PATIENT HISTORY

Name _____ Date _____

Date of Birth _____ Referred By _____

Address _____ City _____ State _____ Zip _____

Phone: (h) _____ (c) _____ (w) _____ [redacted] _____

Sex _____ Age _____ Marital Status _____ Number of Children _____

Occupation _____ Employment _____ [redacted] _____

[redacted] _____ Email _____

Insurance Co. _____ Policy No. _____ Person responsible for payment _____

Chief Complaint #1: _____

How did it start?: _____ Date of onset: _____

Condition related to: ☐ work ☐ auto ☐ chronic ☐ other _____

Dates of similar symptoms: _____

Condition is: ☐ same ☐ better ☐ worse ☐ comes and goes

Provoked by: ☐ sitting ☐ standing ☐ laying ☐ reaching ☐ bending ☐ walking

☐ Other _____

Relieved by: ☐ ice ☐ heat ☐ sleep ☐ sitting ☐ standing ☐ laying ☐ walking

☐ Pain killers, muscle relaxants, anti-inflammatories ☐ other _____

Quality is: ☐ sharp ☐ shooting ☐ aching ☐ cramping ☐ stiffness ☐ spasms

☐ swelling ☐ burning ☐ numbness ☐ tingling ☐ stabbing ☐ other _____

Intensity: Absent 0 1 2 3 4 5 6 7 8 9 10 Severe

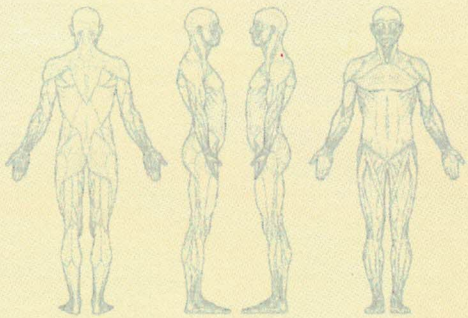
Pain radiates into: _____

Is complaint worse in: ☐ am ☐ pm ☐ afternoon ☐ same all day

Other treatment/ diagnosis/ results: _____

Symptoms last ☐ hours ☐ days ☐ weeks ☐ constant ☐ other _____

Shade the area where you are having symptoms



Chief Complaint #2: _____

How did it start?: _____ Date of onset: _____

Condition related to: ☐ work ☐ auto ☐ chronic ☐ other _____

Dates of similar symptoms: _____

Condition is: ☐ same ☐ better ☐ worse ☐ comes and goes

Provoked by: ☐ sitting ☐ standing ☐ laying ☐ reaching ☐ bending ☐ walking

☐ Other _____

Relieved by: ☐ ice ☐ heat ☐ sleep ☐ sitting ☐ standing ☐ laying ☐ walking

☐ Pain killers, muscle relaxants, anti-inflammatories ☐ other _____

Quality is: ☐ sharp ☐ shooting ☐ aching ☐ cramping ☐ stiffness ☐ spasms

☐ swelling ☐ burning ☐ numbness ☐ tingling ☐ stabbing ☐ other _____

Intensity: Absent 0 1 2 3 4 5 6 7 8 9 10 Severe

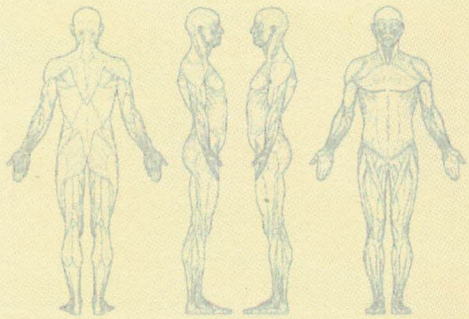
Pain radiates into: _____

Is complaint worse in: ☐ am ☐ pm ☐ afternoon ☐ same all day

Other treatment/ diagnosis/ results: _____

Symptoms last ☐ hours ☐ days ☐ weeks ☐ constant ☐ other _____

Shade the area where you are having symptoms



Chief Complaint #3: _____

How did it start?: _____ Date of onset: _____

Condition related to: ☐ work ☐ auto ☐ chronic ☐ other _____

Dates of similar symptoms: _____

Condition is: ☐ same ☐ better ☐ worse ☐ comes and goes

Provoked by: ☐ sitting ☐ standing ☐ laying ☐ reaching ☐ bending ☐ walking

☐ Other _____

Relieved by: ☐ ice ☐ heat ☐ sleep ☐ sitting ☐ standing ☐ laying ☐ walking

☐ Pain killers, muscle relaxants, anti-inflammatories ☐ other _____

