Preston Chiropractic, LLC

4190 Holiday St NW Canton, OH 44718
(330)966-0030 (p) ~ (330)966-4837 (f)

Date: _____

Confidential Patient Information

Patient Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City: _____ Zip:_____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Primary Insured Information (if different than above):

Name:_____ Date of Birth:_____

Relationship to Patient:_____

Address:_____

Employer:_____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Family Physician: _____ (Note: May we send your health information to this provider? **Y / N**)

Person to contact in case of emergency (Name and Phone): _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Preston Chiropractic, LLC** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date

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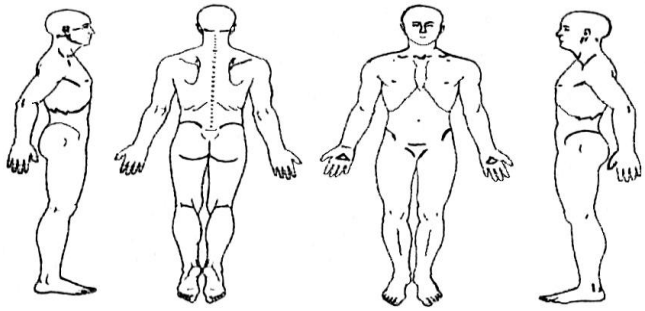
CASE HISTORY

Name: _____ Date:_____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of day) (Occasional → Constant)
a.	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b.	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c.	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d.	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e.	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are <u>worse</u> in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. Symptom (c) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

6. When did your symptoms begin (onset date)? _____
7. How did your symptoms begin? _____
8. Have you experienced these before? _____
9. Do your symptoms radiate (go to other places)? Y N If so, where?_____
10. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
11. Circle the things that make your problems worse:
    Bending - Twisting - Walking - Standing - Sitting - Movement - Lifting - Lying - Sleeping – Inactivity
12. Is there anything you can do to relieve the problems? Y N Describe: _____
    If No, what have you tried that has not helped? _____
13. Have you been treated for this before? Y N If yes, where and when? _____
14. What treatment did you receive? _____
15. Results of previous treatment? ____Good ____Poor Comments _____
16. Were you referred to our office by anyone? _____
17. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation

18. Do you have burning, numbness or tingling? Y N If so, where?_____

19. Do you have weakness of the arms or legs? Y N If so, where?_____

20. Are you right or left hand dominant? Right Left Ambidextrous

21. What position do you sleep in most of the time? Side Stomach Back Multiple

22. Are you a restless sleeper? Y N

23. Is pain keeping you awake or waking you up during your sleep cycle? Y N

Have you ever been under Chiropractic Care? Y N If so, Where/When?_____

Have you had spinal X-Rays / MRI / CT taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Major Accidents: _____ When? _____

Car Accidents:_____ When?_____

What medications are you taking? (check those that apply):

Pain Killers ____
Muscle Relaxers ____
Migraine Medication____
Stomach Medication____
Diabetes Medication____
Cholesterol Medicaton ____
Blood Pressure Medication ____
Anxiety/Anti-Depressants____
Birth Control ___

Other: _____

Any Allergies?_____

I certify that the preceding information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ 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 **Preston Chiropractic, LLC,** 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.

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 understand that upon request I will be given a copy.
I also understand that a copy of these practices is always available in the waiting room magazine rack.

Print Name: _____

Signature: _____ Date: _____

Consent to Evaluate and Treat a Minor(if applicable):

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.