



# APPLICATION FOR CARE AT EMBRACE CHIROPRACTIC - ADULT

**PRACTICE MEMBER HEALTH REVIEW:** Today's Date: \_\_\_/\_\_\_/\_\_\_ PMID#: \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_-\_\_\_-\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Carrier: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Preferred Method of Contact:  Email  Home Phone  Cell Phone

Marital Status:  Single  Married  Divorced  Widowed

Driver's License Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Number of children, names, and ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Previous Chiropractic Care:  No  Yes When: \_\_\_\_\_ Where: \_\_\_\_\_

*Whom may we thank for referring you to this office?* \_\_\_\_\_

## HISTORY of COMPLAINT:

Please identify the condition(s) that brought you to this office:

Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_

Third: \_\_\_\_\_

Fourth: \_\_\_\_\_

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by **circling the number**:

**Primary** or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Second** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Third** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Fourth** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM

How long does it last?  It is constant **OR**  I experience it on and off during the day **OR**  It comes and goes throughout the week

Have you suffered from this before?  No  Yes **If yes**, how many times? \_\_\_\_\_ When was the last episode? \_\_\_\_\_

Have you tried other treatments:  No  Yes **If yes, please state what type of treatment:** \_\_\_\_\_

Who provided it: \_\_\_\_\_ How long ago? \_\_\_\_\_

Were the results  Favorable  Unfavorable → please explain. \_\_\_\_\_

**PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

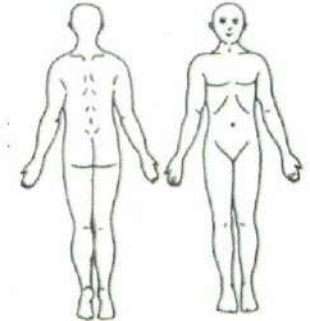
**R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling**

What relieves your symptoms? \_\_\_\_\_

What makes your symptoms feel worse? \_\_\_\_\_

Is your problem the result of ANY type of injury/accident?  No  Yes

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:



**PAST HISTORY:**

Please identify any and all jobs that you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have or **N** for **Never** have had:

- \_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Disability \_\_\_ Cancer  
\_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular/Stroke \_\_\_ Other serious conditions: \_\_\_\_\_

**PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:**

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

**SOCIAL HISTORY:**

1. **Smoking:**  cigars  pipe  cigarettes How often?  Daily  Weekends  Occasionally  Never  
2. **Alcoholic Beverage:** consumption occurs  Daily  Weekends  Occasionally  Never  
3. **Recreational Drug use:**  Daily  Weekends  Occasionally  Never

I hereby authorize payment to be made directly to Embrace Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Embrace Chiropractic for any and all services I receive at this office.

\_\_\_\_\_  
**Practice Member or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date**

Please mark **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Headache                           | <input type="checkbox"/> Pregnant (Now)         | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Prostate Problems        | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Neck Pain                          | <input type="checkbox"/> Frequent Colds/Flu     | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Jaw Pain, TMJ                      | <input type="checkbox"/> Convulsions/Epilepsy   | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Digestive Problems       | <input type="checkbox"/> Heart Problem        |
| <input type="checkbox"/> Shoulder Pain                      | <input type="checkbox"/> Tremors                | <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Colon Trouble            | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Upper Back Pain                    | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Blurred Vision  | <input type="checkbox"/> Diarrhea/Constipation    | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Mid Back Pain                      | <input type="checkbox"/> Pain w/Cough/Sneeze    | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems      | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Low Back Pain                      | <input type="checkbox"/> Foot or Knee Problems  | <input type="checkbox"/> Hearing Loss    | <input type="checkbox"/> Menstrual Problem        | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain                           | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression      | <input type="checkbox"/> PMS                      | <input type="checkbox"/> Lung Problems        |
| <input type="checkbox"/> Back Curvature                     | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable       | <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Kidney Trouble       |
| <input type="checkbox"/> Scoliosis                          | <input type="checkbox"/> Skin Problems          | <input type="checkbox"/> Mood Changes    | <input type="checkbox"/> Learning Disability      | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers |   | <input type="checkbox"/> ADD/ADHD        | <input type="checkbox"/> Eating Disorder          | <input type="checkbox"/> Liver Trouble        |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes     |   | <input type="checkbox"/> Allergies       | <input type="checkbox"/> Trouble Sleeping         | <input type="checkbox"/> Hepatitis (A,B,C)    |

Are you currently taking any medications (prescription or non-prescription)?  No  Yes

If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

## INFORMED CONSENT

### REGARDING Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

**Chiropractic** is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

**Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations.

**Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebrae in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that practice members may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

**I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.**

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Embrace Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. Having this knowledge, I knowingly authorize chiropractic care with Embrace Chiropractic by any means, method, and or techniques, the doctor deems necessary at any time throughout the entire clinical course of my care.

\_\_\_\_\_  
Practice Member or Authorized Person's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



Witness Initials

**REGARDING Parental Consent for Minor Practice Member**

Practice Member Name: \_\_\_\_\_ Practice Member Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Printed name of person legally authorized to sign for

Practice Member: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Practice Member: \_\_\_\_\_

In addition, by signing below, I give permission for the above named minor practice member to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Practice Member: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Practice Member: \_\_\_\_\_

**REGARDING Non-Pregnancy Verification**

**FEMALES ONLY** → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

The first day of my last menstrual cycle was on \_\_\_\_ - \_\_\_\_ - \_\_\_\_ (Date)

I hereby notify all concerned that I neither suspect nor know positively at this time that I may be pregnant. I release this clinic from any and all damages arising from any and all procedures of diagnostic x-rays or care nature with reference to the possibility of pregnancy.

\_\_\_\_\_  
Practice Member or Authorized Person's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



Witness Initials

**EMBRACE CHIROPRACTIC NOTICE OF PRIVACY PRACTICE**

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

**PERMITTED DISCLOSURES:**

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.

10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

**YOUR RIGHTS:**

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. At your request, we will provide you with a copy of your x-rays in our files. **The fee for copying your x-rays on a disc is \$15.00. This fee must be paid in advance.** (Please note: x-rays are utilized in this office to locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctor does not diagnose or treat medical conditions; however, if any abnormalities are noted, we will bring it to your attention so you can seek proper medical advice.

**COMPLAINTS**

If you wish to make a formal complaint about how we handle your health information, please call Drs. Jared Morgan & Stevie Marie Iorio at (724)-674-4563. If she is unavailable, you may make an appointment with our front desk coordinator to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
 200 Independence Ave. SW Room  
 509F HHH Building  
 Washington DC 20201

I have received a copy of EMBRACE CHIROPRACTIC Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Practice Member's Name	DOB	HR#
Practice Member's Signature	Date	
Witness	Date	