



Date: \_\_\_\_\_

### Confidential Patient Information

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
SS#: \_\_\_\_\_ Preference for Phone Call: *Home Cell*  
Date of Birth: \_\_\_\_\_ Marital Status: M S W D # children: \_\_\_\_\_  
Email: \_\_\_\_\_ Occupation: \_\_\_\_\_  
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? \_\_\_\_\_ If yes, have you been adjusted with an instrument? *Yes No*
- Preference for appointment reminders: *email text both*
- Preference to receive statements: *mail email*

#### EMERGENCY CONTACTS

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

May we release Protected Health Information (PHI) to this individual? **YES NO**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

May we release Protected Health Information (PHI) to this individual? **YES NO**

#### CONFIDENTIAL COMMUNICATION

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

- Voicemail of Cell phone on record
- Voicemail of Home phone on record
- Email address of record



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		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									

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:* \_\_\_\_\_

*Please explain:* \_\_\_\_\_

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



Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

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

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

**Check the following conditions you have or had**

<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	Influenza	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	Parkinson's
<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Miscarriage	<input type="checkbox"/>	Polio	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Whooping Cough

**Habits: Heavy/Moderate/Light/Never/Former**

Alcohol \_\_\_\_\_ Coffee \_\_\_\_\_ Tobacco \_\_\_\_\_

Drugs \_\_\_\_\_ Exercise \_\_\_\_\_

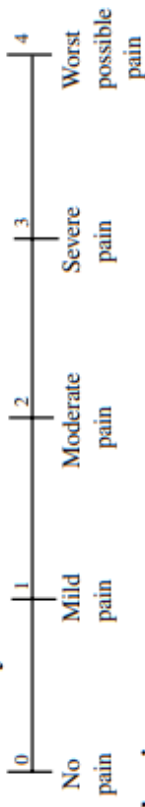
<OVER>

# Functional Rating Index

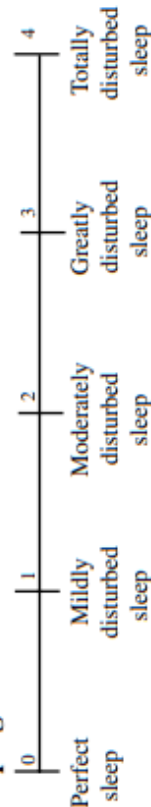
For use with Neck and/or Back Problems only.

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.**

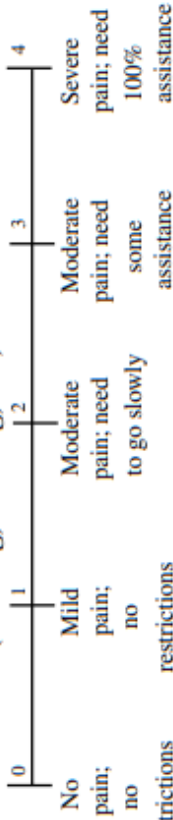
## 1. Pain Intensity



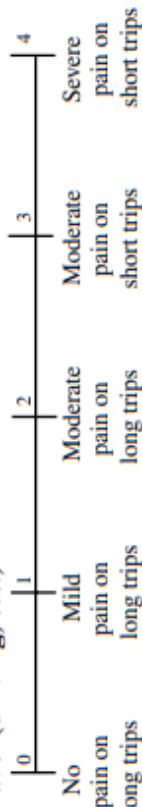
## 2. Sleeping



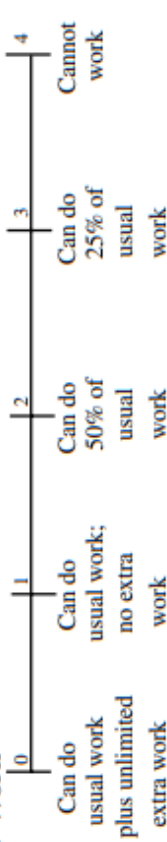
## 3. Personal Care (washing, dressing, etc.)



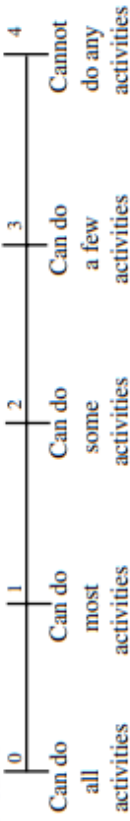
## 4. Travel (driving, etc.)



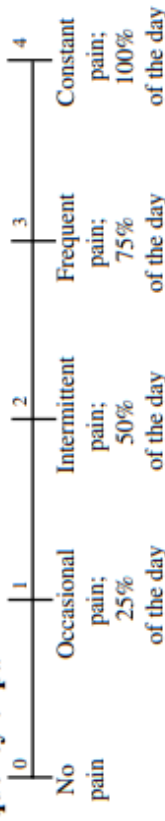
## 5. Work



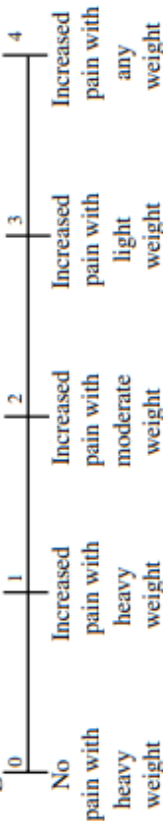
## 6. Recreation



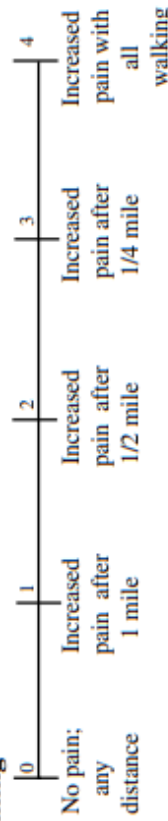
## 7. Frequency of pain



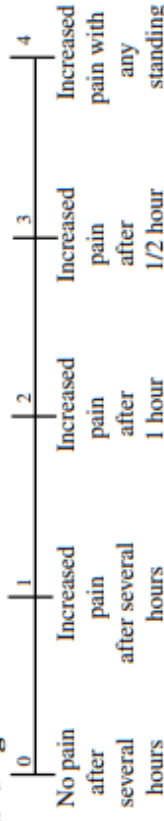
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_

**PRINTED**

**Total Score** \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



# 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 \$15 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.**

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## 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.

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## 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. I understand I can refuse any service in the office. If declined, the doctor will advise an alternative to treatment for the safety of my condition. 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 always 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. With signature, 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: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_



**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.

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

**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**

**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

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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: \_\_\_\_\_

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