Quality is: ☐ sharp ☐ shooting ☐ aching ☐ cramping ☐ stiffness ☐ spasms

☐ swelling ☐ burning ☐ numbness ☐ tingling ☐ stabbing ☐ other _____

Intensity: Absent 0 1 2 3 4 5 6 7 8 9 10 Severe

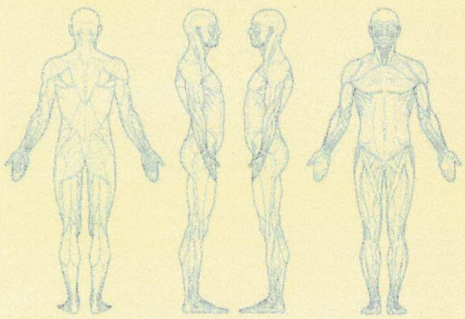
Pain radiates into: _____

Is complaint worse in: ☐ am ☐ pm ☐ afternoon ☐ same all day

Other treatment/ diagnosis/ results: _____

Symptoms last ☐ hours ☐ days ☐ weeks ☐ constant ☐ other _____

Shade the area where you are having symptoms



Past Health History

Please list any hospitalizations, operations and work, auto or personal accidents you've had. Be as specific as possible and include dates, injuries involved and treatment you received.

Please list any significant illnesses you have had, and treatment you have received.

Do you have any allergies?

List any medications you take?

REVIEW OF SYSTEMS

(x) Have (o) Had Circle Appropriate Fields

1. General ☐ Weight gain/ loss ☐ Fatigue ☐ Fainting ☐ Light headed upon rising ☐ Under stress ☐ Crave sweets/ salts ☐ Eating Disorders ☐ Trouble sleeping ☐ Pregnant (now) ☐ Low libido ☐ Poor appetite ☐ Weakness ☐ Fever ☐ Chills

2. Muscular Skeletal ☐ Fractures ☐ Back curvature/ Scoliosis ☐ Arthritis ☐ Swollen painful joints ☐ Neck pain/ Stiffness ☐ Upper back pain/ stiffness R/L ☐ Mid back pain/ stiffness R/L ☐ Low back pain/ stiffness R/L ☐ Head seems to heavy ☐ Head and shoulders feel tired Pain/ Stiffness in: ☐ Shoulders R/L ☐ Elbow R/L ☐ Wrist/Hand R/L ☐ Fingers R/L (1-2-3-4-5) ☐ Hip R/L ☐ Knee R/L☐ Ankle/Foot R/L ☐ Toes: R/L 1-2-3-4-5 ☐ TMJ pain/stiffness ☐ Joint deformity ☐ Paralysis ☐ Osteoporosis ☐ Poor posture ☐ Other: _____

3. Neurological ☐ Knocked unconscious ☐ Siezures/ Convulsions/ Epilepsy ☐ Tremors ☐ Headaches ☐ Numbness (tingling / arms / hands / fingers: R/L 1-2-3-4-5 / butt / thighs / legs / feet / toes: R/L 1-2-3-4-5) ☐ Dizzy ☐ Ringing in ears (Tinnitus) R/L ☐ Hearing loss R/L ☐ Loss of balance

4. Psychological/ Emotional ☐ Mental/ Emotional Disorders ☐ Nervous ☐ Tension ☐ Depressed ☐ Anxiety ☐ Irritable ☐ Moody ☐ Trouble concentrating ☐ Loss of memory ☐ LD / ADD / ADHD / Bipolar ☐ Mistake Sidedness (R from L) ☐ Stutter ☐ Dyslexia ☐ Lose temper

5. Gastrointestinal ☐ Liver problem ☐ Gal Bladder problem ☐ Digestive problems ☐ Excessive gas ☐ Belching/ Bloating after meals ☐ Heartburn/ reflex ☐ Ulcers ☐ Diarrhea/ Constipation ☐ Colon trouble ☐ Hemorrhoids ☐ Hepatitis ☐ Nausea ☐ Vomiting ☐ Cramps ☐ Stool color changes ☐ Abdominal swelling

6. Genitourinary ☐ Prostate problems ☐ Impotence (Erectile Dysfunction) ☐ Kidney trouble/ stones ☐ Frequent urination ☐ Discharge ☐ Burning urination ☐ Menstrual problems/ PMS ☐ Menopausal problems ☐ Bed wetting ☐ VD/ AIDS ☐ Pregnancies ☐ Miscarriages ☐ Trouble getting pregnant

