

Date: _____

Confidential Patient Information

Patients Name: _____	Chief Complaint: _____
Address: _____	Home Phone: _____
City: _____ Zip: _____	Cell Phone: _____
SS#: _____	Email: _____
Date of Birth: _____	Marital Status: M S W D
Occupation: _____	Employer: _____

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? _____

Ins. Company: _____	Ins. Phone #: _____
ID#: _____	Group #: _____
Name of Policy Holder: _____	Policy Holder DOB: _____
Policy Holders Employer: _____	

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

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

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

What medications or drugs are you taking? (check those that apply): Pain Killers _____ Insulin _____ Cholesterol Meds _____
 Blood Pressure Meds _____ Muscle Relaxers _____ Birth Control _____ Other: _____

What brings you to our office? _____

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 **Peltier Chiropractic Wellness 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 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

Peltier Chiropractic Wellness Center
355 Barks Road East, Marion, OH 43302
(740) 389-3330 (p) ~ (740) 389-6880 (f)

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 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 **Peltier Chiropractic Wellness 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.

Women Only:

To the best of my knowledge I am / am NOT pregnant and (give my permission / don't give permission) to x-ray me for diagnostic interpretation.
(Circle one above) (Circle one above)

Missed Appointments:

There is a \$10.00 fee charged for all appointments that are not canceled prior to scheduled visit.

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.

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: _____

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Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPAA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, email or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.



355 Barks Rd., East
Marion, Ohio 43302
740-389-3330

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ___/___/___ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____

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REVIEW OF SYSTEMS

Name: _____

Please mark the line next to any symptoms you have experienced in the past 6 months.

Cardiovascular

High BP _____
High Cholesterol _____
Chest Pain _____
Varicose Veins _____
Heart Surgery _____

Low BP _____
Diabetes _____
Previous Heart Attack _____
Hot/Cold Hands/Feet _____
Other _____

Respiratory

Emphysema _____
Pneumonia _____
Asthma _____

Persistent Cough _____
Allergies _____
Other _____

Digestive

Gas _____
Vomiting _____
Gallbladder Disease _____
Diarrhea _____
Liver Disease _____

Ulcers _____
Nausea _____
Indigestion _____
Constipation _____
Other _____

Eyes/Ears/Nose/Throat

Change in Vision _____
Cataracts _____
Ringing in Ears _____
Ear Infections _____
Nose Bleeds _____
Hoarseness _____
Frequent Strep Infections _____
Trouble Swallowing _____

Contacts/Glasses _____
Sensitive to Light _____
Hearing Loss _____
Drainage _____
Sinus Problems _____
Tonsillectomy _____
Sore Throat _____
Other _____

Reproductive

Infertility _____
Pain with Cycle _____
Ovarian Cysts _____

Hysterectomy _____
Irregular Cycle _____
Other _____

General

Fever _____
Weight Gain _____
Fatigue _____
Sleep Disturbance _____

Chills _____
Weight Loss _____
Irritability _____
Other _____

Please List Previous Surgeries _____

Signature: _____ Date: _____

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CASE HISTORY

Name: _____

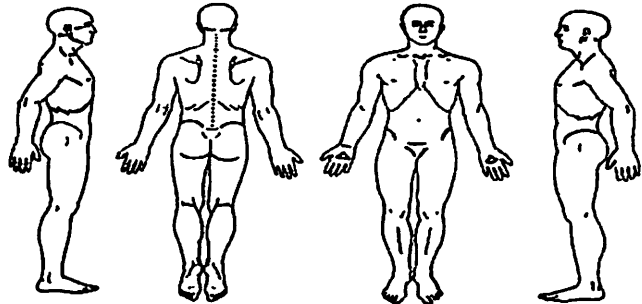
1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

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
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 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

17. List any other major injuries you have had, other than those mentioned above: _____

18. Any other Musculoskeletal problems? No Yes ...Neurological problems? No Yes

Additional information on back side of sheet.

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

Patient/Guardian Signature _____

Date: _____

New Patient Exam

Patient Name: _____

Date: _____ CC: R L

Head Tilt _____	Shld High _____	P Trans _____
Head Rot _____	T Rot _____	P Rot _____
C Trans _____	T Trans _____	P Tilt _____

For Comp _____	Fabere _____	Kemp's _____
Soto Hall _____	Ely's _____	Laseques _____
Derifield _____		

	Cervical ROM			Dorso-Lumbar ROM		
	Norm	Exam	Pain	Norm	Exam	Pain
Flex	60			90		
Ext	50			30		
L. Rot	80			30		
R. Rot	80			30		
L. Lat Flex	40			20		
R. Lat Flex	40			20		

Dual Scales L: _____ R: _____

Height : _____

Present Symptoms: _____

_____	Occ
_____	C1
_____	2
_____	3
_____	4
_____	5
_____	6
_____	7
_____	T1
_____	2
_____	3
_____	4
_____	5
_____	6
_____	7
_____	8
_____	9
_____	10
_____	11
_____	12
_____	L1
_____	2
_____	3
_____	4
_____	5
_____	Sac
_____	RIL
_____	LIL
_____	Coc

Traumas _____

Surgeries _____

Systems Review _____

APT _____ APL _____ LATL _____ LATT _____

X-Ray: C ___ T ___ L ___ Phase: C ___ T ___ L ___

 X RAY VIEW _____
 % C Loss _____
 % L Loss _____

L	Seg	R	
		Occ	CI
	2		
	3		
	4		
	5		
	6		
	7		
	T1		
	2		
	3		
	4		
	5		
	6		
	7		
	8		
	9		
	10		
	11		
	12		
	L1		
	2		
	3		
	4		
	5		
	Sac		
	RIL		
	LIL		
	Coc		
	ASI		
	GSI		