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: _____

_____ _____ **Reviewed by:** _____

Signature of Patient/Parent/Guardian/POA **Date**

Patient Name: **Page 2**

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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Patient Name:

SOCIAL HISTORY

Exercise Activity	**Use of Alcohol**	**Use of Tobacco**	**Work Activity**	**Sleep Habits**
☐ None	☐ Never	☐ Never	☐ Sitting	☐ 0-2 hrs/night
☐ Light	☐ Rarely	☐ Previously, but quit	☐ Standing	☐ 2-4 hrs/night
☐ Moderate	☐ Moderate	☐ Currently	☐ Light labor	☐ 4-6 hrs/night
☐ Strenuous	☐ Daily	_____ Packs per day	☐ Heavy labor	☐ 6-8 hrs/night
	_____ drinks per week	_____ # of years	☐ Other	☐ more than 8 hrs/night

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS please check ☑ any that apply to you

Constitutional
- ☐ Bad general health
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches

Eyes
- ☐ Eye disease/injury
- ☐ Glasses or contact lens
- ☐ Blurred / double vision

Ear, Nose, Throat
- ☐ Hard of Hearing
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sore throat / voice change
- ☐ Swollen glands

Neurological
- ☐ Seizures or Epilepsy
- ☐ Numbness / Tingling
- ☐ Tremors
- ☐ Stroke
- ☐ Multiple Sclerosis

Musculoskeletal
- ☐ Joint Pain / Stiffness
- ☐ Joint Swelling
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Chronic fatigue
- ☐ Fibromyalgia

Cardiovascular
- ☐ Chest pain / Palpitations
- ☐ Dizziness / Fainting
- ☐ Shortness of breath
- ☐ Swelling in hands / feet
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Congestive heart failure

Gastrointestinal
- ☐ Heartburn / Belching
- ☐ Nausea/Vomiting
- ☐ Diarrhea/Constipation
- ☐ Blood in stools
- ☐ Gall bladder problems
- ☐ Liver problems
- ☐ Ulcers

Genito-urinary
- ☐ Pain / Difficulty urinating
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Kidney problems

Respiratory
- ☐ Cough / excessive mucus
- ☐ Congestion / colds / flu
- ☐ Wheezing
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia

Psychiatric
- ☐ Anxiety / Depression
- ☐ Mood Swings
- ☐ Difficulty sleeping
- ☐ Memory loss

Hematologic/Lymphatic
- ☐ Slow to heal after cuts
- ☐ Bleed or bruise easily
- ☐ Anemia
- ☐ Enlarged glands

Endocrine
- ☐ Excessive thirst / urination
- ☐ Heat or cold intolerance
- ☐ Skin becoming drier
- ☐ Diabetes (Type I / Type II)
- ☐ Thyroid disorder

Integumentary (skin, breast)
- ☐ Rash / Sores / Hives
- ☐ Lesions
- ☐ Breast pain or lump
- ☐ Dermatitis/Eczema/dry skin

Allergic/Immunologic
- ☐ Food allergies
- ☐ Airborne allergies
- ☐ Systemic Lupus
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Other (see below)

Other:
Alcoholism
Infertility
Menstrual disorders
Insomnia
Anxiety / depression

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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brothers/Sisters	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

MEDICATIONS / TAKEN FOR:	*SUPPLEMENTS/VITAMINS/HERBS*	*ALLERGIES (Meds, seasonal, etc.)*
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

_____ _____ **Reviewed by:** _____

Signature of Patient/ Parent of Minor/Guardian **Date**

**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 herby give my full consent to treatment.

_____ _____ _____

Printed Name **Signature** **Date**

WITNESS: _____

Assignment / Claim payment agreement

I understand and agree that health insurance and accident insurance are arrangements between my insurance carrier and me. I am aware that by not paying the amount that I am contracted, I may be subject to dismissal from any current health plan. These payable amounts include, but are not limited to any calendar year deductible, office visit co-pays, and any co-insurance payment.

I hereby certify that I (or my dependent, parent, or guardian) have insurance coverage as reported. I assign payments and/or medical benefits, if any, otherwise payable to me for services rendered from this office, directly to Marion Chiropractic Clinic. In the event that an insurance payment would come directly to my attention for services rendered and outstanding at this office, I agree to return said payment to Marion Chiropractic Clinic in an expedited and timely manner, or I may be subject to legal action.

Furthermore, I understand that Marion Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be directly paid to this office will be credited to my account on receipt. However, I understand and agree that 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.

I also understand that if I suspend of terminate my treatment, any fees for professional services rendered to me will be immediately due and payable. I also understand that there could be an interest charge applied monthly on any outstanding balance.

In addition, I hereby authorize this office to release all pertinent information necessary to communicate with personal physicians and other providers, as well as payors, to secure payment of benefits, expedite the payment process, or whenever the insurance company may require the information to make a determination of benefits.

I acknowledge this assignment and authorize the use of the signature below for all insurance submissions. Initials: _____

Patient Name _____

_____ _____ **Reviewed by: _____**

Signature of Patient/Parent/Guardian/POA **Date**

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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 _____