Power Chiropractic Health Center

West End Plaza
113 West End Road
Wilkes Barre, PA 18706
(570) 829-3580

Patient History

(Please Print)
(All information is confidential)

Last Name ______________________ **First Name** ______________________ **Middle Initial** ________

D.O.B ______ /______ / ______ **Age** ________ ☐ **Male** / ☐ **Female**

Address ______________________ **City** ______________________ **State** _____ **ZIP**__________

Phone (H) ______________________ **(W)** ______________________ **(C)** ______________________ **SSN** _______ - ______ - _______

E-mail____

Insurance? ☐ **Yes** ☐ **No** **Insurance** ______________________**Policy #** ______________________

If insured, an insurance card will be required on the first visit so our office can verify your benefit eligibility on your behalf.

Employer's Name ____

Employed: ☐ ***Full-time*** ☐ ***Part-time*** ☐ ***Retired*** ☐ ***Not Employed***

Occupation ____

Student: ☐ ***Full-time*** ☐ ***Part- Time***

If Under 18 **- Name of Guardian** ______________________ **Relationship to Patient** ______________________

Contact Phone (H) ______________________ **(W)** ______________________ **(C)** ______________________

Status: ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced**

Spouse's Name ______________________ **Spouse's Employer** ______________________

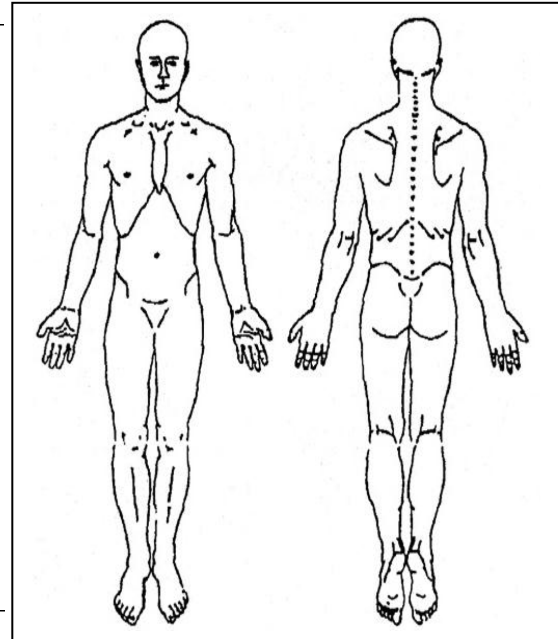
# of Children __________________

How did you hear about us? ☐ Referral ☐ Radio ☐ Television ☐ Health Workshop

Whom can we thank for referring you to us? ____

SUBJECTIVE *(Please fill out completely)*

MARK AREA OF COMPLAINT ON DIAGRAM



Using the body chart above, indicate the region(s) of your complaint using the following symbols:

Ache x x x x x **Burning** / / / / / /
Pins & Needles o o o o **Stabbing** + + + +
Throbbing = = = = **Other** - - - - - -

Major Complaint: ____

My Complaint is best described as: ☐ Pain ☐ Muscle Spasm ☐ Swelling ☐ Numbness ☐ Tingling

WHEN did you first notice your condition? ______________________________

The QUALITY of my main complaint is BEST described as:

☐ Sharp ☐ Dull ☐ Throbbing ☐ Stabbing ☐ Local ☐ Radiating

I experience my complaint: ☐ Constantly ☐ Intermittently

Please rate the *severity* of each complaint you present with today (Please circle)

(0= No Pain….10=Extreme Pain)

1. ____________________________ 0 1 2 3 4 5 6 7 8 9 10
2. ____________________________ 0 1 2 3 4 5 6 7 8 9 10
3. ____________________________ 0 1 2 3 4 5 6 7 8 9 10
4. ____________________________ 0 1 2 3 4 5 6 7 8 9 10

Describe what makes your condition feel better? (i.e. Heat, Ice, Sitting, Standing)

____

Have you had this condition before? ☐ Y ☐ N If yes, when? ____________

Have you lost workdays? ☐ Y ☐ N If yes, how many? ________________

Have you had a similar condition in the past? ☐ Y ☐ N If yes, when? __________

What doctors have you seen for this condition? ________________________

What did they do? ____

When was your last visit to a chiropractor? ____________________________

Name of Chiropractor: ____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine?

