Upper Arlington Family Chiropractic
New Patient Information

4949 Dierker Rd., Upper Arlington, Ohio 43220
(614) 682-6868 www.uafamilychiro.com

GENERAL INFORMATION:

Name: _____ **Date:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone (____) _____-_____ **Cell Phone (____)** _____-_____

Email: _____
Used for appointment reminders, missed appointments and monthly newsletter

Date of Birth _____/_____/_____ **Age:** _____ **Sex:** Male Female

Your Employer's Name: _____ **Occupation:** _____

Marital Status: S M D W **Spouse's / Partner's Name:** _____

Name of Primary Care Physician: _____ **Phone:** _____
May we contact your PCP regarding your status in our office if needed? Yes / No

How did you hear or who referred you to our office? _____

Have you seen a Chiropractor before? Y / N **If so, when:** _____

PURPOSE OF THIS VISIT:

Reason for visit: _____ **When did your symptoms start?** _____/_____/_____

Related to a work injury or auto accident? Y / N **Date of the accident:** _____

Other health care professionals seen for this problem: _____

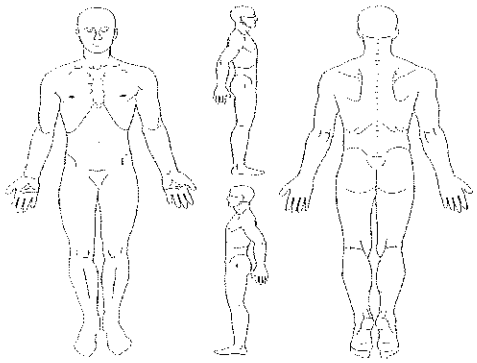
Are you pregnant? Yes_____ **No** _____ **N/A**_____, **Date of last menstrual cycle:** _____

Emergency Contact: _____ **Phone number:** _____

If you give permission for us to communicate with anyone , please complete below:

Name/Phone Number	Relationship	Check all that apply
_____	_____	___ (billing info), ___ (appt info), ___ (medical Info)
_____	_____	___ (billing info), ___ (appt info), ___ (medical Info)

Please mark on the diagram with an "X" or multiple "X"'s where you are experiencing your discomfort:



HEALTH HISTORY:

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke

Other _____

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia

Other _____

Allergies: (Circle all that apply to you)

Eggs	Fish and Shellfish	Milk or Lactose	Peanuts
Soy	Sulfites	Wheat/Glutens	Other _____

Social History: (Circle all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Chew Tobacco:	occasional	often	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Wear Seat Belts:	occasional	always	never

Other _____

Family History: (Circle all that apply)

Arthritis:	Parent	Sibling	
Cancer:	Parent	Sibling	
Diabetes:	Parent	Sibling	Other: _____
Heart Disease	Parent	Sibling	
Hypertension	Parent	Sibling	
Stroke	Parent	Sibling	
Thyroid	Parent	Sibling	

_____ (initial)

CURRENT MEDICATIONS / SUPPLEMENTS

_____

_____

_____

REVIEW OF SYMPTOMS

Please check each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain

_____ (initial)

AUTHORIZATION OF CARE / FINANCIAL POLICY / HIPAA / RELEASE OF RECORDS

I authorize and agree to allow the Doctor to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

Health Insurance: I consent to assign all payments for the services rendered to Upper Arlington Family Chiropractic. I understand that I am responsible for all co-payments, deductibles, co-insurance and other amounts (non-covered services) that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and/or state regulation. I understand that my insurance is a contract between me and my insurance company and that my contract with my insurance entity may or may not cover some or all charges. Some insurances count some or all aspects of our treatment as physical therapy. It is up to the patient to find out if this is the case if going for PT elsewhere.

Automobile Accidents: I understand that Upper Arlington Family Chiropractic requires to have on file my health insurance, my car insurance , person at faults insurance and my driver's license. I give any insurance carrier involved and/or attorney authorization to directly pay Upper Arlington Family Chiropractic for the treatment rendered.

Cash patients: We require payment at the time of service. A "time of service discount" may apply

ACKNOWLEDGEMENT AND UNDERSTANDING

I understand that if it is determined: (a) That there is no insurance coverage, (b) If your insurance company refuses to acknowledge & assign payment directly to the doctor, (c) If your insurance company notifies us that you are responsible for additional payment to our office, (d) If I stop care for any reason, or (e) If a liability claim exists & my attorney refuses to agree to protect the interests of the doctor, or if I have not engaged the services of an attorney, THEN PAYMENT FOR SERVICES RENDERED BY THE DOCTOR AT UPPER ARLINGTON FAMILY CHIROPRACTIC WILL BE MADE ON A CURRENT BASIS AND MY PORTION OF THE CHARGES WILL BE PAID IN FULL. I further understand that if my account gets turned over to a collection agency, I am responsible for all collection fees, interest, attorney fees and any other fees associated with the collection process.

I further authorize Upper Arlington Family Chiropractic to use and/or disclose protected health care information in accordance with the following specific authorizations:

I give permission to Upper Arlington Family Chiropractic to use my name, address, email address, phone numbers and clinical records to contact me with birthday cards, welcome cards, holiday cards, health related e-mails and related information as well as any advertisements, newsletters and office promotions. I give permission to Upper Arlington Family Chiropractic to leave a voicemail, leave a message on an answering machine, send you an email and/or to text the cell phone provided for the purpose of reminders and or missed appointment follow up.

I understand and give permission for Upper Arlington Family Chiropractic to treat me in a semi open room setting (open door). I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to talk to the doctor in a more private setting, the doctor will provide a private room for these meetings.

ACKNOWLEDGE OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I understand and have been provided the opportunity to read the "HIPPA NOTICE OF PRIVACY PRACTICES" that provides more detailed information about the privacy policies of Upper Arlington Family Chiropractic and my rights as a patient. I understand that I will be given a copy of the policy if asked.

RELEASE OF RECORDS

I authorize Upper Arlington Family Chiropractic to release any information deemed necessary concerning my condition to any doctor, insurance company, attorney, collections agency, adjustor, or any other business necessary regarding my case/treatment for purposes related to the health condition or collection of payment and not for marketing purposes.

Patient's Name Printed	Patient's signature	Date
Minor's Name	Guardian of Authorizing care for minor	Date