7. EENT ☐ Light sensitive ☐ Allergy ☐ Sinus problems ☐ Blurred/ Double vision ☐ Ear infections ☐ Speech problems ☐ Nose bleeds ☐ Sore throat ☐ Gum disease ☐ Earaches/ Infections ☐ Tunnel vision ☐ Vision changes (Near / Far) ☐ Eye twitches R/L

8. Cardiovascular ☐ Anemia ☐ Heart problems ☐ Stroke ☐ High/Low Blood Pressure ☐ Varicose veins ☐ Heart arrhythmias ☐ Swelling ankles ☐ High Cholesterol ☐ High triglycerides ☐ Leg pain and pressure while walking

9. Respiratory ☐ Chest pain ☐ Asthma ☐ Lung problems ☐ Difficulty breathing ☐ Wheezing ☐ Emphysema ☐ Hay fever☐ Shortness of breath ☐ Chronic cough

10. Endocrine/ Immune ☐ Thyroid problems ☐ Pituitary problems ☐ Adrenal problems ☐ Immune disorders ☐ Hypoglycemia ☐ Diabetes ☐ Endometriosis ☐ Cancer ☐ Frequent colds/ flu ☐ Breast/ Lungs/ Soreness/ Discharge

11. Skin ☐ Rashes ☐ Worts/ Moles ☐ Bruising easily ☐ Itching ☐ Skin color changes ☐ Excess sweating ☐ Nail changes ☐ Hair loss

Social History

0- None 1- Mild 2- Moderate 3- Excessive

___ Tobacco ___ Alcohol ___ Coffee ___ Soft Drinks ___ Diet Soft Drinks ___ Exercise

___ Medicine ___ Street Drugs ___ Desserts ___ Water ___ Prayer/ Meditation ___ Family Time

___ Job Time ___ Personal Time ___ Marital Status (M / D / S / W)

Family History

Mark any family members who have had the following health conditions

F- Father___ (age) M- Mother___ (age) S- Sister___ (age(s)) B- Brother___ (age(s))

_____ Musculoskeletal _____ Arthritis _____ Back problems _____ Disc problems

_____ Headaches _____ Scoliosis _____ Neurological _____ Gastrointestinal _____ Digestive

_____ Liver/Gal Bladder _____ Genitourinary _____ Kidney _____ Cardiovascular

_____ High Blood Pressure _____ High Cholesterol/ Triglycerides _____ Heart Problems

_____ Respiratory _____ Asthma _____ Emphysema _____ Psychological/ Emotional

_____ Depression/ Anxiety _____ Alzheimers _____ Senility _____ Insomnia _____ Epilepsy

_____ Eyes/ Ears/ Nose/ Throat _____ Endocrine _____ Immune _____ Cancer _____ Diabetes

Chiropractic History

When did you last see a chiropractor: _____ Dr. _____

Why did you see the chiropractor? _____ Were you helped? _____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine?

_____

Did you follow it? _____ If not, why? _____

Why are you changing chiropractors? _____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

_____ Temporary Relief (Help the symptoms but do not fix the cause of the problem)

_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy?)

_____

_____

WHAT ARE YOUR EXPECTATIONS OF US?

_____

_____

WELLNESS COMMITMENT

At our Chiropractic office our goal is to help you achieve your maximum health potential and wellness. Therefore we need to understand your commitment toward this as well. We do not ask for a financial commitment, but we do ask for a cooperative commitment. On a scale of 1 (lest) to 10 (Most):

_____ How committed are you to being at your maximum health potential and wellness?

_____ How important is it to you for your family to be at their maximum health potential and wellness?

_____ How committed are you to preventing arthritis and maximizing your spinal stability?

_____ If we find your problem, how committed are you to correcting it?

The information I have supplied is complete and truthful.

_____

Patient Signature

Stark Family Chiropractic Inc.

Financial Policy

All patients are considered cash/self pay until our staff can verify insurance benefits.

