Warren Family Chiropractic
327 Pennsylvania Ave. W.
Warren, PA 16365

Phone: (814) 230-9402
www.warrenfamilychiropractic.com
Date: _____/_____/_____

Patient Intake Form

Name:____ Date of Birth:____/____/____

Age:_______ Gender (circle): Male/Female/Other

Address:__________________________________City:_________________State:____Zip:_______

Phone: Home___________________ Cell_____________________

Email:____ Occupation:___________________________

Please Indicate If You Are: STUDENT PASTOR MILITARY/VETERAN

Single / Married / Divorced / Widowed

Spouse's Name:___________________________ Number of Children:______

Who may we thank for referring you?____

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CURRENT HEALTH INFORMATION

List your primary health concerns below:

1______________________________ 6______________________________

2______________________________ 7______________________________

3______________________________ 8______________________________

4______________________________ 9______________________________

5______________________________ 10 ____________________________

Please circle if you are **currently** experiencing any of the following:

ADD/ADHD	Hip Pain	Infertility	Numbness in
Chronic	Menstrual	Migraines	Face
Sinusitis	Irregularities	TMJ Disorder	Numbness in
Headaches	Stomach	Chest Pain	Arms
Liver Disease	Disorder	Fibromyalgia	Numbness in
Sciatica	Allergies	Kidney Stones	Hands
Anxiety	Ear Infection	Nausea Ulcers	Numbness in
Depression	Irritable Bowel	Chronic Fatigue	Legs
Heart Disorder	Mid Back Pain	Gastric Reflux	Numbness in
Low Back Pain	Thyroid	Knee Pain L/R	Feet
Shoulder Pain	Problems	Neck Pain	
Asthma	Bladder Issues	Vertigo	
Dizziness	Epilepsy		

Any other health condition not listed above:

__________________ ______________________ ____________________ ____________________

____________________ ___________________

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Have you ever consulted with another Doctor for these conditions? YES / NO

Chiropractor? YES / NO   Medical Doctor? YES / NO

Other?_____________

Who and When did you consult? ____

Please list all medications or prescriptions you are currently taking:
(If you have a list, please provide a copy along with this paperwork)

_____________________________________   _____________________________________

_____________________________________   _____________________________________

_____________________________________   _____________________________________

____

Please rate your health in following areas (circle):

Physical Fitness:	Poor	1 2 3 4 5 6 7 8 9 10	Olympian
Energy Level:	No Energy	1 2 3 4 5 6 7 8 9 10	Energetic
Stress Level:	No Stress	1 2 3 4 5 6 7 8 9 10	Much Stress

Did/Do you smoke or use tobacco?	Always	Sometimes	Rarely	Never
Did/Do you drink alcohol?	Always	Sometimes	Rarely	Never
Did/Do you use illicit drugs?	Always	Sometimes	Rarely	Never

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PAST HEALTH INFORMATION

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

Please circle any of the following health conditions that you have experienced:

Stroke	Spinal Surgery	Diabetes
Cancer	Seizures	Infections
Heart Disease	Spinal Bone Fracture	Miscarriages

List all surgical operations and years:

Surgery:	Date:
________________________	______________________
________________________	______________________
________________________	______________________
________________________	______________________

When was your last leisure, auto, home, or work accident?

______________/_______________/_________________/______________/________________

Have you ever been knocked unconscious? YES / NO

Fractured a bone? YES / NO

If yes, Please describe: ____

Other Trauma: ____

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FAMILY HEALTH HISTORY

Please check any conditions that your family members currently or previously have had:

Condition	Spouse	Son	Daughter	Mother	Father
Arm Pain					
Arthritis					
Asthma					
ADD/ADHD					
Allergies					
Back Trouble					
Bed Wetting					
Cancer					
Carpal Tunnel					
Deceased					
Diabetes					
Digestive Problems					
Disc Problems					
Ear Infections					
Fibromyalgia					
Headaches					
Heartburn					
High Blood Pressure					
Hip Pain					
Leg Pain					
Menstrual Problems					
Migraines					
Neck Pain					
Scoliosis					
Sinus Issues					
TMJ					

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both the Doctor and the Patient to be working towards the same objective. Chiropractic has only one goal. It is important that each practice member understand both the objective and the method that will be used to ascertain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine.

HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of symptoms or disease.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Warren Family Chiropractic's objective is to eliminate interference within the Central Nervous Systems. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________________ have read & fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature ___________________________________ Date: ____/____/____
(Required)

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my care and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

2. Obtain payment from third-party payers.

3. Conduct normal healthcare operations, such as quality assessments and Physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out care, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature ___________________________________ Date: ____/____/____
(Required)

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X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF WARREN FAMILY CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS & CONDITIONS

Print ______________________________________

Signature ___________________________________ Date: _____/_____/_____
(Required)

FEMALE PATIENTS ONLY:

TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT WARREN FAMILY CHIROPRACTIC.

Signature ___________________________________ Date: _____/_____/_____
(Required)

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INFORMED CONSENT

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY.

YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND I GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

Print ____

Signature ______________________________________ Date: ____/____/____
(Required)

If patient is a minor/child, a parent &/or guardian must sign below

________________________________ Date: ____/____/____
Signature of Guardian

________________________________ Date: ____/____/____
Relationship to Minor/Child

____
Witness Signature (Office Staff)

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FINANCIAL POLICY/AGREEMENT

We are committed to providing you with quality chiropractic care. Your health and well-being are our primary concerns. Our office appreciates the consideration you give to the cost of your care. In order to achieve our goals of quality chiropractic care, we need your assistance and understanding of our financial policy. Payments for office visits are due within a one-week period of service. We do offer a Time of Service discount of $5.00 for adjustments and exams when payments are made on the same day. We accept cash, check, and credit cards. All returned checks due to non-sufficient funds will result in a $30 charge to the account.

The normal fees that will be encountered at our office visit will be as follows:

New Patient Exams: $40
Adjustments (Adults): $40
Adjustments (Children*): $30
Children 13 years old and younger

Full-Spine X-Rays: $110
Extremity Adjustments: $15

As a courtesy to our patients, we do take the time to call your insurance carrier (those which our office are credentialed with) to attain your explanation of benefits. If we are not credentialed with your insurance carrier, a receipt of services rendered by Warren Family Chiropractic will be provided and can be sent into your insurance carrier. Fill in your part of the claim and mail it to the insurance company. A doctor's signature is not required. It is not necessary for this office to fill out the insurance claim. Keep a copy of the receipt for your records. You must realize:

1. Not all services are covered benefits. They may select certain services they do not cover.
2. Any unpaid balance is your responsibility.

We realize temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the payment of your account by making financial arrangements.
We DO accept Medicare (65+). We do NOT accept Medicaid.
Any account that is over 60 days past due may be sent to a collections agency. If your account is sent to a collections agency, you will be responsible for any collection cost that we may incur. We are happy to discuss fees or money matters at any time. If you have any questions regarding your care, fees, or service, please bring it to our attention and we will gladly answer all of your questions.
Please sign below to signify that you have taken you time to read and completely understand our financial policy.

____
Printed Name of patient or parent/guardian Date

____
Signature of patient or parent/guardian Date