐ Neck Pain ☐ Mid Back Pain ☐ Low Back Pain ☐ Other _____

Are you here because of an accident? ☐ Yes ☐ No What type? _____

When did your symptoms start? _____

How did your symptoms begin? _____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (Circle all that apply): Sharp/ Dull/ Stiff/ Tight/ Aching/ Spasms/ Throbbing / Stabbing/ Shooting/ Burning/ Cramping/ Tingling/Numbness/ Other_____

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

On a scale of one to ten how intense are your symptoms? Not intense ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

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/ Unknown/ Other:_____

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

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:_____

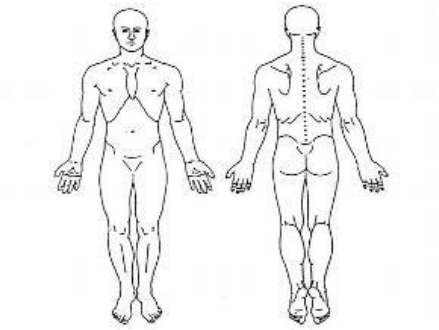
Have you experienced these symptoms in the past?_____

Describe location of problem and draw on diagram.

_____

_____

_____



History of Treatment

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

_____

Have you seen a chiropractor before? ☐ Yes ☐ No How long ago? _____

Medical History

Height: _____ Weight: _____

Please list any medications and/or supplements you are currently taking: _____

_____

Have you ever:

Broken bones?	☐ Yes	☐ No	Please Briefly Explain _____
Been hospitalized?	☐ Yes	☐ No	Please Briefly Explain _____
Been in an auto accident?	☐ Yes	☐ No	Please Briefly Explain _____
Had Sprains/Strains?	☐ Yes	☐ No	Please Briefly Explain _____
Been struck unconscious?	☐ Yes	☐ No	Please Briefly Explain _____
Had surgery?	☐ Yes	☐ No	Please Briefly Explain _____

Family History (list all major diseases such as cancer, heart problems, bone diseases and the relation to yourself):

_____

_____

Please mark how often you have the following:

Alcohol	○ Light	○ Moderate	○ Heavy	○ None
Coffee/Caffeine	○ Light	○ Moderate	○ Heavy	○ None
Tobacco	○ Light	○ Moderate	○ Heavy	○ None
Exercise	○ Light	○ Moderate	○ Heavy	○ None
Water	○ Light	○ Moderate	○ Heavy	○ None
Salty Foods	○ Light	○ Moderate	○ Heavy	○ None
Sugary Foods	○ Light	○ Moderate	○ Heavy	○ None
Artificial Sweeteners	○ Light	○ Moderate	○ Heavy	○ None
Stress	○ Light	○ Moderate	○ Heavy	○ None

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, how many weeks? _____

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Headache	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain

Additional comments you would like the doctor to know: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (patient's name) understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I give permission for the following person/people to have full disclosure of my appointments and/or medical records:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ ____/____/____

Signature Date

Financial Policy

Insurance Coverage

Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. We will accept your insurance in any of the plans that we are providers with. Certain insurance companies will only allow a particular number of visits per year and/or per diagnosis code. If your insurance company denies your care in total and/or partial with regards to the amount of visits necessary for the treatment of your condition, you will be responsible for the remainder of the balance.

It is our office policy to collect either a co-pay/co-insurance or an estimated insurance deductible at the time of visit.

It is our policy that all appointments must be canceled 24 hours prior to scheduled time other than for weather related cancellations. Anyone canceling appointments with less notice, regrettably, will be charged a $35.00 fee for the appointment. If we are not in the office a message on our answering machine will do. THIS IS A POLICY WE DO ENFORCE.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

_____ ____/____/____

Signature Date

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me by the Doctor of Chiropractic of Advanced Chiropractic and/or any other Doctor of Chiropractic, who now or in the future treats me while employed by, working or associated with, or serving as back-up for the Doctors of Chiropractic named below, including those working at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fracture, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent for to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

_____ _____

Printed Name Date

_____ _____

Signature Witness

Chiropractic Consent to evaluate and adjust a minor child:

I, _____ (Parent/Guardian name) being the parent or legal guardian of _____ (Minor's name) have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Printed Name of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Witness