Notice of 24 hour Cancellation:

We are now implementing a 24 hour cancellation policy in order to accommodate all of our patients. With the exception of emergencies, you will be charged with an office visit of $40.00. This policy gives time and opportunity for patients on a waiting list to be seen.

Thank you for your consideration of other patients!

_____(sign) _____(date)

Chiropractic Case History/Patient Information

Date:_____ **Name of Primary Health Insurance:**_____

Name: _____MI_____ Social Security #_____ Home Phone: _____

Address: _____City:_____ State: _____ Zip: _____

E-mail Address: _____ Cell Phone: _____

Age: _____ Birth Date: _____ Gender: M F Marital: M S W D

Occupation: _____ Employer: _____Office Phone:_____

Spouse:_____ Birth Date:_____ Employer:_____

Emergency Contact: _____ Address:_____Phone:_____

Family Medical Doctor: _____

May we have your permission to update your medical doctor regarding your care at this office? _____

How did you hear about us?_____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____ Is this due to: Auto_____ Work_____ Other_____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe: _____

Days lost from work:_____ Date of last physical examination:_____

List all prescription, over-the-counter medications, and nutritional/herbal supplements you are taking:

_____

Have you ever seen a chiropractor before?_____ If yes, Name of Dr.:_____ Location: _____

Date of last visit: _____ (approx)

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have allergies of any kind?

Family Diseases check if applicable and indicate with an/a **F, M, S, B** pertaining to the appropriate family member **F**ather, **M**other, **S**ister, **B**rother):

___ Tuberculosis ___ Cancer ___ Mental Illness ___ Diabetes ___ Asthma
___ Stroke ___ Kidney Disease ___Lung Disease ___ Arthritis ___Liver Disease
___ Heart Disease ___ Other: _____

PAST MEDICAL HISTORY

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No
If yes, please describe: _____

SOCIAL HISTORY:

Do you drink alcoholic beverages? _____ If so, how much per week? _____
Do you use any tobacco products? _____ Do you smoke? ____ If so, packs per day: _____
Do you consume caffeine? ____ If so, how much per day: _____
What are your hobbies? _____
What % of time during the day (at home or at your job) do you spend: lifting_____ sitting_____ bending_____at the computer_____
What type of regular exercise do you perform? ○ None ○ Light ○ Moderate ○ Strenuous

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AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Patient Health Questionnaire – PHQ

Patient Name_____ **Date** ____ / ____ / ____

1. Describe your symptoms _____

_____

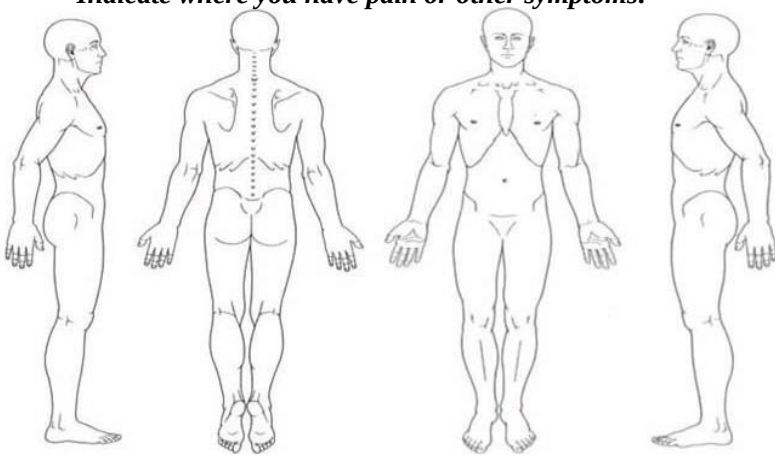
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms:



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting better
② Not changing
③ Getting worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms: None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. For each of the conditions listed below, place a check in the past column if you have had the condition in the past and place a check in the present column if you have the condition presently. Circle L for Left and R for Right where applicable.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Freq. Urination
○	○	Mid Back Pain	○	○	Stroke	○	○	Ruptures
○	○	Low Back Pain	○	○	Angina	○	○	Coughing Blood
			○	○	Kidney Stones	○	○	Eating Disorder
○	○	Shoulder Pain L R	○	○	Kidney Disorders	○	○	Pace Maker
○	○	Elbow/Upper Arm Pain L R	○	○	Bladder Infection	○	○	Allergies
○	○	Wrist Pain L R	○	○	Painful Urination	○	○	Depression
○	○	Hand Pain L R	○	○	Loss of Bladder Control	○	○	Systemic Lupus
			○	○	Prostate Problems	○	○	Epilepsy
○	○	Hip/Upper Leg Pain L R	○	○	Abnormal Weight Gain/Loss	○	○	Dermatitis/Rash
○	○	Knee/Lower Leg Pain L R	○	○	Loss of Appetite	○	○	HIV/AIDS
○	○	Ankle/Foot Pain L R	○	○	Abdominal Pain	○	○	Drug/Alcohol Dependence
○	○	Ulcer	○	○	Osteoarthritis	○	○	Smoking/Use Tobacco Prod.
○	○	Jaw Pain L R	○	○	Hepatitis			
			○	○	Liver/Gall Bladder Disorder			
○	○	Joint Swelling/Stiffness	○	○	Cancer			
○	○	Arthritis	○	○	Tumor	**Females Only**		
○	○	Rheumatoid Arthritis	○	○	Asthma	○	○	Hormonal Rep.
			○	○	Chronic Sinusitis	○	○	Pregnancy
○	○	General Fatigue	○	○	Broken/Fractured Bones	○	○	Birth Control
○	○	Muscular Incoordination	○	○	Circulatory Problems			
○	○	Visual Disturbances	○	○	Seizures/Convulsions	**Other Health Problems**		
○	○	Dizziness	○	○	A Congenital Disease	○	○	
○	○	Numbness/Tingling	○	○	Excessive Bleeding	○	○	

Patient Signature_____ **Date** ____ / ____ / ____

Align SPORTS CHIROPRACTIC & HEALTH CENTER

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Name(s) and Address(es) of Office or Clinic
Align Sports Chiropractic and Health Center
520 Philadelphia St.
Indiana, PA 15701

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____
Printed name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Patients' Representative (if minor or physically incapacitated) Date

Align SPORTS CHIROPRACTIC & HEALTH CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, Align Sports Chiropractic, creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care.

I understand that this information is used as a means of communication among Align Sports Chiropractic personnel and with medical personnel outside of this practice.

I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we bill for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients.

I have been provided an opportunity to review the Notice of Privacy Practices for the Align Sports Chiropractic that provides a more complete review of information used and disclosures.

I understand that I have the right to review this Notice of Privacy Practice before signing this consent.

I understand that the Align Sports Chiropractic may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at t he central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that the Align Sports Chiropractic is not required to agree to the restrictions requested. The procedures to request restriction on information used and disclosure is contained in the Notice of Privacy Practices.

I Acknowledge that I have received a copy of the Notice of Privacy Practices of Align Sports Chiropractic and agree to the liability limitations explained therein.

_____ _____ _____

Signature of Patient or Legal Representative. **Date** **Relationship to Patient**

_____

Printed Name of Patient

Effective Date April 14, 2003