Preferred Health Chiropractic
Your choice for better health...Naturally.

# WELCOME

## PERSONAL INFORMATION

**PLEASE PRINT**

**First Name**:_____**M.I**._____**Last Name**:_____**Preferred Name**:_____

**Address**:_____**City**:_____**State:**_____**Zip:**_____

**Birthdate**:_____/_____/_____ **Age**_____ **Gender**: ☐ Male ☐ Female ☐ Unspecified **SSN**:_____/_____/_____

**Primary Phone**:_____ **Cell Phone**:_____ **Work Phone**:_____

**Home Email**:_____ **Work Email**:_____

*By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

**Which email would you like us to use to communicate with you?** (check one) ☐ Home ☐ Work

**Contact Method:** (check one) ☐ Primary Phone ☐ Cell Phone ☐ Work Phone ☐ Home Email ☐ Work Email

**Status:** (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Children?:** ☐ Yes ☐ No How Many:_____

**Spouse's Name**:_____

**Race:** ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐Native American ☐Other:_____☐ I choose not to specify

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not to specify

**Preferred Language**: ☐ English ☐Spanish ☐ French ☐ Japanese ☐ Chinese ☐ German ☐ Other_____☐ I choose not to specify

**Occupation**:_____ **Employer**:_____

**Emergency Contact**: (Name, Relationship, Phone #)_____

**Family Physician Name**:_____City:_____

**How were you referred to Preferred Health?** ☐ Patient_____ Physician_____

☐ Yellow Pages ☐ Internet ☐ Radio ☐ Newspaper ☐ Sign ☐ Other_____

## INSURANCE OR PRIVATE PAY INFORMATION

***Please provide insurance card(s) to receptionist.***

**Type of Insurance**: ☐Private Ins. ☐ Medicare ☐Auto Ins. ☐ Worker's Comp ☐ Other _____

**Primary Insurance Carrier**:_____ Phone:_____

Policy#_____ Group #_____ Claim#_____

Name of Policy Holder:_____ Relationship to Patient:_____

Policy Holder's Birthdate :_____/_____/_____ Policy Holder's SSN: _____/____/_____ Employer:_____

Is patient covered by another insurance? ☐ Yes ☐ No

**Secondary Insurance Carrier**:_____ Policy #:_____

**ASSIGNMENT/AUTHORIZATION/RELEASE**:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Preferred Health of Marshall, PA all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

☐**Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account: _____

X_____ DATE: _____

**Signature of Patient, Parent or Legal Guardian (if minor)**

## REASON FOR VISIT

**What is the reason for your visit today?** ☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain ☐ Other_____

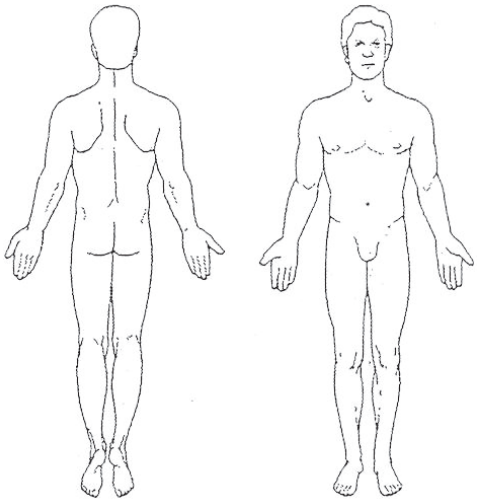
**What caused this complaint(s)?**_____

_____

**When did this complaint begin?** _____/_____/_____ **Is it getting worse?** ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

**Have you had this or similar complaint in the past?** ☐ Yes ☐ No If "Yes", when?_____

**What does your complaint (s) feel like? Circle all** that apply*: Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*_____



**←Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.**

*Area for doctor's notes:*

**On the scale below, please circle the severity of your main complaint right now:**

***No Pain*** ***Moderate Pain*** ***Worst Possible Pain***

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

**What area(s) does the pain radiate, shoot, or travel to?** (if applicable)? _____

**What aggravates this complaint? Circle all that apply**: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:_____

**What relieves this complaint? Circle all that apply:** Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Acupuncture / Nothing / Other:_____

**Are you interested in learning more about acupuncture?** ☐ Yes ☐ No

**How often do you experience your symptoms?** ☐25% of the day ☐ 50% of the day ☐ 75% of the day ☐ 100% of the day

**Timing of complaint**: **Check appropriate box:** ☐ Morning ☐ As day progresses ☐ Afternoon ☐ Evening ☐ While sleeping ☐ During activities ☐ After activities ☐ Symptoms are constant and do not change ☐ Other:_____

**With time are your symptoms:** ☐ Improving ☐ Worsening ☐ Not changing

**Have you seen other doctors for this complaint?** ☐ Yes ☐ No If "Yes", please provide the following information:

Doctor's name:_____ Date consulted:_____Diagnosis_____

**Is this condition interfering with your: Circle all that apply** Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:_____

