

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 at Birth: Male Female

Your Employer's Name: _____ Occupation: _____

Marital Status: S M D W P 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: _____

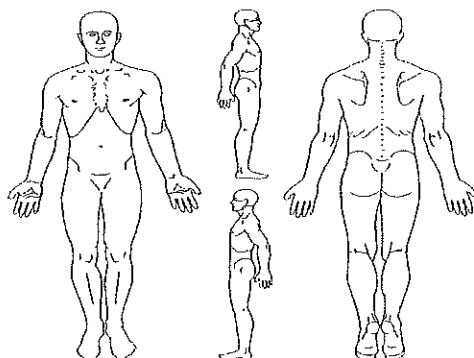
Are you pregnant? Yes _____ No _____ N/A _____, Date of last menstrual cycle: _____

Emergency Contact: _____ Phone number: _____

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

<u>Name/Phone Number</u>	<u>Relationship</u>	<u>Check all that apply</u>
_____	_____	___ (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	Other: _____
Cancer:	Parent	Sibling	
Diabetes:	Parent	Sibling	
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 / 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, office 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 that all media (emails and texts) has a risk of not being secure and information may be intercepted. I understand that I will not send any personal information vial email/text.

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 EMAILS/TEXTS

Although we do our best to be cyber secure and encrypted, events beyond our control may occur. I understand and acknowledge that all media (emails and texts) has a risk of not being secure and information may be intercepted. I understand that I will not send any personal information via email/text.

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

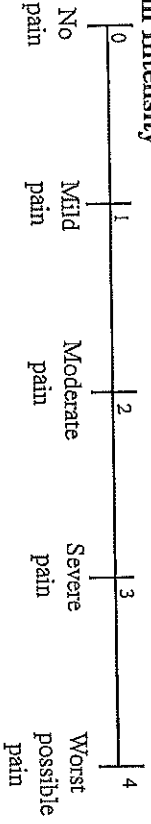
Date

Functional Rating Index

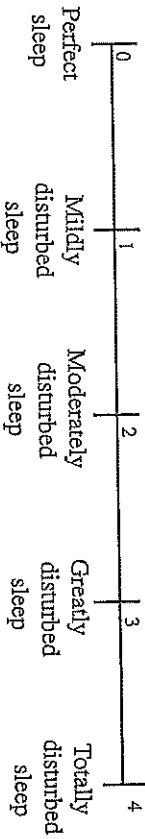
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

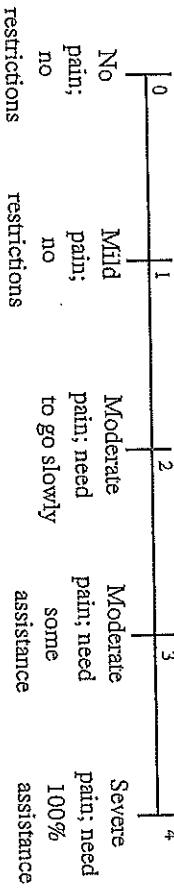
1. Pain Intensity



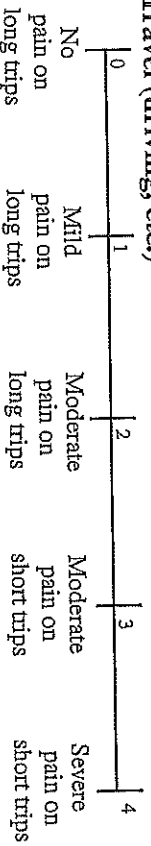
2. Sleeping



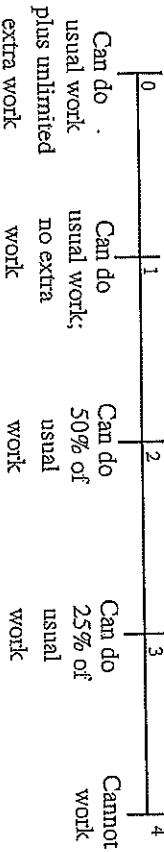
3. Personal Care (washing, dressing, etc.)



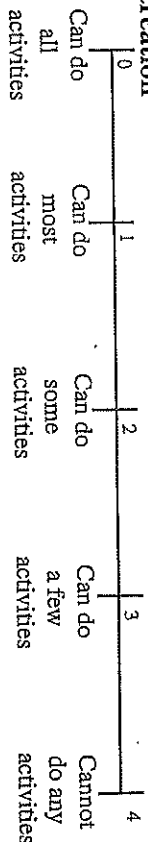
4. Travel (driving, etc.)



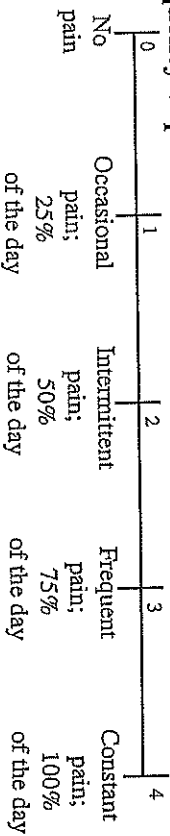
5. Work



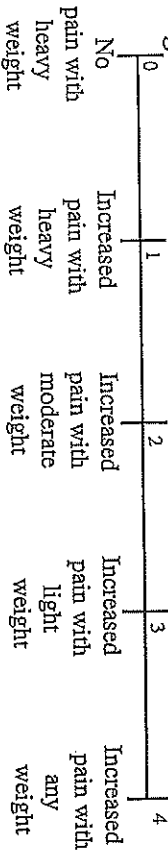
6. Recreation



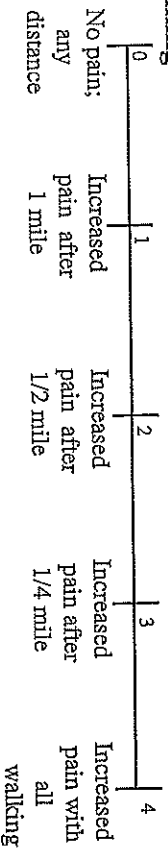
7. Frequency of pain



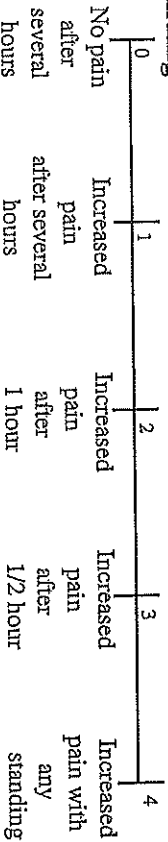
8. Lifting



9. Walking



10. Standing



Total Score _____

Name _____

PRINTED

Signature _____

Date _____

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Upper Arlington, Ohio 43220

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this offices " HIPAA
Notice of Privacy Practices." I understand that I can also have one provided to me upon
request.

Signature

Date

----- Office Use Only Below This Line -----

We attempted to obtain written acknowledgement of receipt of our HIPAA Notice of Privacy
Practices, but could not be obtained because:

- Individual refused to sign
- Communication barriers prevented from occurring
- An emergency situation prevented us from obtaining
- Other (please specify):
