Start to Finish Chiropractic Rehabilitation

1767 Quincy Ave. Dunmore, PA 18509
(570) 341-5544

Patient Information

Today's Date_____

Legal Name _____ DOB ___/___/____ SSN_____

Name you go by (if different) _____

Home Phone_____ Cell Phone_____Email_____

May we contact you via email? Yes / No May we contact you via text? Yes / No

Address _____ City _____ State_____ Zip_____

Gender Identity_____ Sex Assigned at Birth_____ Pronouns_____

Marital Status____ Primary Care Physician_____

Employment Status: □ Full time □ Part time □ Retired □ Self Employed □ Student □ No Employment

Occupation_____ Employer _____ Work Phone_____

Emergency Contact Person_____ Phone_____

Is your injury the result of a work or automobile accident? □ Yes □No

*If YES please ask a staff member for the **Worker's Compensation/MVA information** form.

Primary Insurance Information

Primary Insurance Company_____

Member ID_____ Group Number_____

Effective Date_____ Name of Subscriber_____DOB___/___/____

Relationship to patient: □ Self □ Parent □ Spouse □ Other

Address for subscriber if different from above: _____

Secondary Insurance Information (if applicable)

Secondary Insurance Company_____

Member ID_____ Group Number_____

Effective Date_____ Name of Subscriber_____DOB___/___/____

Relationship to patient: □ Self □ Parent □ Spouse □ Other

Address for subscriber if different from above: _____

Financial Agreement

I authorize payment of my insurance benefits to Start to Finish Chiropractic Rehabilitation. In addition, I agree to pay my financial responsibility. I understand that deductibles, copays, and co-insurance dues are to be paid at the time of service unless prior financial arrangements have been agreed upon. It is understood that I am responsible for any fees for service through this office that are not covered by my insurance.

Signature _____ Date_____

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Today's Visit

What is the biggest reason for your visit today? _____

When did this problem begin? _____

What were you doing when it began? (if unsure, write "unsure") _____

What makes it feel **better**? (if nothing, write "nothing") _____

What makes it feel **worse**? (if nothing, write "nothing") _____

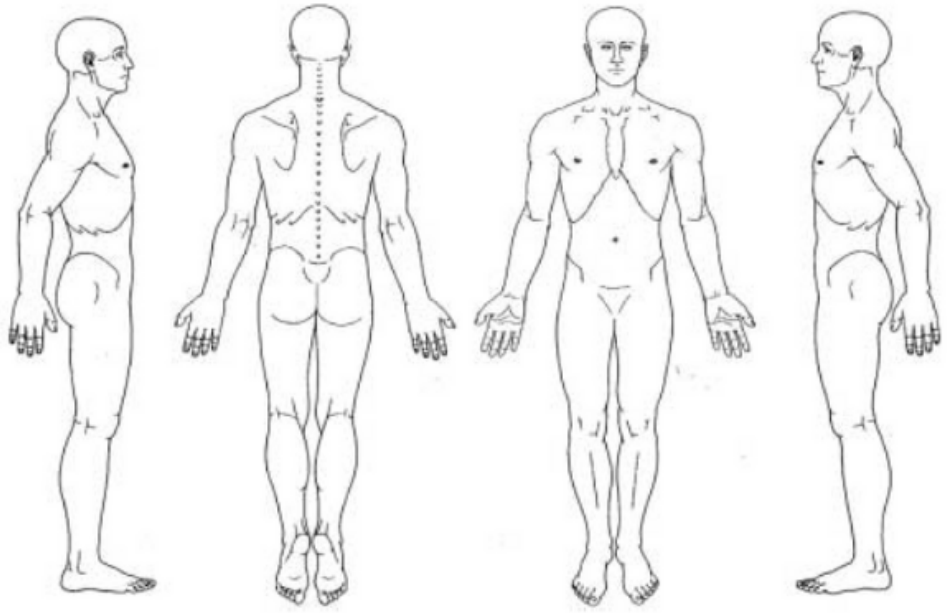
Over time, I feel this problem is getting: __better __worse __staying the same

On a scale of 0 to 10 (with 10 being the worst), how would you rate this problem? _____

Overall, this problem is (circle one): constant / comes and goes / only with specific movements or activities

When is it most noticeable? __Morning __Afternoon __Evening __Night __All the Time __N/A

On the diagram below, please indicate where you are experiencing your problem. Please use the key to the right of the diagram to further describe what you are experiencing.



A = Ache

B = Burning

N = Numbness

P = Pins and Needles

S = Stabbing

T = Throbbing

O = Other

Social Habits (List amount daily/weekly)

Alcohol _____

Caffeine _____

Smoking _____

Other tobacco _____

Medical Cannabis _____

Illicit Drugs _____

How often do you exercise?

__Never __Occasionally __Daily

_____times/week

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Current Health Information:

Height_____ Weight_____

Please circle any of the following symptoms that you have experienced recently.