____

Did you follow it? ___________If not, why? ____

Why are you changing chiropractors?____

What is/are your health goal(s)?____

How do you expect to achieve these goals? ____

List ALL previous Surgeries: ____

List ALL Medications you currently use (prescription and over-the-counter): _________________________

____

List ANY Vitamins/Supplements you are currently using: _______________________________________

____

Is your visit due to an accident, injury or trauma? Y_____N_____ If so, was it AUTO________ Work-related________

Describe the events of the accident: ____

____

Have you seen any other health care providers for this accident, injury or trauma? Y___N___ Who?______________________

What treatment did you receive? ____

****On a scale of 1-10, please <u>circle</u> the importance of your health.**

<u>1 (not important at all) 10 (extremely important)</u>

1 2 3 4 5 6 7 8 9 10

SUPPLEMENTAL HEALTH HISTORY

PLEASE MARK ANY SYMPTOMS YOU HAVE HAD IN THE PAST 12 MONTHS:

Musculoskeletal

- ☐ Auto Accidents
  - ___ 0-1 year ago
  - ___ 1-5 years ago
  - ___ More than 5 years
- ☐ Fractured Bones
- ☐ Pain/Stiff Neck R / L
- ☐ Upper Back Pain/Stiffness
- ☐ Mid Back Pain/Stiffness
- ☐ Low Back Pain/Stiffness
- ☐ Numbness, Tingling or Pain in Buttocks/Legs/Feet/Toes R / L
- ☐ Numbness/Tingling/Pain Arms/Hands/Fingers R / L
- ☐ Swollen/Painful Joints
- ☐ Difficulty in Excessive Standing, Walking, Bending, Riding, Twisting, Lifting, Household Duties
- ☐ Other Accidents/Falls
- ☐ Back Curvature/Scoliosis
- ☐ Shoulder Pain R / L
- ☐ Arthritis
- ☐ Jaw Pain/TMJ R / L
- ☐ Foot Pain R / L
- ☐ Hip Pain R / L

Neurological

- ☐ Convulsions/Epilepsy
- ☐ Learning Disability
- ☐ Loss of Balance
- ☐ Dizziness
- ☐ Ringing in Ears R / L
- ☐ Trouble Concentrating
- ☐ Irritable
- ☐ Fainting
- ☐ Hearing Loss R / L
- ☐ Tremors
- ☐ Double Vision R / L
- ☐ Trouble Sleeping
- ☐ Blurred Vision R / L
- ☐ Mood Changes
- ☐ Headache
- ☐ Pain with cough, sneeze
- ☐ Depressed
- ☐ Stress
- ☐ Eating Disorders

Digestive

- ☐ Diarrhea/Constipation
- ☐ Heartburn
- ☐ Colon Trouble
- ☐ Gall Bladder Trouble
- ☐ Diabetes
- ☐ Ulcers
- ☐ Hemorrhoids

Immune

- ☐ Frequent Colds/Flu
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Ear Infection
- ☐ Allergies/Sinuses
- ☐ Cancer
- ☐ AIDS/HIV

Other Systems

- ☐ Kidney Trouble
- ☐ Chest Pain
- ☐ Lung Problems
- ☐ Heart Problems
- ☐ Liver Trouble
- ☐ High/Low Blood Pressure
- ☐ High/Low Cholesterol
- ☐ Head/Shoulders Feel Tired
- ☐ Stroke
- ☐ Anemia
- ☐ Prostate Problems
- ☐ Impotence
- ☐ Skin Problems
- ☐ Thyroid Problems
- ☐ Varicose Veins
- ☐ Bed Wetting
- ☐ Menopausal Problems
- ☐ Menstrual Problems/PMS
- ☐ Pregnant (now)

Doctor Signature:_______________________________________ **Date:**_______________________________

Goals for My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and other for their correction of whatever is malfunctioning in their bodies.

