Chiropractic Intake and History

The Healing Arts Center of Philadelphia, Barry Silverman, D.C. 123 Chestnut St, Suite 204 Philadelphia, PA 19106

Date _____ Who may we thank for referring you?_____

First Name _____ Middle Initial _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (_____) _____-_____ Email _____

Date of Birth _____/_____/_____ Age_____ Gender Identity _____

☐Single ☐Married ☐Divorced ☐Widowed ☐Partnered Spouse's Name: _____

Occupation _____ Employer_____

Emergency Contact _____ Relationship _____ Phone (_____) _____ -_____

Please indicate method of payment: ☐Personal Insurance ☐Third party Insurance ☐No Insurance - Self Pay

Health Insurance Company _____ ID/Policy #_____

Group #_____ Insured's Name_____

Do you have secondary/supplemental health insurance? ☐Yes ☐No Company_____

ACCIDENT INFORMATION

Is this condition due to an accident? ☐Yes ☐No Date of Accident _____
What type of accident ☐Automobile ☐Work ☐Home ☐Other _____
Who have you reported the accident to ☐Auto Insurance ☐Workers Comp ☐Employer ☐Other
Attorney Name (if applicable)_____ Claim # _____
Insurance Co. _____Adjuster_____ Phone_____

Reason for Visit: _____

When did your symptoms begin?_____ Rate the severity of your pain on a scale of 1 -10_____

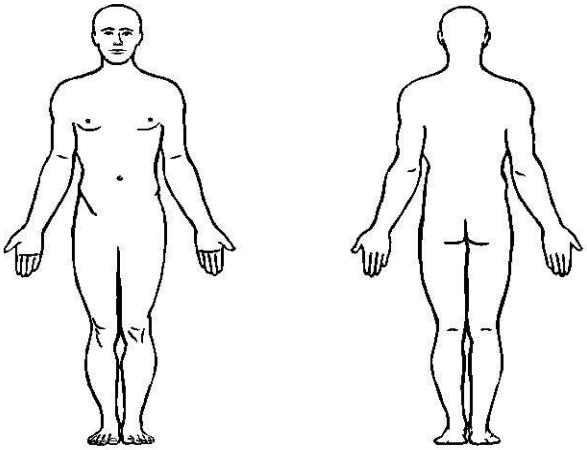
How often do you have this pain? _____ Is it constant or does it come and go? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Does it interfere with your ☐ Work ☐ Sleep ☐Daily Routine ☐Recreation ☐Other_____

Activities or movements that are painful to perform ☐Sitting ☐Standing ☐Walking ☐ Bending ☐Lying down

Are you pregnant? ☐ Yes ☐ No If yes, when is your due date? _____



Mark an X on the picture to the left where you have pain, numbness, or tingling.

What types of pain are you experiencing?

☐ Sharp ☐ Burning ☐ Dull ☐ Tingling
☐ Throbbing ☐ Cramps ☐ Numbness
☐ Stiffness ☐ Aching ☐ Swelling
☐ Shooting ☐ Other _____

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None
☐ Other _____

What level of exercise is normal for you? ☐ None ☐Occasional ☐ Moderate ☐ Daily ☐ Heavy

Does your work activity include any of the following? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

List any known allergies_____

List any medications, vitamins, or supplements you take_____

_____

Have you had any of the following? ☐Fall ☐Head Injury ☐ Broken Bones ☐Dislocation ☐Surgery

If yes, please describe and date_____

_____

Please mark "yes" or "no: to indicate if you have had any of the following:

