Sunbury Chiropractic Center
123 State Route 3
Sunbury, OH 43074
P#: 740-965-4301

Johnstown Chiropractic Center
620 W. Coshocton St.
Johnstown, OH 43031
P#: 740-967-2225

Date: _____

Confidential Patient Information

Patient Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State/Zip:_____ Email: _____

SS#: _____ Preference for Phone Call: *Home* *Cell*

Date of Birth: _____ Marital Status: M S W D # children: _____

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

****Are your present symptoms 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

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____ **Who is responsible for the bill?**_____

How did you hear about our office? _____

Have you had Chiropractic Care previously? _____

EMERGENCY CONTACT

Name: _____ Relationship:_____ Phone number: _____

May we release protected health information to this individual, to include appointments and balances? YES NO

ADDITIONAL CONTACT

Name: _____ Relationship:_____ Phone number: _____

May we release protected health information to this individual, to include appointments and balances? YES NO

ADDITIONAL CONTACT

Name: _____ Relationship:_____ Phone number: _____

May we release protected health information to this individual, to include appointments and balances? YES NO

CONFIDENTIAL COMMUNICATION

IN ADDITION TO MAIL,I HEREBY REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS IN THE FOLLOWING MANNER. (CHECK ALL THAT APPLY)

☐ **Cell phone of record** ☐ Voicemail

☐ **Home phone of record** ☐ Voicemail

☐ **Email address of record**

Preference for appointment reminders: *email* *text*

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Patient Name_____ **DOB** _____

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

Condition / Problem Please list all problems below	**Severity** Minimal → Severe	**Frequency (% of week)** 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

2. Symptoms are worse in the (circle what applies) *morning* *afternoon* *night*
   Increases during the day *same all day* *decreases during the day*
3. When did your symptoms begin? _____
4. How did your symptoms begin? _____
5. What is the quality of pain? (circle all that apply) *Sharp* *Dull* *Achy* *Pins & Needles* *Tightness*
6. Do your symptoms radiate? _____
7. Has your condition? *Improved* *Gotten Worse* *Stayed the same since it began*
8. Is this condition interfering with: *Work* *Sleep* *Daily Routine* *Recreation*
9. Circle the positions that make your problems worse:
   Bending *Lying* *Walking* *Standing* *Sitting* *Movement* *Twisting* *Lifting* *Sleeping*
10. Have you experienced these symptoms before?_____
11. Is there anything that offers relief? ____No ____If Yes, Describe: _____
    If No, what have you tried that has not helped? _____
12. Have you been in an auto accident: *Past year* *Past 5 years* *Over 5 years* *Never*
13. Have you ever been knocked unconscious? _____ If YES, when?_____
14. Have you ever fractured a bone? _____ If YES, where/when?_____
15. List all surgical operations and years performed:_____
    _____
16. List all medication, vitamins, or mineral supplements? (attach copy if necessary) _____
    _____
17. Do you have any allergies? *Food* *Medication* *Seasonal* *Latex* *Other:* _____
18. Do you wear any of the following: *Heel lifts* *Arch Supports* *Back Brace* *Neck Brace* *Other:* _____
19. **Family Health History:** Many health problems are the result of hereditary spinal weaknesses; information about your family members give us a better picture of your total health. Please list your family history below

Relationship		**Past and Present Health Problems**

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Patient Name_____ **DOB** _____

Please check any of the following symptoms which you now have or have had previously.

General		**Muscle & Joint**		**Respiratory**	
	Allergies		Arthritis		Chest pain
	Dizziness		Foot Trouble		Chronic cough
	Fainting		Disc problems		Difficult breathing
	Fatigue		Spinal curvature		Spitting up blood
	Fever				Spitting up phlegm
	Headache				Wheezing
	Loss of Sleep	**Gastro-Intestinal**			
			Constipation	**Genito-Urinary**	
Cardio-Vascular			Diarrhea		Bed Wetting
	Heart Disease		Difficult Digestion		Blood in urine
	High Blood Pressure		Gallbladder Trouble		Frequent urination
	Low Blood Pressure		Hemorrhoids		Inability to control Bladder
	Pain over heart		Nausea		Kidney infection or stones
	Poor Circulation		Pain over stomach		Painful urination
			Vomiting		Prostate Trouble
Eyes, Ears, Nose & Throat			Poor appetite		
	Asthma			**For Women only**	
	Colds				Cramps or backache
	Earache	**Mental Health**			Hot flashes
	Ear Noises		Anxiety		Irregular cycle
	Eye Pain		Depression		Menopausal symptoms
	Failing vision		Bipolar		Painful Menstruation
	Nosebleeds				**Pregnant? *Yes* *No***
	Sore Throat				
	Sinus Infection				

