101 Drake Lane, Milford, PA 18337
Phone: (570) 409-9500
Fax: (570) 409-9505

Patient Information

Full Name _____ Date:_____
First MI Last

Email* _____

* Your email will NOT be shared with any 3d parties and is used for occasional office announcements and promotions.

Address: _____ City:_____ State: _____ Zip: _____

Phone *Home* (_____)_____ *Work* (____)_____ *Cell* (_____)_____ Carrier _____
Please provide carrier for reminder text messages

Primary Contact ☐ Cell ☐ Home ☐ Work Reminder Text Message ☐ Yes ☐ No

Birth Date: _____ Age: _____ Social Security Number: _____-_____-_____ ☐ Female ☐ Male

Employer: _____ Occupation: _____

Marital Status: _____ Spouse's Name: _____

Emergency Contact: _____ Emergency Phone Number: (_____)_____

Whom may we thank for referring you? _____

Health Questionnaire

Current Complaints

Reason for your visit today?: ☐ Headache ☐ Neck Pain ☐ Mid Back Pain ☐ Low Back Pain ☐ Other _____

Are you here because of an accident? ☐ Yes ☐ No What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

How often do you experience symptoms? Constantly Frequently Occasionally Intermittently

Describe your symptoms? Achy Burning Dull Sharp Stiff Throbbing Numbness Shooting Tingling . Cramps Swelling Other_____

Are your symptoms? Getting better Staying the same Getting worse

On a scale of one to ten how intense are your symptoms? Not intense ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

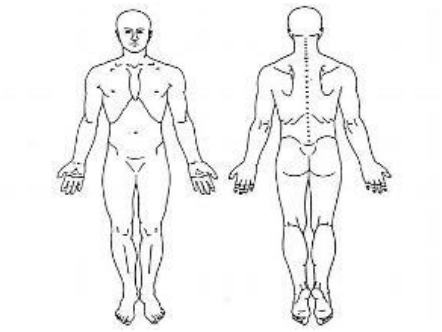
What **aggravates** this complaint? Sitting Standing Walking Getting up from seat Walking stairs Inactivity . Sleeping Physical Activity Exercise Movement Bending forward Bending backward Twisting . Reaching Lifting Desk work Sneezing Coughing Unknown Other:_____

What **relieves** this complaint? Sitting Standing Walking Resting Exercise Movement Stretching Massage Chiropractic Heat Ice Laying down Medication Nothing Unknown Other:_____

Is this condition interfering with your: Sleep Getting in or out of bed or chair Personal care Travel Work Recreation . Lifting Walking Standing Daily Routine Social Activities Exercise Other:_____

Have you experienced these symptoms in the past?_____

Describe location of problem and draw on diagram.



_____

_____

_____

History of Treatment

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

_____

Have you seen a chiropractor before? ☐ Yes ☐ No How long ago? _____

Medical History

Height: _____ Weight: _____

Please list any medications and/or supplements you are currently taking: _____

_____

Have you ever:

Broken bones?	☐ Yes	☐ No	Please Briefly Explain _____
Been hospitalized?	☐ Yes	☐ No	Please Briefly Explain _____
Been in an auto accident?	☐ Yes	☐ No	Please Briefly Explain _____
Had Sprains/Strains?	☐ Yes	☐ No	Please Briefly Explain _____
Been struck unconscious?	☐ Yes	☐ No	Please Briefly Explain _____
Had surgery?	☐ Yes	☐ No	Please Briefly Explain _____

Family History (list all major diseases such as cancer, heart problems, bone diseases and the relation to yourself):

_____

_____

Do you exercise? □ Yes □ No Hours/week _____What activity(s)? _____

Do you drink alcoholic beverages? □ Yes □ No _____drinks per day/week/month

Do you smoke? □ Yes □ No _____packs per day How many years have you been smoking? _____

