

PATIENT INFORMATION	INSURANCE INFORMATION
Name:	Insurance Co:
Address:	Policy ID#:
City:	Group #:
State: Zip:	Subscribers name:
Sex: Male Female Age:	Relationship to patient:
Date of Birth://	□ Self □ Spouse □ Child □ Other:
Social Security #:	If other than self Address:
Phone #: Home	City:
Cell-	State: Zip:
Work-	
Email:@	Is there a secondary health insurance?:
Employer:	□ yes □ no If yes, please list:
Occupation:	Is this related to auto or work injury?: □ yes □ no
How did you hear about us? :	
Have you ever been to a chiropractor before?: u yes units no	HIPAA INFORMATION
Primary Doctor:	I have read and understood the "Notice of Privacy Practices" for Bloomsburg Family Chiropractic. I
Phone:	understand that if I have any questions regarding this policy I may ask the doctor.
Filone	
EMERGENCY CONTACT:	I authorize the office to contact me at: □ home □ work □cell ;
Name:	and may leave message at: □ home □ work □ cell.
Phone:	
	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: ___

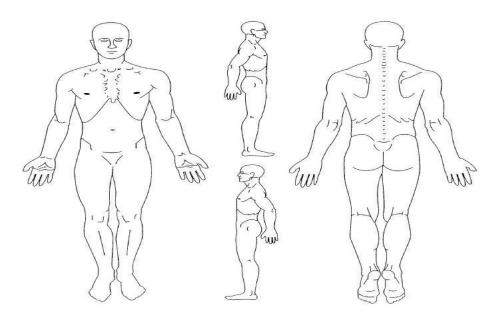
Date: ___

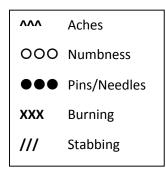


► What is your current complaint?:

Are these a re	esult of:	□ acc	ident/inju	у 🗆	work	□ auto		other	□ wors	ening long	g term problem	
When was the	e onset c	of this pr	oblem?: _					□ gr	adual	□ suc	lden	
Since the ons	set, how l	has it ch	anged?:	□ getting	g better	□ ge	tting wa	rse □ r	not chang	jing		
 How frequent 	ly does t	his both		□ consta -100% of the o		□ frequer 51-75% of the c		□ OCCAS (26-50% of th		□ intern (0-25% of		
On a scale of	0-10, (w	rith 10 b	eing the n	nost painf	ul and C) being no	pain at	all), how v	would yo	u rate you	ır pain?	
0 (no pain)	1	2	3		5 derate pa	6 iin)	7	8		10 vere pain)		
How would yo	ou descri	be the c	uality of t	he sympt	oms you	l are expe	iencing	?:				
□ dull □ tingling		p bing		bbing nping		rning mbness		ep liating		hing fness	□ other:	
Radiation: do	es it affe	ct other	areas of y	our body	? If so,	where doe	s it radi	ate?				

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





► 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?: use 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



□ mild effect

(painful, can do)

Employment, ADL, and Recreation Information:

Description of work: _____

Condition's effect on work:

no effect (no pain, can perform) 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 □ multiple sclerosis □ epilepsy skin disorder stroke □ headaches □ gout □ GI problems □ ulcer □ immune disorders □ hepatitis □ HIV/AIDS □ tuberculosis □ back pain □ osteoporosis □ neck pain □ hip pain □ knee pain scoliosis □ foot pain □ shoulder pain □ TMJ pain □ anxiety □ depression □ blood disorder □ dizziness □ numbness □ bruising □ high cholesterol □ asthma emphysema pneumonia □ blurred vision □ hearing loss □ aortic aneurysm □ low energy eczema □ 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



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		
Famile	ily History: check	all that apply					
	□ Arthritis	Diabetes	Heart disease	□ Thyro	bid	Depression	Multiple Sclerosis
	Cancer	Stroke	Hypertension	□ Autoi	mmune	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										
Patier	nt Signat	ture								Date (MM/DD/YYYY)
****	*****	*****		. x x x x 3	*****		OFFICE	E USE C)NLY	********
ICD-10) Dx:									
Tx:	Ice	Heat	Stim	TE	US	MSTM	Drop	F/D	Activator	CMT-D