Signal Hill Chiropractic Center, Inc Date_____
Confidential Patient History

Name (including middle initial) _____ Male/Female

Home phone (____)_____ Cell (____)_____ Work (___) _____

Address _____ City _____ State _____ Zip _____

Birth Date _____/_____/_____ Age _____ Social Security # _____-_____-_____

Ethnicity: ( ) Hispanic ( ) Not Hispanic or Latino ( ) Decline to Answer

Race: ( ) Black or African ( ) White (Caucasian) ( ) Other ( ) Decline to Answer

Email _____ (to receive our news letter)

Number of children _____ Marital Status M / S / W / D / Other Preferred Language_____

Occupation _____ Employer(s) _____

Address_____ City _____ State _____ Zip _____

Name of Spouse _____ Phone (___)_____ Birth Date ___/____/_____

Name of Emergency Contact _____ Phone (____)_____
(Nearest relative not living in your home)

How do you prefer to be addressed? _____

Whom may we thank for referring you? _____

FAMILY DR./PRIMARY CARE
PHYSICIAN:_____

With your permission we will be keeping your family doctor or referring doctor informed regarding your care at this office by sending them office notes.
(Please check yes or no if you want us to inform your doctor): Yes ____ No ____

Please specify name and address. _____

_____

Present Complaint _____

_____

When did your problem begin? Specific date if possible_____

How did your problem begin? _____

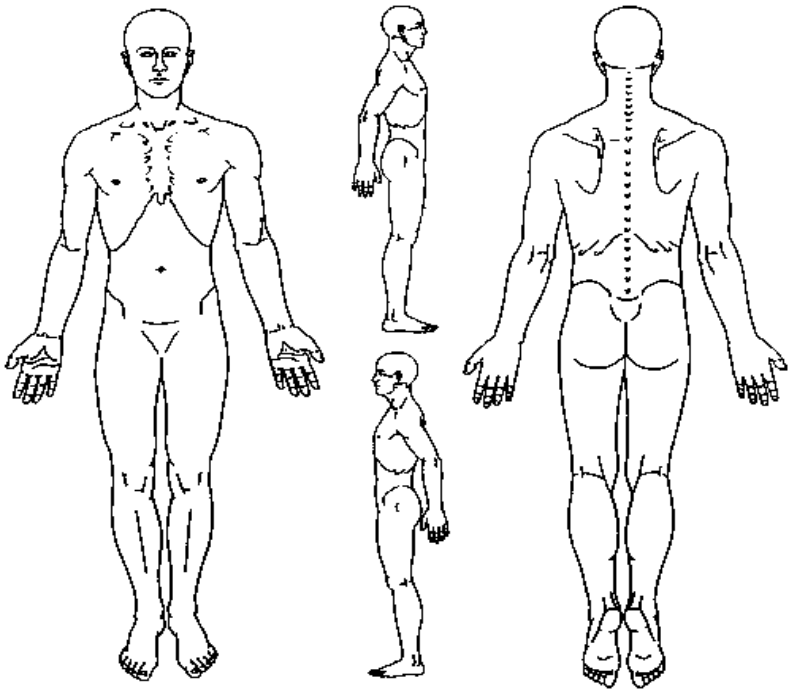
In the past have you had anything similar to this? YES NO Please explain:_____

_____

MARK THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.
INCLUDE SYMTOMS OF PAIN, NUMBNESS OR TINGLING, ETC.

Using the symbols listed below, mark on the two drawings below which areas on your body where you feel the described sensations:

Numbness	= = =
Dull Ache	**O O O**
Hot Burning	**X X X**
Sharp Stabbing	/ / /
Pins and Needles	+ + +
Other _____	*** * ***
_____	



Please circle on the line below the level or intensity of pain you are presently experiencing:

Absolutely Pain Free _____ *Worse Pain You Could Ever Have*

1 2 3 4 5 6 7 8 9 10

Please describe the character of your current pain. You may check one or more answers.
( ) Sharp ( ) Stabbing ( ) Burning ( ) Shooting ( ) Aches ( ) Soreness ( ) Weakness ( ) Throbbing
( ) Numbness ( ) Dull ( ) Constricting ( ) Stiff ( ) Other _____