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, how many weeks? _____

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
		Abdominal Pain			Excessive thirst			Neck pain
		Abnormal weight gain/loss			Frequent urination			Painful urination
		Allergies			General fatigue			Prostate problems
		Angina			Hand pain			Shoulder pain
		Ankle/foot pain			Heart Attack			Smoking/tobacco use
		Arthritis			Hepatitis			Stroke
		Asthma			High blood pressure			Systemic Lupus
		Bladder infection			Hip/upper leg pain			Thoracic outlet syndrome
		Cancer			HIV/AIDS			Tumor
		Chest pains			Hormone therapy			Ulcer
		Chronic sinusitis			Jaw Pain			Stroke
		Depression			Joint swelling/Stiffness			Systemic Lupus
		Dermatitis/Eczema			Kidney stones			Thoracic outlet syndrome
		Disc Herniation			Knee/lower leg pain			Upper back pain
		Dizziness			Liver/gallbladder disorder			Wrist pain
		Drug/Alcohol Abuse			Loss of bladder control			Other:
		Elbow/upper arm pain			Low back pain			
		Epilepsy/seizure disorder			Mid back pain			

Additional comments you would like the doctor to know: _____

INSURANCE/PRIVATE PAY INFORMATION

If you are not using insurance, please skip to page 4 (Private Pay Information)

Private Insurance Information

Insurance Company Name: _____ Policy Holder's Name: _____
Policy Holder's Birth Date: _____ Relationship to Patient: _____
Policy ID Number: _____ Group Number: _____

ASSIGNMENT/AUTHORIZATION/RELEASE (for those using insurance)

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Advanced Chiropractic of Milford all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

_____ ____/____/____
Signature Date

Please continue to page 4: Financial Policy

IF YOU ARE NOT USING INSURANCE, PLEASE READ AND SIGN THE FOLLOWING:

Private Pay Information

By signing below, I confirm that I am either uninsured or have chosen not to use insurance for these services. I understand that I am personally responsible for full payment at the time services are provided. I also acknowledge that by electing to proceed as a private pay client, I cannot submit claims to my insurance provider for reimbursement.

_____ ____/____/____

Signature Date

Financial Policy

Whether you are using insurance or electing to self-pay, please review the following policy carefully:

If you are using insurance: Your insurance policy is a contract between you and your insurance company. While we may be in-network with your plan and are happy to bill insurance on your behalf, any required co-pays, co-insurance, and/or deductibles are your financial responsibility. Please note that some insurance plans limit the number of visits or restrict coverage based on diagnosis codes. If your insurance company denies coverage—either partially or in full—you will be responsible for any remaining balance.

If you are not using insurance: Patients who are self-pay are responsible for the full cost of services at the time they are rendered. By electing to be a private pay client, you understand that you cannot submit claims to your insurance provider for reimbursement.

Payment Policy: **It is our office policy to collect co-pays, co-insurance, or estimated deductibles at the time of service for insurance clients, and to collect full payment at the time of service for private pay patients**

Cancellation Policy: Appointments must be canceled with at least 24 hours' notice, except in cases of weather-related conditions. Appointments canceled with less than 24 hours' notice will incur a $45 fee. If our office is closed, you may leave a voicemail to cancel your appointment. This policy is enforced.

By signing below, I acknowledge that I have read, understand, and agree to the terms of this financial and cancellation policy. I understand that I am personally responsible for any charges related to my care.

_____ ____/____/____

Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ ____/____/____

Signature Date

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me by the Doctor of Chiropractic of Advanced Chiropractic and/or any other Doctor of Chiropractic, who now or in the future treats me while employed by, working or associated with, or serving as back-up for the Doctors of Chiropractic named below, including those working at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fracture, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon 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 read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent for to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

_____ _____

Printed Name Date

_____ _____

Signature Witness

Chiropractic Consent to evaluate and adjust a minor child:

I, _____ (Parent/Guardian name) being the parent or legal guardian of _____ (Minor's name) have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Printed Name of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Witness