Bloomsburg
FAMILY CHIROPRACTIC, PLLC

Please allow us to photocopy your driver's license and insurance card.
All information is confidential.

PATIENT INFORMATION

Name: ______________________________________

Address: ____________________________________

City: ______________________________________

State: ______ Zip: _________

Sex: □ Male □ Female Age:_____

Date of Birth: ______/______/__________

Social Security #: _____-____-______

Phone #: Home- ___________________________

Cell- ___________________________

Work- ___________________________

Email: __________________________@______.______

Employer: __________________________________

Occupation: _________________________________

How did you hear about us? :

____

Have you ever been to a chiropractor before?: □ yes □ no

Primary Doctor: ___________________________

Phone: _________________________________

EMERGENCY CONTACT:

Name: ______________________________

Phone: ______________________________

INSURANCE INFORMATION

Insurance Co: _______________________________

Policy ID#: _________________________________

Group #: ___________________________________

Subscribers name: ___________________________

Relationship to patient:
□ Self □ Spouse □ Child □ Other: ________

If other than self - - -

Address: ___________________________

City: ___________________________

State: ______ Zip: _________

Is there a secondary health insurance?:
□ yes □ no If yes, please list: __________________

Is this related to auto or work injury?: □ yes □ no

HIPAA INFORMATION

I have read and understood the "Notice of Privacy Practices" for Bloomsburg Family Chiropractic. I understand that if I have any questions regarding this policy I may ask the doctor.

I authorize the office to contact me at:
□ home □ work □cell ;
and may leave message at:
□ home □ work □ cell.

Signature: _____________________________
Date: ______________

ASSIGNMENT OF BENEFITS

I (________________________________) hereby instruct and direct my insurance company (_______________________) to pay by check made out to Bloomsburg Family Chiropractic. For the professional or medical expense benefits allowed and otherwise payable to me under my current insurance policy as payment toward the total charges 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. (1: a photocopy of this assignment shall be considered as effective and valid as the original; 2: I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case; 3: I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf) I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered as per the financial policy. The financial policy is posted in the waiting room, on the back of this form, and a copy will be furnished on request.

Signature: ____________________________________ Date: _______________

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► What is your current complaint?:
____
____
____

► Are these a result of: □ accident/injury □ work □ auto □other □ worsening long term problem

► When was the onset of this problem?: ________________________________ □ gradual □ sudden

► Since the onset, how has it changed?: □ getting better □ getting worse □ not changing

► How frequently does this bother you?: □ constant (76-100% of the day) □ frequent (51-75% of the day) □ occasional (26-50% of the day) □ intermittent (0-25% of the day)

► On a scale of 0-10, (with 10 being the most painful and 0 being no pain at all), how would you rate your pain?

0 (no pain) 1 2 3 4 5 (moderate pain) 6 7 8 9 10 (severe pain)

► How would you describe the quality of the symptoms you are experiencing?:
□ dull □ sharp □ throbbing □ burning □ deep □ aching □ other: ______________
□ tingling □ stabbing □ cramping □ numbness □ radiating □ stiffness ______________

► Radiation: does it affect other areas of your body? If so, where does it radiate? ____

► Location: please mark the body diagram where you are experiencing your current symptoms, using the appropriate symbols.

^^^	Aches
OOO	Numbness
●●●	Pins/Needles
XXX	Burning
///	Stabbing

► Aggravating factors: what tends to worsen the problem or increase pain?: ____

► Relieving factors: what tends to lessen the problem or decrease pain?: ____

► Prior interventions: have you had any other treatment for this?: □ yes □ no
If yes, please check which treatment:
□ prescription medication □ OTC drugs □ homeopathic remedies □ massage
□ physical therapy □ surgery □ acupuncture □ chiropractic

► Is the problem worse at a certain time of day?: □ morning □ midday □ night □ comes and goes

____

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Employment, ADL, and Recreation Information:

