

Marion Chiropractic Clinic

1036 Mount Vernon Ave., Marion, Ohio 43302 ♦ 3967 Presidential Pkwy. Suite B, Powell, Ohio 43065

CHIROPRACTIC PATIENT INFORMATION

Today's Date: _____
Name _____
Address _____
City _____
State _____ Zip _____
SS# _____ Sex: Male Female
Date of birth _____ Age _____
Marital status: Single Married Divorced Separated Widow
Occupation _____
Employer _____
Spouse's Name _____
Spouse's Employer _____
Do you have kids? Yes No: # of children _____
Name of primary care doctor: _____
May we contact them regarding your health? Yes No
Have you ever had chiropractic care? Yes No
How did you hear about this office or referred by whom?

INSURANCE INFORMATION

Insurance Cash/credit card BWC PI Other _____
Name of policy holder: _____
Relationship to patient _____
Insurance Name: _____
ID# _____ Group #: _____
****Please provide a copy of your insurance card for verification ****
Is the patient covered by additional insurance? Yes No
Secondary Insurance Co.: _____

ACCIDENT INFORMATION

Is this injury/condition due to an accident? Yes No
If yes, date of accident _____
Type of accident Auto Work Home Other _____
Have you made a report of your accident? Yes No
To Whom? Auto Insurance Employer Workers' Comp
 Attorney Police Other _____
Insurance name: _____
Attorney Name (if applicable) _____

PHONE NUMBERS, E-MAIL, & EMERGENCY CONTACT

Home #: _____ Cell: _____ May we leave a message? Yes No
E-Mail Address: _____ May we contact you by e-mail? Yes No
Would you be interested in receiving an e-mail health newsletter? Yes No If yes, please initial: _____
Would you be interested in receiving text appointment reminders? Yes No If yes, please initial: _____
Emergency Contact Information
Name _____ Relationship _____ Best contact phone #: _____
Other contact information: _____

Financial Policy/Agreement and Assignment Information

NOTICE TO OUR NEW PATIENTS:

It is the policy of this office for patients to make payment (cash payments, co-payments, etc.) for services rendered **prior to each visit**. Other payment arrangements (ie. payment plans, etc) must be specifically discussed and/or approved by this office prior to treatment initiation. Deductible payments will be billed on receipt of insurance EOB. Initials: _____

ASSIGNMENT TO PAY BENEFITS TO PHYSICIAN:

I hereby certify that I (or my dependent, parent, or guardian) have insurance coverage as stated above. I assign payments and/or medical benefits, if any, otherwise payable to me for services rendered from this office, directly to Marion Chiropractic Clinic. I understand I am personally and financially responsible for payment in full for all charges and expenses related to my treatment not covered by this assignment, regardless of insurance coverage. In addition, I hereby authorize this office to release all information necessary to communicate with personal physicians and other providers, as well as payors to secure payment of benefits. I acknowledge this assignment and authorize the use of the signature below for all insurance submissions. Initials: _____

Signature of Patient/Parent/Guardian/POA

Date

Reviewed by:

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Patient Name:

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CURRENT COMPLAINT(S) / CONDITION(S)

What is (are) your present complaint(s) or reason for your visit? When did your symptoms appear?

- 1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

How did your problem start? _____

Rate your pain level today, on a scale from 0 (no pain) to 10 (the worst pain imaginable): _____

Rate your pain level at it's worst, on a scale from 0 (no pain) to 10 (the worst pain imaginable): _____

Describe the pain: [] Sharp / stabbing [] Dull / aching [] Burning [] Stiffness [] Tingling [] Numbness
[] Throbbing [] Shooting [] Cramping [] Swelling [] Other: _____

Does it interfere with? [] Work [] Sleep [] Recreation [] Daily Activity [] Exercise [] Other _____

What other activities does it interfere with? What would you like to do that you currently can't do?

Have you ever had this problem before? [] Yes [] No If yes, when? _____

What treatment have you had? [] MD [] PT [] Medication [] Injections [] Surgery [] Other _____

Has the treatment helped? [] Yes [] No If yes, explain: _____

Have you had chiropractic care for this condition? [] Yes [] No If yes, when? _____

What are your goals from your treatment? Check all that apply:

- [] I just want relief from my immediate symptoms / pain. I'm not interested in preventing future problems.
[] I want to correct the causes to prevent future problems. I want to be more proactive regarding my health.
[] Other goals (Explain): I would like to be able to:

Do you have any infectious diseases or other serious illness? [] Yes [] No Explain:
Do you have a pacemaker: [] Yes [] No Have you had any hip or knee replacements? [] Yes [] No

DATES OF MOST RECENT EXAMS

Spinal X-ray _____ Physical exam _____ Chest X-ray _____ Blood work _____ Other _____

LIST ALL PREVIOUS INJURIES, HOSPITALIZATIONS, AND/OR SURGERIES

Injuries/Falls: _____
Surgeries: _____
Fractures: _____
Other illnesses, hospitalizations or information: _____

FOR FEMALES ONLY

Do you use birth control: [] Yes [] No Are you pregnant: [] Yes [] No Due date: _____ Date of last period: _____

** By selecting no, I hereby notify all concerned that I neither suspect nor know positively at this time that I may be or am pregnant. Initials _____

