Glendale Family Chiropractic

1125 Congress Ave, Glendale, OH
Ph: (513) 771-1109 Fax: (513) 771-1129

Patient Information

Patient Title: *(check one)* ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Rev.

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____Fax # _____ Cell Phone:_____

Age:_____ Birth Date:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. The following person(s) have my permission to receive my personal health information:

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

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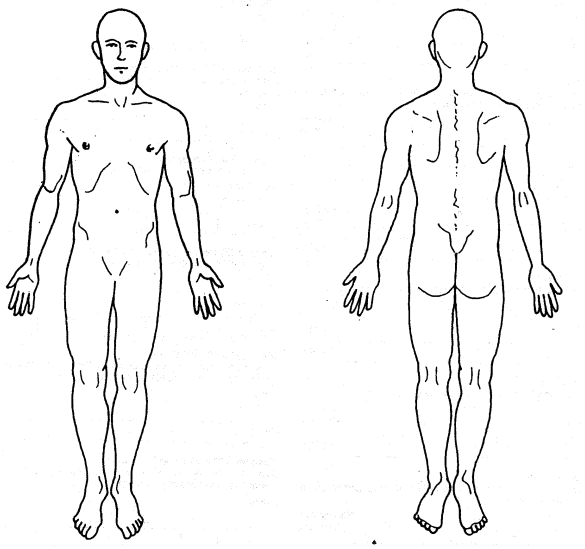
Patient Condition

Reason(s) for visit: _____
Is this condition due to an accident? □ Yes □ No □ Auto □ Work □ Home □ Other Date____
What was the mechanism of accident/injury? _____
When did your symptoms appear? _____
Is it constant or does it come and go? _____
How often do you have this problem? _____How long does the pain last? _____
Does the pain radiate? □ Yes □ No If yes, Explain: _____
Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation
Activities or movements that are difficult / painful to perform:
□ Sitting □ Standing □ Walking □ Bending □ Lying Down
Mark an "X" on the picture below where you have pain, numbness or tingling.



Circle your pain on the below scale of 0 to 10:
(**at rest**) □ No Pain 0 1 2 3 4 5 6 7 8 9 10 □ Extreme Pain
(**with activity**) □ No Pain 0 1 2 3 4 5 6 7 8 9 10 □ Extreme Pain
What time of day is your current pain/problem worse?
□ Morning □ Late in the day □ Middle of night □ As day progresses □ N/A
My current pain/problem seems to be:
□ Getting better □ Staying the same □ Getting worse □ N/A Explain: _____
My current pain/problem can be described as (check all that apply):
□ Electric □ Sharp □ Stabbing □ Knife-like □ Piercing □ Shooting □ Achy □ Griping
□ Heavy □ Cramp-like □ Burning □ Deep □ Superficial
□ Stiffness (am >1-2 hours or PM or Both) □ Spasm □ Tearing □ N/A
What treatment have you already received for your condition?
□ Medications □ Surgery □ None □ Physical Therapy □ Chiropractic Care
Name of other doctor(s) who have treated you for this condition and how _____
Were you satisfied with the results of your treatment? □ Yes □ No Explain_____

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Allergies

Are you allergic to any medication(s)? □ Yes □ No **If yes, which medications?**_____
Are you allergic to any of the following?
□ Bee Sting □ Latex □ Peanuts □ Shellfish
□ Dairy □ Mold □ Pollen □ Wheat
□ Eggs □ Nuts □ Other_____
Describe the reaction:_____

Smoking History

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoke ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

Not interested 0 1 2 3 4 5 6 7 8 9 10 Very interested

Medications

Current medications, including frequency and dosage if known. If there are no current medications, check here: □

	Medication Name	**Quantity / Dosage** (ie. 1 tablet / 5 mg)	**Frequency** (ie. 2 times / day)	**Start Date**
1				
2				
3				
4				
5				
6				
7				

Do you currently use any recreational drugs? □ Yes □ No

Social History

WORK ACTIVITY: What is your job description: _____

What do you do most of the day at work? □ Sitting □ Standing □ Light Labor

□ Heavy Labor □ Other:_____

What job did you do during most of your life? _____

How would you describe the physical stress level at work? □ Low □ Medium □ High

EDUCATION : Mark the highest level of education completed: □ Elementary school

□ Middle school □ High School □ Vocational School □ GED □ Associates Degree

□ Bachelors Degree □ Graduate Degree □ Doctorate □ other

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DIET/NUTRITION:

Are you on any special diet? □ Yes □ No

Is your weight a concern for you emotionally or physically? _____

Have you gained or lost over 10 pounds in the past 6 months without wanting to? □ Yes □ No

My dietary intake consists mainly of the following: (Mark all that apply)

□ Fruits □ Vegetables □ Whole Grains □ High Fiber
□ Low Fiber □ High Salt □ Low Salt □ High Sugar
□ Low Sugar □ Low Carbohydrate □ High Fat □ Low Saturated Fats
□ High Protein □ Low Calorie

Rate your appetite on the below scale of 1 to 10:
Normal Appetite 1 2 3 4 5 6 7 8 9 10 Eat Nothing

How many 8 ounce glasses of water do you drink a day? _____

Alcohol Use: Now? □ Yes □ No If yes, amount weekly?_____ How long?_____ years
In the past? □ Yes □ No If yes, amount weekly____ How long?_____ years

How many coffee caffeine drinks do you drink a day? Cups ___

How many soda caffeine drinks do you drink a day? Cans ____

Current Vitamins, Minerals, Herbs, etc. List ANY/ALL non-prescription items you are CURRENTLY taking in the table below.

