

Upper Arlington Family Chiropractic

New Patient Information

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

GENERAL INFORMATION:

Name: _____ Date: _____

Preferred Name/Nickname: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone (____) _____ - _____ Email: _____

Date of Birth ____ / ____ / ____ Age: _____ Sex at Birth: Male Female

Occupation: _____

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

Primary Care Physician: _____
May we contact them if clinically necessary? Yes / No

How did you hear about our office? _____

Have you received chiropractic care before? Y / N If yes, when?: _____

PURPOSE OF THIS VISIT:

What brings you in today?: _____

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: _____

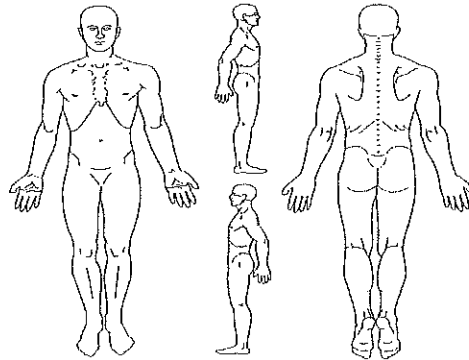
Any chance you may be pregnant? Yes _____ No _____ N/A _____ If Yes, Due date: _____

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 pain, stiffness, numbness or discomfort:



HEALTH HISTORY:

Medical Conditions: (Circle all that apply to you)

Arthritis Cancer Diabetes Heart Disease
 Hypertension Psychiatric Illness Skin Disorder Stroke
 Blood clot disorder Osteoporosis / Osteopenia
 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/Vape: occasional often 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
 Clotting disorders Parent Sibling

CURRENT MEDICATIONS / SUPPLEMENTS

REVIEW OF SYMPTOMS

Please check any symptoms or conditions you currently experience or have experienced recently:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Foot / Ankle Pain |
| <input type="checkbox"/> Numbness / Tingling | <input type="checkbox"/> Weakness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Balance Problems |
| <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Walking Difficulty |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | | <input type="checkbox"/> Fever / Chills |
| <input type="checkbox"/> Recent Trauma / Fall | <input type="checkbox"/> Cancer History | | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Bowel / Bladder Changes | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | |

Please list any other medical conditions, symptoms, injuries, or health concerns important for the doctor to know:

Anything else the doctor should know about your health history?

**** Please inform the doctor of any significant medical conditions, recent illnesses, surgeries, injuries, or changes in your health.**

PATIENT AUTHORIZATION & FINANCIAL POLICY

I authorize Upper Arlington Family Chiropractic to provide chiropractic care, SoftWave, rehabilitative exercises, and related therapies for the purpose of improving pain, mobility, function, and overall musculoskeletal health. I understand that I am financially responsible for services provided.

HEALTH INSURANCE

As a courtesy, Upper Arlington Family Chiropractic may bill your insurance company on your behalf. Patients are responsible for all co-pays, co-insurance, deductibles, non-covered services, and any balances determined by their insurance plan. Payment is due at the time of service for any patient responsibility known at the time of the visit. Insurance coverage is a contract between the patient and their insurance company. Some insurance plans may classify portions of chiropractic treatment or rehabilitation services as physical therapy or combine these benefits. Patients are responsible for understanding their individual insurance coverage and benefit limitations.

AUTOMOBILE ACCIDENT CASES

Patients seeking treatment related to an automobile accident must either retain legal representation with a letter of protection, or pay cash for services directly at the time of treatment. Upper Arlington Family Chiropractic does not accept delayed-payment arrangements through automobile insurance claims. We do not bill ANY automobile insurance.

SELF-PAY PATIENTS

Payment is due at the time of service. Self-pay rates may apply.

FINANCIAL RESPONSIBILITY

I understand that I am ultimately responsible for payment of services provided by Upper Arlington Family Chiropractic regardless of insurance coverage or claim status. Any unpaid balances may be subject to collection activity and associated fees as permitted by law.

COMMUNICATION CONSENT

I authorize Upper Arlington Family Chiropractic to contact me by phone, voicemail, email, and/or text message regarding appointment reminders, missed appointments, office updates, and educational or informational communications. Standard messaging and data rates may apply. While reasonable safeguards are used, electronic communication carries some privacy risk. Patients should avoid sending sensitive medical information through unsecured email or text messaging.

OPEN TREATMENT AREA

I understand that portions of treatment (exercises) may occur in an open treatment setting where limited health information could potentially be overheard. Private consultation areas are available upon request.

RELEASE OF RECORDS

I authorize Upper Arlington Family Chiropractic to release relevant medical and billing information as necessary for treatment, insurance processing, healthcare coordination, legal matters, or payment collection purposes.

