ALIGNED CHIROPRACTIC
& PHYSICAL REHABILITATION

39000 Mentor Ave.
Willoughby, OH 44094
p. 440.953.3950
f. 440.953.3953

1610 West 11th St.
Ashtabula, OH 44004
p. 440.536.5475
f. 440.536.5451

HEALTH HISTORY INFORMATION

All information you supply is confidential according to HIPPA.

_____ _____
Today's Date Please List your Primary Doctor's Name and Phone #

_____ O Male O Female _____
First Name Middle Initial Last Name Social Security #

_____ _____ Married? OYes ONo
Street Address Birth Date

_____ ____ _____ (____)_____ (____)_____ (____)_____
City State Zip Code Home Phone Cell Phone Work Phone

_____ _____ (____)_____
Email Address Emergency Contact Person Phone

_____ _____ May we contact you at work? OYes ONo
Your Occupation Employer's Name

_____ _____ Who carries policy? OSelf OSpouse OParent
Insurance Carrier Policy Number

_____ _____
Insured's First Name Middle Initial Last Name Insured's Employer

INJURY OR ILLNESS INFORMATION

What is the current reason that you are seeking care/evaluation at our office? OWork Injury OCar Accident OHealth/Wellness

When did this problem begin? _____ OEvaluation ONutrition OOther_____

Describe the Injury/Illness:_____

_____ _____
Current Symptoms/Complaints: **Pain Level (0 – 10)**

What type of pain are you having? ODull/Achy OThrobbing OSharp OStiffness OBurning ONumbness/Tingling OStabbing

Do the Symptoms travel anywhere? _____ O Other_____

What makes it worse?_____

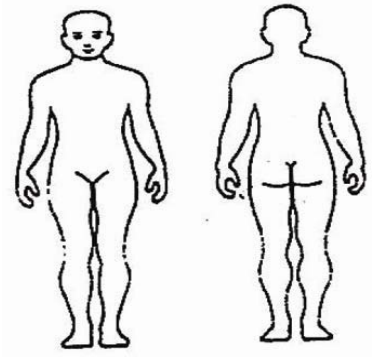
What makes it better?_____

Is the pain Constant? OYes ONo If not, how often?_____

What have you tried to relieve pain? _____

_____

Location of your Pain (Mark an X):



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Please list activities (work/home/hobbies/relations) that you cannot do as a result of your symptoms: _____

_____

Please mark the following that you've had or currently have: O Neck Pain O Back Pain O Shoulder Pain O Elbow/Wrist Pain O Hip Pain O Knee Pain O Ankle/Foot Pain O Headaches O TMJ Issues O Scoliosis O Arthritis O Osteoporosis O Depression O Numbness/Tingling O Anxiety O High Blood Pressure O Low Blood Pressure O High Cholesterol O Heart issues O Asthma O Emphysema O Shortness of Breath O Pneumonia O COPD O Congestive Heart Failure O Anorexia/Bulemia O Food Allergy O Ulcer O Heartburn O Bowel/Bladder Issues O Psoriasis O Hair loss O Other Skin Issues O Thyroid Disorders O Hypoglycemia O Immune Disorders O Chronic Infections O Swollen Glands O Low Libido O Kidney Stones O Prostate Issues O PMS Issues O Erectile Dysfunction O Fainting O Loss of Apetite O Low Energy/Fatigue O Sudden Weight Change O Weakness O Cancer _____
O Other _____

PAST HISTORY/FAMILY HISTORY

Please mark the following injury/illnesses you've had or currently have: O AIDS O Alcoholism O Allergies O Arteriosclerosis O Chicken Pox O Diabetes O Epilepsy O Glaucoma O Goiter O Gout O Heart Disease O Hepatitis O Measles O Multiple Sclerosis O Mumps O Sexually Transmitted Disease O Stroke O Tuberculosis O Rheumatoid Arthritis O Broken Bone O Spine or Nerve Disorder O Knocked Unconscious O Injured in an Accident O Used any Brace/Crutch
O Other _____