AIDS/HIV	☐Yes☐No	Chicken Pox	☐Yes☐No	Kidney Disease	☐Yes☐No	Rheumatoid Arthritis	☐Yes☐No
Alcoholism	☐Yes☐No	Diabetes	☐Yes☐No	Liver Disease	☐Yes☐No	Scarlet Fever	☐Yes ☐No
Allergy Shots	☐Yes☐No	Emphysema	☐Yes☐No	Measles	☐Yes ☐No	STDs	☐Yes☐No
Anemia	☐Yes☐No	Epilepsy	☐Yes☐No	Migraines	☐Yes☐No	Stroke	☐Yes☐No
Anorexia	☐Yes☐No	Fractures	☐Yes☐No	Miscarriage	☐Yes☐No	Suicide Attempt	☐Yes☐No
Appendicitis	☐Yes☐No	Glaucoma	☐Yes☐No	Mononucleosis	☐Yes☐No	Thyroid Problem	☐Yes☐No
Arthritis	☐Yes☐No	Goiter	☐Yes☐No	Multiple Sclerosis	☐Yes☐No	Tonsilitis	☐Yes☐No
Asthma	☐Yes☐No	Gonnorrhea	☐Yes☐No	Mumps	☐Yes☐No	Tuberculosis	☐Yes☐No
Bleeding Disorder	☐Yes☐No	Gout	☐Yes☐No	Osteoporosis	☐Yes☐No	Tumors/Growths	☐Yes☐No
		Heart Disease	☐Yes☐No	Pacemaker	☐Yes☐No	Typhoid Fever	☐Yes☐No
Breast Lump	☐Yes☐No	Hepatitis	☐Yes☐No	Parkinson's	☐Yes☐No	Ulcers	☐Yes☐No
Bronchitis	☐Yes☐No	Hernia	☐Yes☐No	Pinched Nerve	☐Yes☐No	Vaginal Infections	☐Yes☐No
Bulimia	☐Yes☐No	Herniated Disk	☐Yes☐No	Pneumonia	☐Yes☐No	Whooping Cough	☐Yes☐No
Cancer	☐Yes☐No	Herpes	☐Yes☐No	Polio	☐Yes☐No	OTHER _____	
Cataracts	☐Yes☐No	High Blood Pressure	☐Yes☐No	Prostate Problem	☐Yes☐No	_____	
Chemical Dependency	☐Yes☐No			Prosthesis	☐Yes☐No	_____	
		High Cholesterol	☐Yes☐No	Psychiatric Care	☐Yes☐No	_____	

To properly assess your condition, we must understand how much your neck and/or back problems affect your ability to manage daily activities. For each item please circle the number which most closely describes your condition right now

PAIN INTENSITY	**0** No Pain	**1** Mild Pain	**2** Moderate Pain	**3** Severe Pain	**4** Worst Possible Pain
SLEEPING	**0** Perfect Sleep	**1** Mildly Disturbed Sleep	**2** Moderately Disturbed Sleep	**3** Greatly Disturbed Sleep	**4** Totally Disturbed Sleep
PERSONAL CARE washing, dressing, etc	**0** No Pain no restrictions	**1** Mild Pain no restrictions	**2** Moderate Pain need to go slowly	**3** Moderate Pain need some help	**4** Severe Pain need 100% assistance
TRAVEL Driving etc,	**0** No Pain on long trips	**1** Mild Pain on long trips	**2** Moderate Pain on long trips	**3** Moderate Pain on short trips	**4** Severe Pain on short trips
WORK	**0** Can do usual work Plus unlimited work	**1** Can do usual work no extra	**2** Can do 50% of usual work	**3** Can do 25% of usual work	**4** Cannot work
RECREATION	**0** Can do all activities	**1** Can do most activities	**2** Can do some activities	**3** Can do a few activities	**4** Cannot do any activities
FREQUENCY OF PAIN	**0** No Pain	**1** Occasional pain 25% of the day	**2** Intermittent Pain 50% of the day	**3** Frequent Pain 75% of the day	**4** Constant Pain 100% of the day
LIFTING	**0** No Pain with heavy weight	**1** Increased Pain with heavy weight	**2** Increased Pain with moderate weight	**3** Increased Pain with light weight	**4** Increased Pain with any weight
WALKING	**0** No Pain Any distance	**1** Increased Pain after 1 mile	**2** Increased Pain after ½ mile	**3** Increased Pain after ¼ mile	**4** Increased Pain with all walking
STANDING	**0** No Pain after several hours	**1** Increased Pain after several hours	**2** Increased Pain after 1 hour	**3** Increased Pain after ½ hour	**4** Increased Pain with any standing

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OFFICE POLICIES:

PRIVACY

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation. You may request changes to your records. Our practice has the right to accept or deny your request.

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information given to me and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic.

INSURANCE + PAYMENT

I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

We participate in most insurance plans, including Medicare. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage.

If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles can be considered fraud.

I have read and understood the payment and privacy policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**