Your doctor will weigh your needs and desires when recommending your treatment program

__ **Relief Care:** Symptomatic relief of pain or discomfort

__ **Corrective Care:** Correcting and relieving the cause of the problem as well as symptoms.

__ **Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care.

Awareness of Chiropractic Principles

Were you aware that…

Doctors of Chiropractic work with the nervous system? **Y__ N__**

The nervous system controls all organ systems and their functions? **Y__ N__**

Chiropractic is the largest natural healing profession in the world? **Y__ N__**

If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? **Y__ N__**

Has any *adult* in your family seen a Chiropractor? **Y__ N__**

Has any *child* in your family seen a Chiropractor? **Y__ N__**

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the
privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10/01/2008, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all
health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health-care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an

authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up chiropractic supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter-intelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patients under certain circumstances.

POWER CHIROPRACTIC

Office Usage: At Power Chiropractic we have a semi-open adjusting area so that we can serve as many families as possible. We may also use or disclose your health

information to provide you with appointment reminders (such as voicemail messages, phone calls, birthday cards, postcards, or letters). We may also use your written “Patient’s Speak Out” testimonial form on our wall or in our testimony binder.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies. We will use the format you request unless we cannot practicably do so (You must make a request in writing to obtain access to your health information. You may request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you $2.00 for each page to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.) All requests must be submitted in writing to the address at the end of this notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Questions and Complaints:
You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to us at the address that follows. We will not take any action against you for filing a complaint.

If you would like further information about our privacy practices, please contact:

Power Chiropractic
West End Plaza
113 West End Rd
Wilkes Barre, PA 18706

Patient Signature: ________________________________ Date: ___________________________

INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic care and we agree to provide this care, it is essential for both of us to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understands the objective and the method with which it will be obtained. This prevents any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental, and spiritual well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 freely-movable vertebrae in the spinal column, including the skull (top of spine) and sacrum/pelvis (bottom of spine) which causes alteration of nerve function and interference to the transmission of nerve impulses. This misalignment results in a lessening of the body's God-given, innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or conditions other than vertebral subluxation; however, if during the course of a chiropractic examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's God-given, innate wisdom. Our only method is the specific adjustment of vertebral subluxation. However, we may use other procedures to help your body hold the adjustments.

Open adjusting rooms: We keep an open environment in the office to create a sense of warmth, family, healing, and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or over-hear conversation. If there is a need to discuss something of a personal or private nature, you may request an appointment in one of our private rooms. The doctor or trained team member will speak with you about your condition or other matters in the private room.

Family and Close Friends Involved in Your Care: Our office has an open, family-centered approach to wellness and we believe it is in all our patient's best interests to have the support and cooperation of their families. Therefore, our office requires that the spouse or significant other be present when the doctor goes over the patient's report and recommendations for care.

POLICIES

1. All 1st adjustment charges are payable when services are rendered.
2. The fee paid for X-rays is for the analysis of those X-rays. X-ray film is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary.
3. I have read the Power Chiropractic Notice of Patient Privacy Practices.
4. If an appointment cannot be kept, kindly give 24 hours notice so another patient may have your time slot.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Power Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Power Chiropractic and will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered me are charged directly to me and that I am personally responsible for payment.

In case of emergency,
notify____

Phone #____

____has read and fully understand the above
(Print Name)
statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on that basis.

_______________________________________ ___________________
(Signature) *(Date)*

COMPLETE IF THE PATIENT IS A MINOR:

Child's name____

____________________________________, being the parent or legal guardian of the
(Parent/Guardian Print Name)
aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____ ___________________________
(Parent's/Guardian's Signature) *(Date)*