How often are complaints present?
( ) Constant/ 100% of the time ( ) Frequent/ 75% ( ) Intermittent/ 50% ( ) Occasional/ 25%
Comments: _____

Is your pain: ( ) Increasing ( ) Decreasing ( ) Not Changing ( ) Varies

Pain is aggravated by: ( ) Walking ( ) Sitting ( ) Standing ( ) Riding in car ( ) Lifting
( ) Bending ( ) Stretching ( ) Twisting ( ) Running ( ) Transitioning from seated to standing
( ) Other _____

What would you like to do, but can't, because of your pain? _____

_____

Pain is reduced by:
( ) Medicine ( ) Exercise ( ) Rest ( ) Chiropractic ( ) Physical Therapy ( ) Supplements ( ) Heat ( ) Ice
( ) Other _____

Are your complaints affecting your ability to work or be active?
( ) No effect ( ) Some physical restrictions ( ) Unable to perform regular duties

Is there any dizziness associated with symptoms? YES NO Any fever or chills? YES NO

Any change in bowel or bladder (bathroom) function? YES NO

Are your complaints affecting your ability to sleep? YES NO Explain:_____

On average, how many hours of sleep do you get per night? _____
Do you sleep through the night uninterrupted? YES NO

For your present complaint have you seen any other doctors or had any physical therapy? YES NO

If yes, who? What treatment? _____

Have you missed any days of work or school? YES NO Dates missed:_____

Have you ever broken any bones? YES NO Explain:_____

Have you been in the hospital or had surgery for any reason? YES NO Please explain: _____
Have you ever been in an accident? YES NO Please explain _____

What Supplements are you taking? _____

What *non-prescription* medication are you taking? Tylenol ____ Ibuprofen ____ Aspirin _____

Other: _____

What *Prescription* Medications or Drugs are you taking?
******* If you take more than 4 Prescription Medications, please provide us with a medications list*******
Medication Name _____Dosage & Frequency_____

Medication Name _____ Dosage& Frequency _____

Medication Name _____Dosage& Frequency _____

Medication Name _____Dosage &Frequency _____

Do you have any medication allergies? If so, please list mediation name, reaction & onset date_____

_____

Smoking Status: ( ) Every day smoker ( ) Occasional smoker ( ) Former smoker ( ) Never smoked

Consume alcohol? YES NO How Much:_____

What is your exercise routine?_____

Other health concerns:_____

INFORMED CONSENT

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of joints with the doctor's hands or with the use of a machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy applications, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Although exceedingly rare, stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Adjustments have been associated with strokes that arise from the vertebral artery. This stroke is called the "extension-rotation-thrust atlas adjustment". We do not do this type adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. This type of stroke can also occur with normal daily activities involving turning and extending the neck. The most recent studies (Journal of the CCA, Vol. 37 No. 2, June 1993) estimate that the incident of this type of stroke is 1 per every 3 million upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will fracture a rib bone. This occurs only on patients that have weakened bones form such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptoms, disease or condition as a result of treatment in this office. We will always give you our best care, and if result are not acceptable, we will refer you to another provider who we feel will assist your situation. If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

_____	_____
Patient's Name Printed	Today's Date
_____	_____
Patient's Signature	Parent/Guardian Signature for Minor

Patient Name: _____ ACCT#: _____

Employer: _____
Claim/Group Number: _____
SS# or ID#: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Signal Hill Chiropractic Center
930 Lila Avenue
Milford, Ohio 45150

OR

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o Signal Hill Chiropractic Center
930 Lila Avenue
Milford, Ohio 45150

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated this _____ day of _____ 20_____

_____
Signature of Policyholder

_____
Signature of Claimant, if other than Policyholder

_____
Witness

This practice is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Please advise us if you would like a copy of our policy regarding your protected health information.

I have been offered or have received a copy of Signal Hill Chiropractic Center's Notice of Privacy Policies.

Name:_____

Date:_____