**Preston Chiropractic, LLC**
4190 Holiday Street NW Canton, OH 44718
(330)966-0030 (phone) ~ (330)966-4837 (fax)

Date: ____________________

# Confidential Patient Information

**Patient Name**: ________________________________ Phone: _________________________________

Address: _____________________________________ City: _________________________ Zip:__________

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

Employer: ____________________________________ Occupation: __________________________________

Email: ______________________________________ Referred by:___________________________________

**Primary Insured Information** (if different than above):

Name:__________________________________________ Date of Birth:_______________

Relationship to Patient:___________________________ Phone: ____________________________

Address:________________________________________ City: _________________________ Zip:__________

Employer:_________________________________

Is your present condition related to, or the result of an auto collision, work-related injury or other personal injury? Y N

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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PrestonChiropractics.com

**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 contraindicated. 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 have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: ____________________________________________

Signature: ______________________________________ Date: _________________________

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

I, ________________________ being the parent or legal guardian of _______________________DOB:_______________

have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature: ______________________________________________ Date: _______________________

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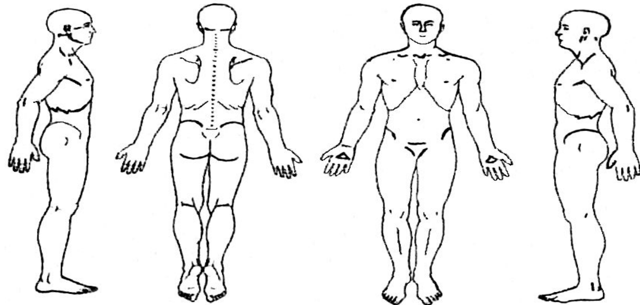
# CASE HISTORY

Name: ________________________________ Date:____________________

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

| Condition / Problem | Average Severity<br>Minimal Severe | Frequency (% of day)<br>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 |

(**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. Pain Quality: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. When did your symptoms begin (onset date)? ________________________________________________
5. How did your symptoms begin? ________________________________________________
6. Have you experienced these before? ________________________________________________
7. Do your symptoms radiate? Y N If so, where?________________________________________
8. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
9. Circle the things that make your problems worse: Other? ________________________________________

   Bend Forward - Bend Back - Twist - Walk - Stand - Sit - Sit to Stand - Lift - Sleep - Inactive Postures
10. Is there anything you can do to relieve the problems? Y N Describe: ________________________________

    If No, what have you tried that has not helped? ________________________________________________
11. Have you been treated for this before? Y N How long ago? ________________________________________
12. What treatment did you receive? ________________________________________________
13. Results of previous treatment? ____Good ____Poor Comments ________________________________
14. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
15. Do you have headaches: Y N Pain Quality: ____________________________Intensity: _______0-10

    Headache Frequency:____________________ Duration:___________________ Onset Date:________________

    Known Headache Triggers:________________________________________________

    Relieving Factors: ________________________________________________

    Have you been treated for headaches in the past? ____ No ____ Yes If so, where?________________________

16. Do you have burning, numbness or tingling? Y N If so, where?_______________________________________________
17. Do you have weakness of the arms or legs? Y N If so, where: _______________________________________________
18. Are you right or left handed? Right Left Ambidextrous
19. Is your sleep affected by pain? Y N
20. What position do you sleep most of the time? Side Stomach Back Multiple
21. Are you a restless sleeper by nature? Y N Age of Mattress: ______________________
22. Does pain prevent you from getting to sleep? Y N
23. Does pain wake you from sleep? Y N
24. About how many hours do you sleep at night? _______________

**Past Relevant History:**

Have you ever been under Chiropractic Care? Y N

If so, Where? ___________________________ Last Chiropractic Treatment Date: _________________

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

Operations? _______________________________________________________ When? _________________

Serious Illness: ___________________________________________________ When? _________________

Major Accidents: ___________________________________________________ When? _________________

Car Accidents:_______________________________________________________ When?__________________

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

| Check | Circle: | Duration: |
|---|---|---|
| Pain Relievers ____ | Prescription or Over the Counter? | ___________ |
| Muscle Relaxants ____ | Prescription or Over the Counter? | ___________ |
| Headache Medications ____ | Prescription or Over the Counter? | ___________ |
| Stomach Medication ____ | Prescription or Over the Counter? | ___________ |
| Diabetes Medication ____ | Oral or Injected? | ___________ |
| Cholesterol Medication____ | | ___________ |
| Blood Pressure Medication ____ | | ___________ |
| Anxiety/Antidepressants ____ | | ___________ |
| Birth Control ____ | | ___________ |
| Other: _____________________________________ | | |

Allergies?_________________________________________

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

Patient/Guardian Signature _________________________________________________ Date: _______________