Patient Name Printed _____
Patient Signature _____

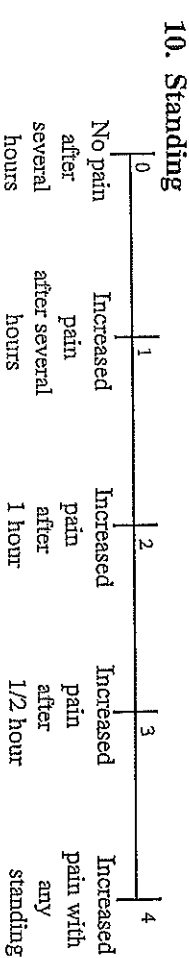
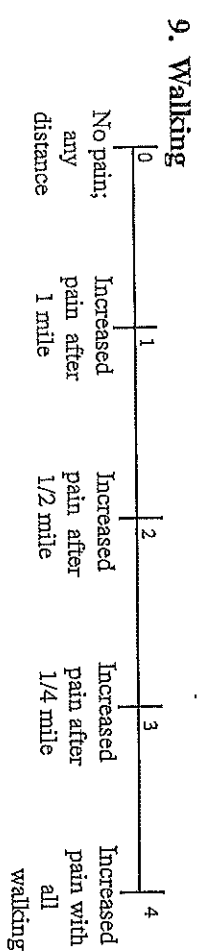
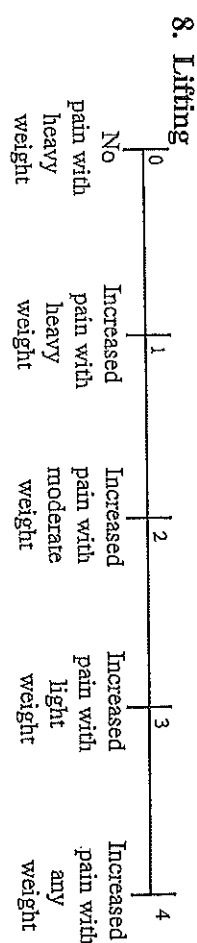
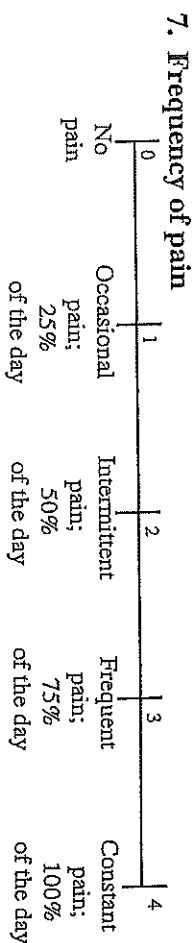
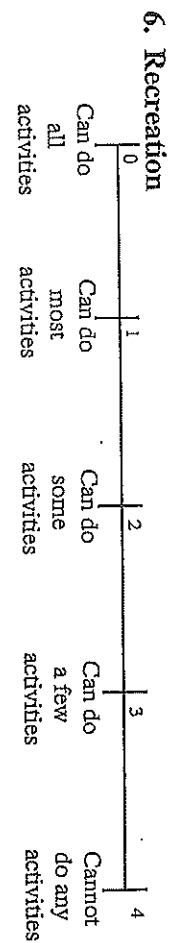
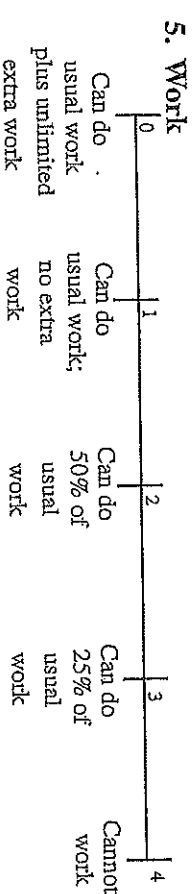
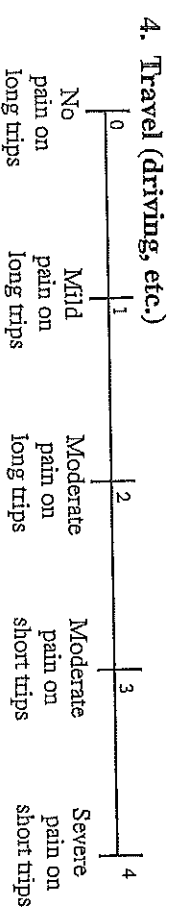
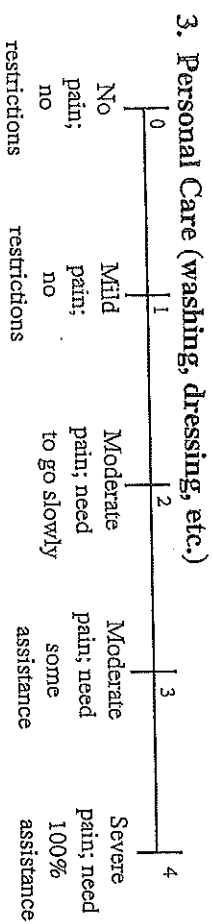
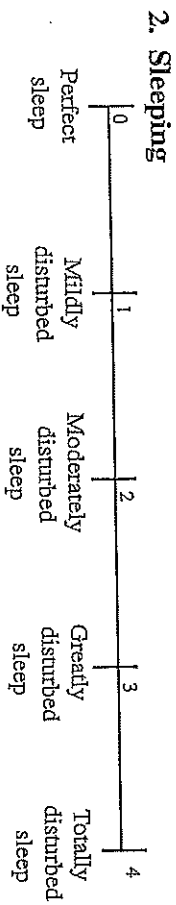
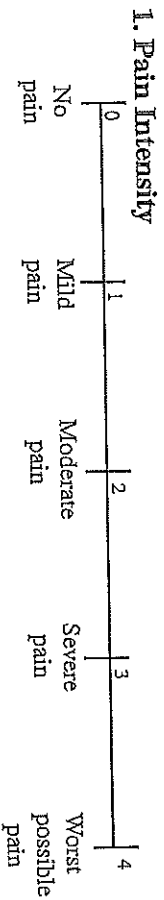
Date _____
Date _____

Minor's Name _____
Guardian Signature _____

Date _____
Date _____

Functional Rating Index

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**.



Name _____ **PRINTED**

Signature _____

Date _____

Upper Arlington Family Chiropractic

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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):