Please list any surgeries you have ever had: _____

Please list all current medications/Supplements:_____

_____

Please List all Disorders in your immediate family and/or causes of death: _____

_____

SOCIAL HISTORY/DAILY LIFE

Do you drink alcohol? O Yes O No – How Often? _____ Do you smoke? O Yes O No – How Often? _____

How many times a week to you Exercise? _____ drink caffeine/coffee? _____ take pain medication? _____

How much water do you drink per day? _____ Does work cause you stress? _____ Other Stress? _____

How much sleep do you get per night? _____ Hours What position do you sleep in? _____ How old is mattress? _____

How many meals a day do you eat? _____ Do you snack? _____ Would you say your diet is nutritious? _____

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Please mark (x) how the following activities are affected by your injury/symptoms:

Sitting	no issue____	limited ____	unable ____	**Self Care**	no issue____	limited ____	unable ____
Standing	no issue____	limited ____	unable ____	**Care of Others**	no issue____	limited ____	unable ____
Walking	no issue____	limited ____	unable ____	**Lifting**	no issue____	limited ____	unable ____
Sleeping	no issue____	limited ____	unable ____	**Reaching**	no issue____	limited ____	unable ____
Climbing Stairs	no issue____	limited ____	unable ____	**Reach Overhead**	no issue____	limited ____	unable ____
Working	no issue____	limited ____	unable ____	**House Chores**	no issue____	limited ____	unable ____
Lying Down	no issue____	limited ____	unable ____	**Exercise**	no issue____	limited ____	unable ____
Bending	no issue____	limited ____	unable ____	**Concentrating**	no issue____	limited ____	unable ____
Using computer	no issue____	limited ____	unable ____	**Enjoying Life**	no issue____	limited ____	unable ____
Driving	no issue____	limited ____	unable ____	**Being Social**	no issue____	limited ____	unable ____

Please tell us what you would like to accomplish to change your health/symptoms: _____

_____

Please tell us anything further you feel we may need to know: _____

_____

CONSENT FOR TREATMENT

Initials _____ I give my consent for the chiropractic physician to provide treatment that he/she feels medically appropriate for my current injuries/symptoms. I understand that chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials_____ I understand that my health records are private and this office follows all the HIPPA regulations and I provide my consent to send my medical records to any insurance company, attorney, or other third party that requires the records for payment of services or requires the medical file.

Initials_____ I provide my consent for x-ray examination if the chiropractic physician feels it is medically necessary. I (if female) recognize that x-ray radiation can be hazardous to an unborn child and I provide my consent that I am not pregnant at this time.

Initials_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials ____ I grant permission to obtain/review previous bureau of workers compensation claims, as they may affect current complaints.

Initials ____ In the event I received solicitation through phone, mail, or other avenue, I affirm that Aligned Chiropractic and Physical Rehabilitation did not misrepresent themselves as an Insurance Company or the Bureau of Workers Compensation.

Initials____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

For child under the age of 18: _____ _____
Minors Full Name Date

_____ _____
Print Name Sign Name Date

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Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment 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 care if he/she 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 healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor 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 regimen. I understand that if I am accepted as a patient by a physician at **Aligned Chiropractic and Physical Rehabilitation**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

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Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPAA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, email or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

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CONSENT TO RECEIVE MASSAGE/MANUAL THERAPY

I understand that massage/manual therapy may provide benefits for certain conditions but results may differ from individual to individual. These benefits may include relief of muscular tension, increasing circulation, reduction in the symptoms of injury-related conditions, and provision of general wellbeing. I also understand that massage/manual therapy may produce side effects such as muscle soreness, bruising and/or discoloration, increased awareness of areas of pain and light-headedness amongst other possible temporary outcomes. I will tell the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly. I am aware that the therapist does not diagnose illnesses, prescribe medications nor physically manipulate the spine or its immediate articulations. I understand that massage/manual therapy is not a substitute for medical care and that it is recommended that I work with my doctor for any condition I may have. I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

_____
Print

_____
Sign

_____
Date