# ProHealth Chiropractic and Injury Center

## 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 **ProHealth Chiropractic and Injury Center**, 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.

### 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 **ProHealth Chiropractic and Injury Center** 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.

### Consent to Evaluate and Treat a Minor:

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.

### 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: _____ Date_____

Signature: _____ Date: _____

# ProHealth Chiropractic and Injury Center

1329 Cherry Way Drive Suite 500 Gahanna, OH 43230
696 West Cherry Street Sunbury, OH 43074

## Confidential Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Cell Phone: _____

City: _____ Zip:_____ Employer: _____

State: _____ Email: _____

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

Occupation: _____

Address of Insured (if different than above): _____

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

How did you hear about our office?_____

What is your **goal** in our office? _____

## Emergency Contact

In the even that we would need to communicate your healthcare information, please provide the information for whom we may contact:

Name: _____

Phone # _____

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

Have you ever been under Chiropractic Care? Y N If so, Who? _____

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

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

Smoking Status- Circle one- Current Smoker Previous Smoker Never a Smoker

_____ _____

Signature of Insured / Guardian Date

PROHEALTH CHIROPRACTIC AND INJURY CENTER

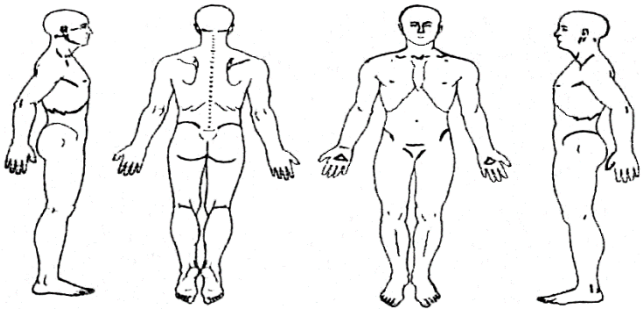
# CASE HISTORY

Chief Complaint:_____

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 | Frequency (% of week) |
|---|---|---|
| | Minimal Severe | 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 |

(Please mark the figures where you experience pain.)



2. Symptoms are worse 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. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation

_____ _____

Signature of Insured / Guardian Date

17. Do you or have you recently felt dizzy? Y or N
18. Do you or have you recently felt confused? Y or N
19. What makes your pain **better**?_____
20. What makes your pain **worse?**_____
21. List any other major injuries you have had, other than those mentioned above: _____

_____

22. Any other Musculoskeletal problems Y or N _____
23. Any other Neurological problems Y or N _____
24. Any blood conditions (HIV positive) Y or N _____
25. Circle each one that applies to **YOUR** current/ past health - **Stroke**, **High Blood Pressure, High Cholesterol, High Triglycerides, Heart Attack, Cancer**, **Headaches, Neck/ Back Pain, Scoliosis, Blood condition**
26. Allergies: Y or N _____
27. **Family History**: Circle each that applies to your *family*- **Stroke**, **High Blood Pressure, High Cholesterol, High Triglycerides, Heart Attack, Cancer, Headaches, Neck/ Back Pain, Scoliosis**
28. Any other information you would like the doctor to know? Please list here:

_____

_____

_____

_____

29. Are you open to improving your health or losing weight with the help of nutrition and supplements? Y or N

**Current:** Height _____ Weight _____

## Current Medications

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

Pain Killers ____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ____ Birth Control ___

Name: Dose:

_____

_____

_____

_____

_____

_____