Constitutional	Fever	Night Sweats	Unexplained Weight Loss
Eyes	Red Eyes	Blurred Vision	Vision Loss
Ears/Nose/Mouth	Nose Bleeds	Sore Throat	Hearing Loss / Tinnitus
Cardiovascular	Chest Pains	Palpitations	Leg Swelling
Respiratory	Shortness of Breath	Chronic Cough	Wheezing
Gastrointestinal	Nausea	Vomiting	Diarrhea
Genitourinary	Burning w/ Urination	Blood in Urine	Urinary Inconsistency
Skin	Rash	Hives	Skin Infection
Neurological	Headache	Tremor	Seizures
Psychiatric	Depression/Anxiety	Panic Attacks	Suicidal Ideation
Endocrine	Excessive Thirst	Excessive Urination	Hot/Cold Intolerance
Hematological	Easy Bruising	Easy Bleeding	Swollen Glands
Allergy/Immune	Runny Nose	Itchy Eyes	Sinus Congestion

Past Medical History:

Please circle any that apply.

High Blood Pressure	Coronary Artery Disease	Vascular Disease	Emphysema
Diabetes	Congestive Heart Failure	Heart Disease/Attack	Thyroid Disease
Lyme's Disease	Bleeding Disorder	Seizure	Gastric Reflux
Multiple Sclerosis	Enlarged Prostate	Hepatitis	Liver Disease
Osteopenia/Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Gout
Kidney Disease	Stomach Ulcers	Asthma	COPD
Cancer	Scoliosis	Depression	Anxiety

Have you ever had a stroke or TIA?	__Yes	__No	__Unsure
Do you have a pacemaker?	__Yes	__No	__Unsure
Do you wear an insulin pump?	__Yes	__No	__Unsure
Is there any chance you could be pregnant?	__Yes	__No	__Unsure
Any recent changes in bowel/bladder control?	__Yes	__No	__Unsure
Recent unexplained weight loss/gain	__Yes	__No	__Unsure
Are you currently taking blood thinners?	__Yes	__No	__Unsure
Do you have low bone density?	__Yes	__No	__Unsure

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Family History:

Please circle any that apply.

High Blood Pressure	Coronary Artery Disease	Vascular Disease	Emphysema
Diabetes	Congestive Heart Failure	Heart Disease/Attack	Thyroid Disease
Lyme's Disease	Bleeding Disorder	Seizure	Gastric Reflux
Multiple Sclerosis	Enlarged Prostate	Hepatitis	Liver Disease
Osteopenia/Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Gout
Kidney Disease	Stomach Ulcers	Asthma	COPD
Cancer	Scoliosis	Depression	Anxiety

Surgical History:

Please list any surgical procedures you have had including approximate month/year.

_____

_____

_____

Medications:

Please list any medications you have taken during the past 6 months.

_____

_____

_____

Allergies:

Please list anything you might have an allergic reaction from.

_____

_____

_____

Patient Signature_____ **Date**_____

Parent/Guardian Signature_____ **Date**_____

Reviewed by Physician_____ **Date**_____

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Informed Consent

I hereby request and consent to the performance of manual chiropractic treatments and other chiropractic procedure, including various modes of physical therapy and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic treatment. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of all other healthcare interventions, results of chiropractic care are not guaranteed, and there is no promise of cure. I further understand and am informed that in the practice of chiropractic, as in the practice of medicine, there are some inherent risks of treatment, including, but not limited to, soreness, bruising, sprain/strain, dislocation, fracture, and stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic care. These treatment options include, but are not limited to: self-administered over-the-counter analgesics and rest, medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers, physical therapy, steroid injections, bracing, and surgery. I understand and have been informed that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedure(s). I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ **Date**_____

Parent/Guardian Signature_____ **Date**_____

Physician Signature_____**Date**_____

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HIPAA Acknowledgement Agreement

As required by the Health Insurance Portability and Accountability Act, we adhere to the standards set forth in the NOTICE OF PRIVATE PRACTICES available at our front desk as well as our website. This document states that we reserve the right to contact you by email, mail, or phone. We may leave messages regarding appointments, payments, and treatment issues. I was offered a copy of the Notice of private practices for Start to Finish Chiropractic Rehabilitation and I hereby give them permission to contact me.

Signature _____ Date_____

Authorization for Release of Medical Records

I Hereby authorize Start to Finish Chiropractic Rehabilitation to obtain any medical, surgical, or diagnostic imaging reports relevant to my treatment. I authorize Start to Finish Chiropractic Rehabilitation to release my medical records to my insurance company to facilitate payment, as well as to other healthcare providers involved in my healthcare when applicable.

Signature _____ Date_____

Consent to treat a minor

Parent/caretaker name_____ DOB___/___/____

Home Phone_____ Address _____

City _____ State____ Zip _____ Employer_____

Work Phone _____

*** I hereby authorize the chiropractor(s) employed at Start to Finish Chiropractic Rehabilitation to evaluate and treat my child/dependent as they deem necessary.**

Signature _____ Date_____