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SOCIAL HISTORY

Exercise Activity <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous	Use of Alcohol <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Daily _____ drinks per week	Use of Tobacco <input type="checkbox"/> Never <input type="checkbox"/> Previously, but quit <input type="checkbox"/> Currently _____ Packs per day _____ # of years	Work Activity <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light labor <input type="checkbox"/> Heavy labor <input type="checkbox"/> Other	Sleep Habits <input type="checkbox"/> 0-2 hrs/night <input type="checkbox"/> 2-4 hrs/night <input type="checkbox"/> 4-6 hrs/night <input type="checkbox"/> 6-8 hrs/night <input type="checkbox"/> more than 8 hrs/night
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PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS *please check any that apply to you*

Constitutional <input type="checkbox"/> Bad general health <input type="checkbox"/> Recent weight change <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches Eyes <input type="checkbox"/> Eye disease/injury <input type="checkbox"/> Glasses or contact lens <input type="checkbox"/> Blurred / double vision Ear, Nose, Throat <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Vertigo <input type="checkbox"/> Sinus problems <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sore throat / voice change <input type="checkbox"/> Swollen glands Neurological <input type="checkbox"/> Seizures or Epilepsy <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Tremors <input type="checkbox"/> Stroke <input type="checkbox"/> Multiple Sclerosis	Musculoskeletal <input type="checkbox"/> Joint Pain / Stiffness <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Fibromyalgia Cardiovascular <input type="checkbox"/> Chest pain / Palpitations <input type="checkbox"/> Dizziness / Fainting <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Swelling in hands / feet <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart attack <input type="checkbox"/> Congestive heart failure Gastrointestinal <input type="checkbox"/> Heartburn / Belching <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Blood in stools <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> Liver problems <input type="checkbox"/> Ulcers	Genito-urinary <input type="checkbox"/> Pain / Difficulty urinating <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney problems Respiratory <input type="checkbox"/> Cough / excessive mucus <input type="checkbox"/> Congestion / colds / flu <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia Psychiatric <input type="checkbox"/> Anxiety / Depression <input type="checkbox"/> Mood Swings <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Memory loss Hematologic/Lymphatic <input type="checkbox"/> Slow to heal after cuts <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Anemia <input type="checkbox"/> Enlarged glands	Endocrine <input type="checkbox"/> Excessive thirst / urination <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Skin becoming drier <input type="checkbox"/> Diabetes (Type I / Type II) <input type="checkbox"/> Thyroid disorder Integumentary (skin, breast) <input type="checkbox"/> Rash / Sores / Hives <input type="checkbox"/> Lesions <input type="checkbox"/> Breast pain or lump <input type="checkbox"/> Dermatitis/Eczema/dry skin Allergic/Immunologic <input type="checkbox"/> Food allergies <input type="checkbox"/> Airborne allergies <input type="checkbox"/> Systemic Lupus <input type="checkbox"/> Cancer <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Other (see below) Other: Alcoholism Infertility Menstrual disorders Insomnia Anxiety / depression
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FAMILY HISTORY

	Living		Rheumatoid Arthritis		Cancer		Diabetes		Heart, Lung, or Hypertension		Neck, Back, or Disc problems	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brothers/Sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATIONS / TAKEN FOR: SUPPLEMENTS/VITAMINS/HERBS ALLERGIES (Meds, seasonal, etc.)

1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
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Signature of Patient/ Parent of Minor/Guardian _____ Date _____ Reviewed by: _____

**To the best of my knowledge, the questions on these forms have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Marion Chiropractic Clinic of any changes in my personal information, insurance changes, or medical status in a timely manner. Initials: _____

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”. You may feel movement of the joint.

Ancillary treatments: Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, traction, or exercise/rehab may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to cerebrovascular injury or stroke. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could also produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. Fractures are rare occurrences and generally result from underlying weakness of the bone, which we check for during the history and exam and other testing. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures during examination. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles, which may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate the condition is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. By signing below, I have freely decided to undergo the recommended treatment. Having been informed of the risks, I hereby give my full consent to treatment.

Printed Name

Signature

Date

WITNESS: _____

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PATIENT NAME: _____

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS CAREFULLY.

Our commitment at Marion Chiropractic Clinic is to serve our patients with professionalism and high quality care, being sure at all times to protect the privacy and security of all protected health information.

During the course of serving your interests, it may be necessary to share information with other healthcare providers or business associates as allowed by law.

We at Marion Chiropractic Clinic are committed to obeying all Federal, State, and Local laws and regulations regarding privacy practices. If any uses or disclosures are necessary, information will only be released with the below written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided by law.

If you have any questions or comments regarding your protected health information, feel free to contact a member of our staff or the doctor.

AUTHORIZATION TO RELEASE INFORMATION ACCORDING TO HIPAA:

I hereby authorize Marion Chiropractic Clinic LLC, to release any information acquired in the course of my examination and/or treatment in accordance to HIPAA (Health Insurance Portability and Accountability Act) guidelines. I understand this protected patient health information will be utilized for the purpose of relevant treatment, healthcare operations, and co-ordination of care. The release of information will also include but not be limited to the processing of medical claims or information requested by insurance companies and/or other legal representatives after which proper authorization is received at this office. I also understand that a more detailed account of the privacy policies and procedures can be requested prior to signing this form. If there is anyone you do not want to receive your medical information / records, please inform the office. I understand and agree to the release of my health information as stated above, and allowed by law, which is in accordance to HIPAA guidelines.

SIGNED _____ DATE _____

(Patient or parent if a minor)

WITNESS _____ DATE _____