

Today's Date: _____

Name _____

Today you have the following physical complaints:

Is this complaint:
Sharp, Dull, Achy, Throbbing,
Numb, Shooting or Other
(explain)?

How often do you feel this complaint? Constant, Daily, "Off & On", Weekly?

How long have you had this?

Is it getting better, worse, or staying the same?

What makes it better?

What makes it worse?

On a scale of 1-10 Rate your discomfort:

How have you taken care of this in the past? How has it worked for you?

This issue is affecting my:

Helping this issue would increase my quality of life by:

Please list any areas of pain/discomfort or concern in the spaces below. List them in order of most severe to least severe. Use the choices below each listed condition to describe the condition and how it affects you.

1.

Sharp
Dull
Achy
Throbbing
Numb
Electric / Shooting
Other _____

Constant
Daily
Off & On
Weekly
Monthly
Other _____

Better
Worse
Same

Circle One:
0 1 2 3 4 5 6 7 8 9 10
10 = Excruciating
0 = No Discomfort

Job / Home Life /
Exercise / Hobby
/Other _____

2.

Sharp
Dull
Achy
Throbbing
Numb
Electric / Shooting
Other _____

Constant
Daily
Off & On
Weekly
Monthly
Other _____

Better
Worse
Same

Circle One:
0 1 2 3 4 5 6 7 8 9 10
10 = Excruciating
0 = No Discomfort

Job / Home Life /
Exercise / Hobby
/Other _____

3.

Sharp
Dull
Achy
Throbbing
Numb
Electric / Shooting
Other _____

Constant
Daily
Off & On
Weekly
Monthly
Other _____

Better
Worse
Same

Circle One:
0 1 2 3 4 5 6 7 8 9 10
10 = Excruciating
0 = No Discomfort

Job / Home Life /
Exercise / Hobby
/Other _____

Date _____

CONFIDENTIAL PATIENT INFORMATION

Welcome to Community Chiropractic Center. Thank you for taking a few moments to tell us about yourself. Please fill out this form as accurately as possible. If you have any questions we will be happy to assist you.

PERSONAL INFORMATION

Name _____ Address _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____

Mobile Phone _____ E-mail _____

Sex _____ Male _____ Female Age _____ Date of Birth _____

Occupation _____ Weight _____ Height _____

Employer _____ Address _____

Married _____ S _____ W _____ D _____ Children _____ Name of Spouse _____

Referred By _____

Is any other member of your family being treated in this office? _____

Have you ever had chiropractic care before? _____

For what problem? _____

Were the results satisfactory? Yes ___ No ___ N/A _____

Any current concerns about chiropractic care or massage therapy? _____



1717 Swede Road, Suite #106
Blue Bell, PA 19422

HEALTH HISTORY

What is your major symptom? _____

How and when did it occur? _____

If this is a recurrence, when was the first time you noticed this problem? _____

List any major accidents you have had other than those that might be mentioned above: _____

Have you been treated by a medical physician or other health care provider for this ailment? ___ Yes ___ No

Where? _____

Describe the type of treatment (medications/physical therapy/surgery/etc.) _____

Diagnosis of previous physician _____

Length of time under care _____ Results _____

Family physician's name _____ Phone _____

Does anyone else in your family have a history of the same or similar condition? _____ Yes _____ No

If yes, please briefly describe _____

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

Are you allergic to anything you are aware of? _____

Are you presently taking any medication(s) (aspirin included)? Yes _____ No _____

If yes, name them _____

Have you ever broken any bones? (fractures) _____ Any dislocations? _____

What operations/surgeries have you had? _____ Year _____

_____ Year _____

_____ Year _____

Have you had any cosmetic surgery, breast implants, etc.? _____ Year _____

Have you had any surgery to replace hip, knee, etc? _____ Year _____

Give dates you have had any of the following (if exact date is unknown, give approximate date)

MRI _____ CT Scan _____ X-Ray _____

Other special medical treatment/tests _____

At what hospital or office were these tests taken? _____

Name of doctor who ordered tests _____

(Female) Date of last menstrual period _____

(Female) Do you have any reason to believe that you may be pregnant? Yes _____ No _____

Do you have any health problems not listed above? _____

SOCIAL HISTORY

Smoker _____ Yes or _____ No, If Yes, How many packs _____ How many years _____

Other forms of Tobacco _____ Yes or _____ No, If Yes, How much _____

Alcohol _____ Yes or _____ No, If Yes, How much _____

Exercise _____ Heavy _____ Moderate _____ Light _____ None

Sleep _____ Heavy _____ Moderate _____ Light _____ None

Appetite _____ Heavy _____ Moderate _____ Light _____ None

PATIENT SIGNATURE _____ DATE _____

PATIENT NAME _____

GUARDIAN OR SPOUSE'S SIGNATURE AUTHORIZING CARE _____ DATE _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

Date

For further information regarding this notice, please contact our Doctor at (484)-688-0664

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE**

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Community Chiropractic Center
1717 Swede Road Suite 106
Blue Bell, PA 19422

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company. I understand that whatever amounts Community Chiropractic Center does not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Insured's Signature _____

Date _____

Witness (CCC Staff) _____

INFORMED CONSENT

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome, costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

The doctor is aware of these complications, and in order to minimize their occurrence will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should inform the doctor when he/she takes you clinical history.

PATIENT SIGNATURE _____ DATE _____

PATIENT NAME _____

GUARDIAN'S SIGNATURE AUTHORIZING CARE _____ DATE _____