WARDS CORNER CHIROPRACTIC & SPORTS REHAB

550 Wards Corner Road, Loveland OH 45140
(513) 677-6787 (p) ~ (513) (513) 677-2260(f)

Confidential Patient Information

Patients Name:

Address: Home Phone:

City: Zip: Cell Phone:

SS#: Email:

Date of Birth: Age: Marital Status: M S W D

Spouse's Name:

Occupation: Employer:

Address of Insured (if different than above):

If a minor – Parent Name: Other Parent Name:

Primary Ins:	Secondary Ins:
Ins. Phone #:	Ins. Phone #:
ID #:	ID #:
Group #:	Group #:
Name of Policy Holder:	Name of Policy Holder:
Policy Holder DOB:	Policy Holder DOB
Policy Holders Employer:	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):

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline Preferred Language:

Race: White Black/African American Asian American Indian Native Hawaiian/Other Pacific Island Other Decline

Do you smoke? No Yes If yes: Current every day Current some days Former smoker Never

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 **WARDS CORNER CHIROPRACTIC & SPORTS REHAB** 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.

Signature of Insured / Guardian Date

PATIENT CASE HISTORY

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

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

List any **Allergies:**

Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Pencillin Rafweed/Pollen
Rubber Seasonal Allergies Shellfish Soaps Wheat X-Ray Dye Other:

List any **surgeries:**

Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist Other:

List **ALL Past Medical History** conditions:

Ankle Pain Arm Pain Arthritis Asthma Back Pain Broken Bones Cancer Chest Pain Depression
Diabetes Dizziness Elbow Pain Epilepsy Eye/Vision Problems Fainting Fatigue Foot Pain
Generic Spinal Condition Hand Pain Headaches Hearing Problems Hepatitis High Blood Pressure
Hip Pain HIV Jaw Pain Joint Stiffness Knee Pain Leg Pain Menstrual Problems Mid-Back Pain
Minor Heart Problem Multiple Sclerosis Neck Pain Neurological Problems Pacemaker Parkinson's
Polio Prostate Problems Shoulder Pain Significant Weight Change Spinal Cord Injury Sprain/Strain
Stroke/Heart Attack Other

List Type of **Medication** you are taking:

Anxiety Muscle Relaxors Pain Killers Insulin Birth Control Cardiovacular Allergy Seizure
Other:

List your **Family History:**

Arthritis Asthma Back Pain Cancer Depression Diabetes Epilepsy Genetic Spinal Condition
High Blood Pressure Heart Problems Multiple Sclerosis Neurological Problems Parkinson's Polio
Prostate Problems Stroke/Heart Attack Other:

Have you ever had chiropractic care? No Yes When was last adjustment?

Why? Where?

Have you had any auto or other accidents? No Yes

Describe:

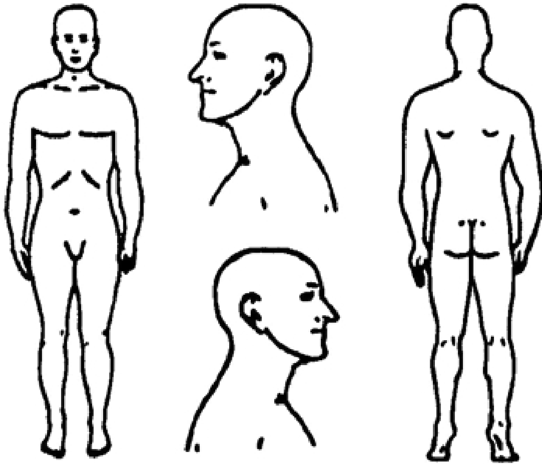
Date of last physical examination:

Do you drink alcohol? No Yes – how many per day?

You drink caffeine? No Yes – how many per day?

Do you exercise? No Yes (what forms and how often):

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM



Main reason for consulting the office:

Become pain free

Explanation of my condition

Learn how to care for my condition

Reduce symptoms

Resume normal activity level

What is your complaint? Date problem began?

How did this problem begin (falling, lifting, etc.)?

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other:

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0 = no effect and 10 = no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc.)?

What makes your pain better (ice, heat, massage, etc.)?

What is your SECOND complaint? Date problem began?

How did this problem begin (falling, lifting, etc.)?

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other:

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0 = no effect and 10 = no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc.)?

What makes your pain better (ice, heat, massage, etc.)?

What is your THIRD complaint? Date problem began?

How did this problem begin (falling, lifting, etc.)?

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other:

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0 = no effect and 10 = no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc.)?

What makes your pain better (ice, heat, massage, etc.)?