*office staff _____DL

Dr. Jennifer Finn
Dr. Krysten Schab
203 Greenwood Ave Unit 2
Clarks Summit, PA 18411
(570) 586-3440

ADULT PERSONAL INFORMATION

Legal Name _____ **Date** _____

Address_____

_____

Cell phone _____ Email _____

Date of Birth _____ **Age** _____ **Sex** _____ Gender _____Pronouns_____

Preferred Name (if different than legal name) _____ Occupation _____

Marital Status (check) ___Single ___Married ____Partnership ___Separated ___Widowed ____Divorced

Name of Spouse _____Do you have any children? If so, how many _____

Emergency Contact _____ **Relationship** _____ Phone (____) _____

ADDITIONAL INFORMATION

Can we leave a detailed message on your cell phone? _____ If alternate # please indicate_____

Can ***we leave appointment related info*** with anyone answering your phone? _____

Would you like to receive a text appointment reminder? _____

Do you give permission for the doctor to text you? _____

Would you like to receive *email updates* from the office and staff: _____ We promise not to spam!

How would you like to *receive bills for balances* on your account? *If you opt for email/text, you can submit payment online with a credit card. If you opt for mail, you will need to mail a payment back.
Check one of the following: ____Email ____Text ____Mail

How did you hear about Finn Chiropractic Center? _____If you were referred by someone, please let us know! **We are grateful for referrals** and would like to thank them personally!

Reason for Seeking Chiropractic Care

Please check reason(s) for care:

____ **Wellness Focused** ___ Family/Friend Recommended ___Not sure

____ **Problem Focused** and if so, describe: _____

Is it due to an *auto-accident or worker's compensation case*? _____

Problem/Pain/Discomfort

If pain/discomfort is involved, please answer the following:

When did it start? _____

When does it occur? ___constant ___AM ___PM ___comes & goes ___other

How frequent does it occur? ___constant ___frequent ___occasional ___intermittent

Severity of pain on a scale of 1 (mild) to 10 (severe): _____

Type of pain/discomfort: ___dull ___sharp ___achy ___shooting ___stiffness ___throbby ___burning

___numbness ___tingling ___swelling ____other and if so, explain _____

Since it started, it is currently: _____about the same _____ getting better _____ getting worse

It is impacting: ___work ____walking ___lifting ___sitting ___reclining ___bathing ___bending ___driving

___exercise ___sleep ___standing ___other: _____

Have you had this or something similar before? _____

Have you seen someone for this problem and if so, who? _____

What have you done to help relieve this problem? _____

_____ Did it help? _____

Health History

Do you currently have *any (other) health concerns*? If so, please explain

_____

_____

Did you have *covid, covid vaccine, and/or monoclonal antibodies*? If so, please explain

_____

How would you rate *your current health*? Poor Fair Average Good Excellent
How would you rate *your family's health*? Poor Fair Average Good Excellent

Are you currently seeking medical attention and if so, for what? _____

_____

_____

Have you received chiropractic care before? _____ If so, date of last visit _____
Is anyone in your family currently under chiropractic care? If yes, who? _____

Physical Stress

Please **check** any of the following that **currently apply (C)** or have applied in **the past (P)**

___ Accident Prone
___ Repetitive Tasks
___ Prolonged Driving
___ Prolonged Standing
___ Other
___ **Surgery**
___ Automobile Accident
___ Slips/Falls
___ Manual Labor
___**Bone Fracture or Dislocation**
___ Sports/Exercise
___ Poor Posture
___ Hospitalizations

Explain any of the above: _____

_____

Chemical Stress

Please list any current **medications** and/or supplements

_____

_____

_____

Please **check** any of the following:

___ Exposure to secondhand smoke
___ **Smoker**
___ **Allergies** If so, explain _____
___Caffeine
___ Alcohol
___Recreational Drugs
___ Junk food

Emotional Stress

Please **check** any of the following:

___ Relationships
___ Career
___ Family
___Finances
___ School
___ Depression
___Anxiety
___ Attention/ Focus
___ Easily Irritated

What do you feel is the *primary stress* in your life? _____

Wellness History

What does wellness mean to you? _____

What activities or modalities support your health and wellness journey in addition to chiropractic?

_____

Anything else we should know that would help us best serve you? _____

_____

Insurance Information

Primary Policyholder's Name: _____Policyholder's Date Of Birth: _____

Address (if different than above): _____

_____

Patient relationship to primary policyholder: self _____ spouse _____ child _____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such chiropractic care to a third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

(Signature of Patient or Guardian)