FAIRVIEW PARK CHIROPRACTIC CENTER

FAIRVIEW PARK CHIROPRACTIC CENTER INC

WELCOME

PLEASE FILL OUT ALL INFORMATION BELOW

TODAY'S DATE _____ S.S. # _____

NAME _____ SEX _____ AGE _____

HOME PH# _____ CELL/WORK PH# _____

E-MAIL (FOR NEWSLETTERS AND INFO.) _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

BIRTHDATE _____ MARITAL STATUS M S W D (CIRCLE ONE)

HOW MANY CHILDREN DO YOU HAVE? _____ (WE TREAT YOUNG KIDS TOO!)

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____

NAME OF SPOUSE_____ SPOUSE'S OCCUPATION _____

WHOM SHALL WE NOTIFY IN CASE OF AN EMERGENCY? _____

PH# OF PERSON TO NOTIFY _____

WE TRULY APPRECIATE REFERRALS TO OUR OFFICE! WHOM MAY WE

THANK FOR REFERRING YOU? _____

HOW DID YOU HEAR ABOUT US? _____

PAYMENTS AND CO-PAYMENTS ARE EXPECTED AT TIME OF SERVICE

IF YOUR ACCOUNT WOULD BECOME DELIQUENT AND COLLECTION PROCEDURES ARE NECESSARY TO COLLECT, A $36 COLLECTION CHARGE WILL BE ASSESSED.

NAME OF PERSON RESPONSIBLE FOR PAYMENT _____

PATIENT'S SIGNATURE _____

GUARDIAN'S SIGNATURE (IF PATIENT IS A MINOR) _____

PATIENT NAME: _____ Case No. _____

DATE OF BIRTH: _____

FAIRVIEW PARK CHIROPRACTIC CENTER
TODD W. SMITH, D.C.
21881 LORAIN RD.
FAIRVIEW PARK, OH 44126
440-331-9033

DATE _____ INTERVIEWER _____

Do you have chest pain?	Yes ___	No ___
Do you have any change in bowel or bladder habits?	Yes ___	No ___
Do you have a sore that does not heal?	Yes ___	No ___
Do you have any unusual bleeding or discharge?	Yes ___	No ___
Do you have any thickening in your breasts or elsewhere?	Yes ___	No ___
Do you have indigestion or difficulty in swallowing?	Yes ___	No ___
Do you have a change in any wart or mole?	Yes ___	No ___
Do you have a nagging cough or hoarseness?	Yes ___	No ___
Do you have headaches for hours or days?	Yes ___	No ___
Do you have blurred vision?	Yes ___	No ___
Do you have night sweats?	Yes ___	No ___
Do you have pain in neck, jaw or face?	Yes ___	No ___
Do you have a drooping eyelid or any change in your pupils?	Yes ___	No ___
Do you have vertigo (dizziness)?	Yes ___	No ___
Do you have double vision?	Yes ___	No ___
Do you have any visual disturbances?	Yes ___	No ___
Do you have any nausea or vomiting?	Yes ___	No ___
Do you have any slurred speech?	Yes ___	No ___
Do you have any ringing in your ears?	Yes ___	No ___
Do you pass out easily (faint)?	Yes ___	No ___
Do you take birth control pills?	Yes ___	No ___
Do you have a history of stroke in your family?	Yes ___	No ___

What prescription medication are you taking if any?