	Vitamin, Mineral, Herb	**Quantity/Dosage** (ie: 1 tablet/ 5mg)	**Frequency** (ie: 2 times/ day)	**Start Date**
1				
2				
3				
4				
5				

Health Review:

How many hours of sleep are you getting per night? ❑ Less than 5 ❑ 6-8 ❑8-10 ❑10+
How many days a week do you exercise for 30 minutes or more? ❑ 0 ❑ 1-2 ❑3-4 ❑4-6 ❑7
How would you rate the intensity of your exercise? ❑ Low intensity ❑ Moderate ❑ High intensity
How would you rate your emotional stress level? ❑No stress ❑Moderate ❑Very stressed
List your major stressors: _____
What are your health goals? _____

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Personal Health History

Are your currently under the care of a Healthcare Provider or any other doctor? □ Yes □ No
If yes, for what condition(s)

_____

Provider's Name _____ Phone Number _____
Has any doctor diagnosed you with Hypertension recently? □ Yes □ No
If yes, describe:

_____

Has any doctor diagnosed you with Diabetes recently? □ Yes □ No
If yes, was your blood lab-work test for hemoglobin A1c >9.0% □ Yes □ No □ Not Sure
If yes, other comments regarding Diabetes: _____
Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?
□ Yes □ No

Do you wear any of the following? □ Heel Lifts □ Innersoles □ Arch Supports □ Orthotics □
Other_____
For how long? _____ Were they prescribed by a doctor?
□ Yes □ No
Have you seen a chiropractor in the past? □ Yes □ No Date of last visit_____
If yes, name and location of previous Chiropractor_____

Date of last:				
	Chiropractic Exam		Prostate/PSA	
	Cholesterol		Mammogram	
	MRI		Pap Smear	
	CT-Scan		Colon	
	Spinal X-ray		Stool check for blood	
	Bone Density Scan			

Childhood Illnesses:

□ ADD □ depression □ Psoriasis
□ atopic dermatitis □ diabetes □ Rash
□ allergies/hayfever □ ear infections □ scoliosis
□ anemia □ fetal drug exposure □ seizures
□ asthma □ headaches □ sickle cell
□ bedwetting □ hepatitis □ spina bifida
□ cerebral palsy □ HIV □ other:
□ chicken pox □ measles
□ crohn's/colitis □ mumps

Immunization:

□ All recommended vaccines
□ Not vaccinated
□ adenovirus
□ DTaP(diphtheria,tetanus,pertussis)
□ haemophilus B □ hepatitis B
□ Influenza □ IPV(polio)
□ MMR(measles,mumps, rubella)
□ pneumococcal □ rotavirus
□ tetanus □ varivax(chicken pox)
□ other:_____

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Adult Illnesses:

☐ ADD	☐ CVA (stoke)	☐ heart disease	☐ multiple sclerosis
☐ Alzheimer's	☐ cystic kidney disease	☐ hepatitis	☐ Parkinson Disease
☐ arthritis	☐ depression	☐ HIV	☐ Unspecified pleural effusion
☐ asthma	☐ diabetes	☐ high blood pressure	☐ pneumonia
☐ cancer	☐ eczema	☐ influenza pneumonia	☐ psoriasis
☐ cerebral palsy	☐ emphysema	☐ liver disease	☐ psychiatric condition
☐ chicken pox	☐ eye problems	☐ lung disease	☐ scoliosis
☐ colitis	☐ fibromyalgia	☐ lupus erythema	☐ seizures
☐ shingles	☐ STD's (unspecified)	☐ suicide attempt(s)	☐ thyroid problems
☐ vertigo	☐ Other: _____		

Injuries: (List date next to injury)

☐ back injury	☐ fracture	☐ laceration (severe)
☐ broken bones	☐ head injury	☐ motor vehicle accident
☐ disability	☐ industrial accident	☐ soft tissue injury
☐ fall (severe)	☐ joint injury	☐ Other: _____

Surgeries:

	Date	**Procedure (ie: knee repair)**	**Description**	
1				In Patient/Out Patient
2				In Patient/Out Patient
3				In Patient/Out Patient
4				In Patient/Out Patient
5				In Patient/Out Patient

Family History

Relation	**Age**	**List any serious illness** (ie: cancer, diabetes, heart disease)
Father		
Paternal grandfather		
Paternal grandmother		
Mother		
Maternal grandfather		
Maternal grandmother		
Brother(s)		
Sister(s)		
Child(ren)		

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Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITH OR WITHOUT INSURANCE

We request that 100% of the services be paid at the time of the visit. We are happy to accept your check, Master Card or Visa, and HSA. Patients who pay the entire treatment plan in full may qualify to receive a 20% time-of-service discount. We will be happy to provide you with a statement of your charges for reimbursement.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office will be happy to print any uncovered services so the patient can mail them into their secondary insurance. Our office completes and files the forms for Medicare at no charge.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan' or HSA. We will be happy to provide you with a statement of your charges for reimbursement.

CANCELLATION/ NO-SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **If an appointment is not cancelled at least 24 hours in advance you will be charged a $25 fee.**

I have read and understand the payment policy of Glendale Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Glendale Family Chiropractic and my insurance company. I also understand that all services must be paid in full at the time of the visit.

_____*Date:*_____
Patient's signature (or guardian if patient is a minor)

_____*Date:*_____
Witness