► Description of work: ____

► Condition's effect on work: □ no effect (no pain, can perform) □ mild effect (painful, can do) □ moderate (painful, limited ability) □ severe (painful, cannot perform)

Daily Activities: Effects of Current Condition on Performance

► Place an (X) in the box of those that apply:

	No effect	Mild (painful, can do)	Moderate (painful, limited)	Severe (cannot perform)
Bending				
Self care				
Carrying				
Sitting to Standing				
Climbing Stairs				
Driving				
Extended Computer Use				
Household Chores				
Kneeling				
Lifting				
Pet Care				
Reading				
Bathing				
Dressing				
Sleeping				
Sitting				
Standing				
Walking				
Yard work				

► **Medical Conditions**: check all that apply to you

□ arthritis □ cancer □ diabetes □ heart disease □ hypertension □ psychiatric illness
□ skin disorder □ stroke □ headaches □ multiple sclerosis □ epilepsy □ gout
□ hepatitis □ HIV/AIDS □ tuberculosis □ GI problems □ ulcer □ immune disorders
□ osteoporosis □ scoliosis □ neck pain □ back pain □ hip pain □ knee pain
□ foot pain □ shoulder pain □ TMJ pain □ anxiety □ depression □ blood disorder
□ dizziness □ numbness □ bruising □ high cholesterol □ asthma □ emphysema
□ pneumonia □ blurred vision □ hearing loss □ aortic aneurysm □ eczema □ low energy
□ kidney stones □ fainting □ fatigue □ sudden weight change □ psoriasis
□ other: ______________________________

► **Surgeries**: please list all surgeries and hospitalizations

□ spine □ pacemaker □ other: ____
____

► **Injuries**: please list any significant traumas or accidents you have had in your lifetime

____
____

► **Allergies**: please list any allergies you may have, and your reaction to the allergen

____
____

____

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► **Social History**: check all that apply to you

Caffeine Use:	□ daily	□ weekly	□ occasionally	□ never
Alcohol Use:	□ daily	□ weekly	□ occasionally	□ never
Tobacco Use:	□ daily	□ weekly	□ occasionally	□ never
Pain Relievers:	□ daily	□ weekly	□ occasionally	□ never
Exercise:	□ daily	□ weekly	□ occasionally	□ never

► **Family History**: check all that apply

□ Arthritis	□ Diabetes	□ Heart disease	□ Thyroid	□ Depression	□ Multiple Sclerosis
□ Cancer	□ Stroke	□ Hypertension	□ Autoimmune	□ Other: ______________________	

► **Medications/Supplements**: please list all medications or supplements you currently take, and the reason for taking them.
____
____
____
____

► **Imaging**: have you had any recent x-rays, MRI's, or CT scans?: □ yes □ no if yes, of what? ___________________________

Acknowledgements

To set clear expectations, improve communications, and help you get the best results**, please read each statement and initial your agreement.**

_______ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_______ I may request a copy of the Privacy Policy and understand that it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_______ I acknowledge that any insurance I may have in an agreement between the carrier and me that I am responsible for the payment of any covered or non-covered services I receive.

_______ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

Informed Consent

_______ *I have received information from my doctor about my condition and proposed chiropractic treatment program, including anticipated **benefits**, the reasonable foreseeable **risks** and **side effects** of the treatment, and **alternatives** to the proposed treatment, including no treatment. I understand that, as in all health care, there are some risks to chiropractic treatment. The risks include, but are not limited to, bruising, soreness, worsening of symptoms, muscle strains, sprains, fractures, dislocations, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I have had the opportunity to **ask questions** about my condition and the recommended care. I understand that I may ask further questions at any time and **wish to continue with chiropractic treatment**.*

If patient is a minor, print child's full name: ____

x____ ___________________________

Patient Signature Date (MM/DD/YYYY)

×× OFFICE USE ONLY ×××

ICD-10 Dx: ___________ ___________ ___________ ___________ ___________

Tx: Ice Heat Stim TE US MSTM Drop F/D Activator CMT-D

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