[ ] High blood pressure medication
[ ] Blood thinners
[ ] Other_____
[ ] List allergies or adverse reactions to medications_____
_____

Have you ever had cancer? Yes ___ No ___

Does your pain ever wake you from a sound sleep? Yes ___ No ___

Are you losing weight now without trying? Yes ___ No ___

Are you coughing up blood or noticing it in your stools or urine? Yes ___ No ___

Have you had any loss of bladder or bowel control? Yes ___ No ___

Have you lost consciousness or had double vision recently? Yes ___ No ___

Are you seeing any other doctor now for any reason? Yes ___ No ___

Note: _____

Are you taking any medications or over-the-counter drugs? Yes ___ No ___

Please indicate type (aspirin, etc.) _____

What was the date of onset of your last menses? _____

SOCIAL HISTORY

SMOKER _____YES or _____NO, If Yes, How many packs_____
ALCOHOL _____YES or _____NO, If Yes, How much_____

FAMILY HISTORY

Did your mother or father have any of the following:
Put an **M** for mother, **F** for father, and **B** for both

( ) High Blood Pressure
( ) Heart Attack
( ) Emphysema
( ) Seizures-Convulsions
( ) HIV Positive
( ) Asthma
( ) Diabetes
( ) Kidney Disease
( ) Pacemaker
( ) Ulcer or Stomach Problems
( ) Stroke
( ) Arthritis-Rheumatism
( ) Mental Illness
( ) Thyroid Disease
( ) Circulation Problems
( ) Cancer
( ) Osteoporosis

Comments:_____

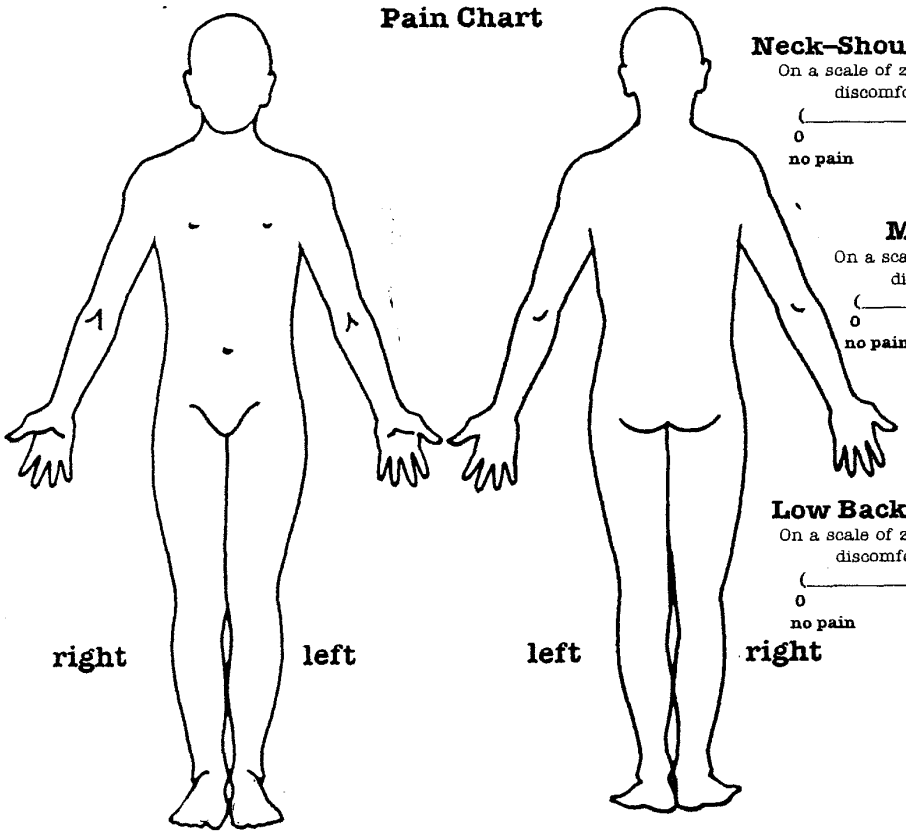
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Pain Chart



Neck–Shoulder–Arm Pain
On a scale of zero to 10, I rate my discomfort as follows:
0 — 10
no pain — **severe pain**

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:
0 — 10
no pain — **severe pain**

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:
0 — 10
no pain — **severe pain**

Date:_____

_____
Signature

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

Signature Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Fairview Park Chiropractic Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ Date: _____