Check the following conditions you have or had

	Alcoholism		Cold Sores		Influenza		Pleurisy		Parkinson's
	Appendicitis		Diabetes		Measles		Pneumonia		Stroke
	Arteriosclerosis		Eczema		Miscarriage		Polio		Tuberculosis
	Arthritis		Emphysema		Multiple Sclerosis		Rheumatic Fever		Ulcers
	Cancer		Epilepsy		Mumps		Scarlet Fever		Whooping Cough

Habits: Heavy/Moderate/Light/Never/Former

Alcohol _____ Coffee _____ Tobacco _____

Drugs _____ Exercise_____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

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Financial Policy and Consents

At Sunbury Chiropractic Center, Inc., our mission is "Relief First, Wellness Always." Our recommendations for care are based on a desire to see you get well and stay well with maintenance care. Chiropractic care is covered under many insurance plans, personal injury coverage, worker's compensation coverage, Medicare, and Medicaid. **All medical concerns are to be discussed with the doctor and all financial concerns are to be discussed with office staff.** We accept Visa, Mastercard, Discover, Care Credit, and will be happy to extend a payment plan. We require a payment every month for any balance on the account or appointments will not be scheduled. If you feel you might qualify for our financial hardship policy, please notify office staff for an application. Should payment be refused by your bank for a check written, the office will charge a fee of $12 to offset the charges we will incur. The privilege of insurance assignment begins when our office receives and verifies your insurance information. This service is a courtesy to you and is not a guarantee of coverage. We always recommend your participation in verifying your own chiropractic coverage, too. Your insurance policy is a relationship between you and your insurance provider. State law allows insurance carriers to retract or correct processing of claims for up to 2 years from the date of service. **All treatments considered maintenance are generally not covered benefits and could be the responsibility of the patient.**

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 health care benefits and hereby assign at clinic's request, and pay directly to **Sunbury Chiropractic Center, Inc** 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 authorize the use of this signature on all my insurance and/or health benefits claim submissions. If I do not have insurance, I will pay at the time services are rendered.

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 or appeals 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 TREAT

A patient gives the doctor permission and authority to care for them 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, deformities, use of recreational drugs/alcohol or use of CBD oil which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. If during the course of care, non-chiropractic or unusual findings are encountered, the doctor will advise the patient of those findings and recommend that service be sought by another health care provider. Chiropractic care may or may not improve a condition. The patient will be made aware of alternatives to chiropractic treatment.

I understand that if I am accepted as a patient by a physician at **Sunbury Chiropractic Center, Inc.**, 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 or new diagnosis. If applicable, I consent to the examination, diagnostic x-rays, chiropractic adjustment and any ancillary procedures such as physiotherapy and/or rehabilitative procedures.

I have read and fully understand the CONSENTS ON THIS PAGE.

Patient/Guardian Signature: _____ Date: _____

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Chiropractic Appointments: Our doctors' schedules are extremely busy. In order to provide you sufficient time with the doctor, we ask that you call the office 24 hours in advance or ASAP if you will not be able to make your appointment or need to reschedule. This allows us time to schedule another patient that may be on a wait list. If you are more than 15 minutes late, you may be asked to reschedule your appointment.

INITIALS:_____

Massage Missed Appointments: There is a $25 fee charged for all **MASSAGE** appointments that are not canceled 24 hours prior to scheduled appointment.

INITIALS:_____

X-RAY OVERREAD: I understand that my doctor may submit my x-rays to Professional Imaging Consultants, Inc. for radiological evaluation and analysis by a Radiologist. **There will NOT be a fee for this second opinion**, as Sunbury Chiropractic Center will cover all costs as a courtesy.

Benjamin Glass, DC, DACBR
Chiropractic Radiologist
8230 Crystal Creek Drive
North Royalton, OH 44133

INITIALS: ____

NOTICE OF PRIVACY PRACTICES: I have been offered the copy of Notice of Privacy Practices which outlines how my Protected Health Information may be used and disclosed, and how I can get access to the information ☐ Yes received ☐ Offered but Declined

INITIALS:_____

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MINOR ONLY: 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 adjustment, therapy, evaluation and/or diagnostic x-rays by any doctor or office staff with or without a parent or guardian present.

☐ Mother/Legal Guardian:_____

☐ Father/Legal Guardian:_____

I understand that information will be disclosed to all parents or guardians unless court documents are presented stating otherwise. All legal guardians need to submit court documents to our office to prove guardianship. I understand that some insurance plans consider spinal manipulation on children under the age of 2 years to be experimental and may not be covered. By signing this, you understand that your child's visit, if applicable, may be denied by the insurance company and you will be financially responsible for all denied services rendered.

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I have read and fully understand the consents on this page.

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____ DOB: _____