____**Patients with Insurance:** We will bill your insurance for services rendered in the office. We will do our best to check on your benefits prior to receiving care, however insurance companies will not allow that a quote of coverage is a guarantee of benefits. **We will collect 100% of services not covered by your insurance carrier. If you have a copay, coinsurance, or unmet deductible, you will be responsible to payment at time of service.** Insurance is a contract between the patient and their carrier, so it is important you take responsibility for understanding your benefits. If your policy prohibits collection of deductible and/or coinsurance prior to claim processing, we will require a credit card to be kept on file. **If your insurance sends payment checks to you, rather than to this office, you will be required to keep a credit card on file.** Payment for services not covered due to unmet deductible, coinsurance amount, or policy exclusions, or **payments sent directly to patient will be automatically processed after receipt of Explanation of Benefits (EOB) from your insurance carrier.**
Patient Initials_____ Staff Initials_____

____**Medicare Patients: Medicare Part B only covers manipulation of the spine. All other services are not covered and will be your responsibility.** You will be required to meet your annual Part B deductible and pay 20% of the allowed fee on the spinal manipulation, in addition to 100% of all non-covered services. Medicare Part B patients with a Supplemental policy will generally have their deductible and the 20% copay covered by the supplement. However supplemental policies generally do NOT pay for services that Medicare does not allow. Medicare patients will be required to sign an Advanced Beneficiary Notice (ABN) prior to starting care, any time there is a significant change in diagnosis, and/or at the beginning of each year. **Patient Initials_____ Staff Initials_____**

____**Personal Injury:** Most Personal Injury claims are covered 100%. However, it is your responsibility to provide our office with the documentation necessary to prove a valid claim, including the name(s) and contact information of any claims adjuster/attorney handling the case, the claim numbers, and mailing address to send bills. Failure to provide the documentation needed will result in immediate conversion of your case to cash, and all payment will be due immediately. **Patient Initials_____ Staff Initials_____**

____**Patients without insurance coverage:** You will be required to pay for your services at the time they are rendered. If payment at time of service is going to produce a financial hardship, we do offer cash payment plans for a significant savings. You will be required to keep a credit card on file to qualify for the payment plans. Please discuss this option with one of the doctors if you feel it is necessary to complete the care you need. **Patient Initials_____ Staff Initials____**

____I have read and understand the financial policy of Stark Family Chiropractic Inc. I also understand that if I have insurance, or a valid auto claim, my carrier may pay for some to most of the charges billed, but no benefits are guaranteed. I understand that I am ultimately financially responsible for all services not paid by insurance of other third party. Should there be a balance due at the end of my treatment plan, I will receive an invoice for that amount and I will pay it upon receipt, or I will contact Stark Family Chiropractic Inc to make payment arrangements.

Print Name_____ Date_____

Signature_____ Staff Initials_____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care, and we accept a patient for such care, it is essential for both of us to be working towards the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you can make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy, and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors, we understand that health is a state of optimal physical, mental, and social well-being, and not merely the absence of disease of infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one of more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce the vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand or instrument where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at any time we encounter a non-chiropractic or unusual finding, we will advise you of those findings and recommend some further testing, or refer you to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although extremely rare, it is possible to suffer from other side effects: i.e. muscle spasms, stiffness, rib fracture, headache, dizziness, or stroke. There are treatment options available for your condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery.

All questions regarding the doctor's objective to my care in this office have been answered to my satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read, and fully understand, the above statements and therefore accept chiropractic care on this basis.

Print Name _____ Signature _____ Date _____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the doctor has my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

Signature _____ Date _____

Stark Family Chiropractic Inc.

Notice of Privacy Practices

This notice describes how your information is stored, may be used, and/or disclosed.

How we store your information: Patient information is stored here in the office on a secure server with no outside access. Patient charts and x-ray films are also stored here in the office. Patient charts/x-ray films do not leave the premises unless one of the doctors needs to review notes about your case after hours. In this instance, the patient chart is solely in the doctor's possession until the following morning when said chart is returned to the office.

What we do not do with your information: Information that you have provided to us about your financial situation, medical conditions, and care you have received is held in the strictest of confidence. This applies whether information was communicated during a discussion, in writing, via email, over the phone (including information left on voice mails), or text.

We do not give out, exchange, barter, rent, sell, or disseminate any information about our patients to anyone who receives our services. Know that any and all patient information is confidential and is held in a HIPAA compliant manner.

How we do use your information: Information is only used as is reasonably necessary to process your care, send billing to an insurance company, or to provide you with health care services which may require communication between Stark Family Chiropractic Inc. and other health care providers.

No patient's information or identifying photos will ever be used without patient's advanced written permission.

Printed Name:_____

Signature:_____

Date:_____