**Is your complaint interfering with your daily activities?** ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

NAME:_____ DATE:_____

## HEALTH HISTORY

| Please check **ALL** of the health conditions below that apply to **you** currently or in the past. | | | | **Family History** Mark **ALL** conditions that run in your family | | Relationship: (Father,Mother,Sister,Brother) |
|---|---|---|---|---|---|---|
| ☐ | Osteoarthritis/Degenerative Joint Disease | ☐ | Whiplash Injury *Date of injury:* | ☐ | Cancer *Type:* | |
| ☐ | Asthma | ☐ | Headaches | ☐ | Anemia | |
| ☐ | Diabetes ☐ Type I ☐ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? ☐ Yes ☐ No ☐ Not Sure | ☐ | Joint Pain (circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:_____ | ☐ | Diabetes (check one) ☐Type I ☐ Type II | |
| ☐ | Anemia | ☐ | Migraines | ☐ | Heart Problems / Stroke | |
| ☐ | Cancer/Tumor | ☐ | Osteoporosis /Osteopenia | ☐ | High Blood Pressure | |
| ☐ | Rheumatoid Arthritis | ☐ | Epilepsy / Seizures | ☐ | Genetic Disorders | |
| ☐ | Depression/ Anxiety | ☐ | Fibromyalgia / Chronic Fatigue | ☐ | Rheumatoid Arthritis | |
| ☐ | Disc Herniation | ☐ | Genetic Disorders | ☐ | Other (List): | |
| ☐ | High Blood Pressure /Hypertension | ☐ | Please list any other medical conditions: | | | |
| ☐ | Heart Disease / Stroke | | | | | |

**WOMEN ONLY:** **Currently Pregnant?** ☐ Yes ☐No **Painful /Abnormal Menstrual Cycle?** ☐ Yes ☐ No **Menopause?** ☐ Yes ☐ No **Miscarriage?** ☐ Yes ☐ No **Do you have children?** ☐ Yes ☐ No **If "Yes",** type of birth? **Circle** Vaginal or C-Section

**FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)**

_____

_____

**SURGERIES and/or HOSPITALIZATIONS (List and Date):**

_____

_____

**Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?** ☐ Yes ☐ No

**List current prescription medications**, including frequency and dosage if known. **If there are NO current medications, check here** ☐

| *Name of prescription medication* | *Dosage/Start date* | 4. | |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |

**List any known allergies you have had to prescription medications. If NO medication allergies are known, check here** ☐

1._____ 2._____

## SOCIAL HISTORY

**Do you exercise?** ☐ Yes ☐ No **Times per week?** **Intensity?** ☐ Light ☐ Moderate ☐ Strenuous **Type?**

**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 smoker ☐ Current sometimes smoker **Circle level below ↓:**

**If "Yes"**, what is your level of interest in quitting smoking? ( 0 = NO interest, 10=very interested) **0 1 2 3 4 5 6 7 8 9 10**

**Do you drink alcohol?** ☐ Yes ☐ No **How many drinks per week?** **For how many years?**

**Do you drink caffeine?** ☐ Yes ☐ No **How many drinks per day?** **What type?** ☐ Coffee ☐ Tea ☐ Soft Drinks ☐ Energy Drinks

**Do you take pain killers?** ☐ Yes ☐ No **How often?** ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

**What type?** ☐ Aspirin ☐ Ibuprofen ☐ Tylenol ☐ Other_____

**What do your work duties include?** ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Other:

**Please describe your overall health right now?** ☐ Excellent ☐ Very Good ☐ Good ☐Fair ☐ Poor

**What is your current stress level?** ☐ Mild ☐ Moderate ☐ High

**Have you seen a chiropractor in the past?** ☐ Yes ☐ No

**What are your hobbies?**

NAME:_____ DATE:_____

## INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

### *The nature of the chiropractic adjustment:*

The primary treatment I use, as a Doctor of Chiropractic, is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

### *Analysis / Examination / Treatment*

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

| | | | |
|---|---|---|---|
| ☐ spinal manipulative therapy | ☐ palpation | ☐ vital signs | ☐ range of motion testing |
| ☐ orthopedic testing | ☐ basic neurological testing | ☐ muscle strength testing | ☐ postural analysis |
| ☐ EMS | ☐ ultrasound | ☐ hot/cold therapy | ☐ radiographic studies |

☐ Other (please explain)_____

### *The material risks inherent in chiropractic adjustment.*

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

### *The probability of those risks occurring.*

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

### *The availability and nature of other treatment options.*

Other treatment options for your condition may include:

1-Self-administered, over-the-counter analgesics and rest 2-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers 3-Hospitalization 4-Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

### *The risks and dangers attendant to remaining untreated.*

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE "BOX" AND SIGN BELOW:

**I have read** ☐ or **have had read to me** ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor of Chiropractic at Preferred Health of Marshall, PA and have had my questions answered to my satisfaction. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Preferred Health of Marshall, PA responsible for any errors or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ Dated:_____

_____ _____

Patient's Name (Please print) Doctor's Name (Please print)

X_____ _____

**Signature of Patient, Parent or Legal Guardian (if a minor)** Doctor's Signature

REV6/18