Ages 18 & over

Peak Family Chiropractic LLC.

132 Merz Blvd. Fairlawn, Ohio 44333
(330) 670-9400(p) ~ (330) 670-9401(f)

Date: _____

Who may we thank for referring you to our office? _____

Patient Information

Name:_____ _____ _____ Date of Birth:_____ Age:_____
Last First MI

Address:_____ City:_____ State:_____ Zip:_____ Sex: _____

Home Phone:_____ Cell Phone:_____ Cell Phone Carrier:_____

Email:_____ Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Partner

Employed? ☐ Yes ☐ No Employer:_____ Occupation:_____

Spouse Name:_____ Spouse Employer:_____ Spouse Occupation:_____

In Case Of Emergency, Contact:

Name:_____ Relationship:_____ Contact Number:_____

Health Insurance Information

Name of Insurance Company: _____ Policy Number:_____

Name of Insured (Policy Holder) _____ Group Number:_____

Insured Date of Birth: _____

Name of Secondary Insurance:_____ Policy Number:_____

Name of Insured (Policy Holder) _____ Group Number:_____

Insured Date of Birth: _____

Is your office visit due to an auto accident or work injury? ☐ Yes ☐ No If yes, which one applies? ☐ Auto accident ☐ Work Injury

Current Health Conditions

What is your chief problem or symptom? _____

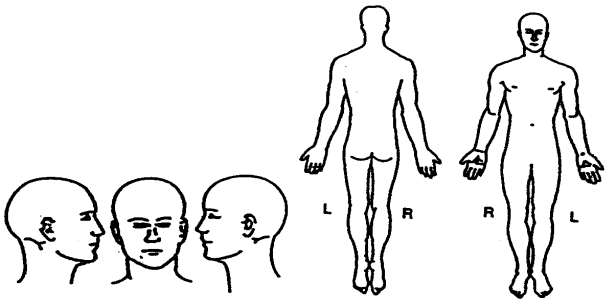
How long has it been a problem?_____ When is it worse?_____

Was there an injury or episode? (How did it start?) _____ Date:_____

How intense are your symptoms? (circle) **0 1 2 3 4 5 6 7 8 9 10**
No symptoms ***intense symptoms***

What does the pain feel like? (Check where appropriate)

- ☐ Numbness
- ☐ Dull
- ☐ Sharp
- ☐ Throbbing
- ☐ Tingling
- ☐ Aching
- ☐ Shooting
- ☐ Stabbing
- ☐ Stiffness
- ☐ Cramping
- ☐ Burning
- ☐ Swelling
- ☐ Other: _____



Circle location(s) of symptom on the body drawing

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Does your pain radiate?_____ If so, Where to? _____

What makes your pain better?_____
(Examples: Over the counter medication, hot pack/cold pack, rest, exercise, sitting, standing, etc.)

What makes your pain worse?_____
(Examples: sitting, standing, exercise, computer work, walking, etc.)

What treatments have you tried since suffering with this problem?_____
(Ice, Heat, Physical Therapy, Chiropractic, Massage, over the counter medication, prescription medication, etc.)

Please identify how your current condition effects your life. Place an "X" in the most appropriate box:

Condition	No Effect	Painful (Can Do)	Painful (Limits Activity)	Unable to Perform at all
Sit to stand				
Climbing Stairs				
Pet Care				
Driving				
Extended Computer Use				
Household Chores				
Lifting Children				
Reading/Concentration				
Bathing				
Dressing				
Shaving				
Sexual Activities				
Sleep				
Static Standing				
Static Sitting				
Yard Work				
Walking				
Sweeping/Vacuuming				
Dishes				
Laundry				
Garbage				
Lifting Groceries				
Other:				
Other:				

How do you want to handle this problem?

_____ Temporary Relief (Help the symptom but do not fix the cause of the problem)

_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

On a scale from 0-10 (10 being the most and 1 being the least)

_____ How committed are you to correcting your problem

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Social and Health History

Please check all of the items that apply to you now and in the past:

- ☐ Arthritis/Gout
- ☐ Eye Pain/Strain
- ☐ Jaw Pain
- ☐ Gall Stones
- ☐ Anemia
- ☐ Shortness of Breath
- ☐ Shoulder/Elbow Pain
- ☐ Abdominal Pain
- ☐ Skin Problems
- ☐ Depression/Anxiety
- ☐ Dizziness
- ☐ Bleeding Gums
- ☐ Swallowing Difficulty
- ☐ Hypertension
- ☐ Irregular Heart Beat
- ☐ Wrist or Hand Pain
- ☐ Diabetes
- ☐ Broken Bones
- ☐ Pregnancy
- ☐ Seizures
- ☐ Neck Pain/Spasms
- ☐ Thyroid Problems
- ☐ Stroke
- ☐ HIV/AIDS
- ☐ Low Back Pain
- ☐ Groin or Rectal Pain
- ☐ Digestive Problems
- ☐ Seasonal Allergies
- ☐ Ringing in Ears
- ☐ Chronic Fatigue
- ☐ Chest Pain
- ☐ Kidney Stones
- ☐ Asthma/Bronchitis
- ☐ Hip/Knee/Leg Pain
- ☐ Female Disorders
- ☐ Nausea-Vomiting
- ☐ Headaches
- ☐ Blurred Vision
- ☐ Heart Disease
- ☐ Chest Congestion
- ☐ Pancreatitis
- ☐ Mid Back Pain
- ☐ Foot or Ankle Pain
- ☐ Urinary Problems
- ☐ Irregular Bowels
- ☐ Aneurysm

Do you Smoke? Yes____ No____ Comments:_____
Do you Consume Alcohol? Yes____ No____ Comments:_____
Do you use Illicit Drugs? Yes____ No____ Comments:_____

Have you ever seen a Chiropractor? Yes_____ No_____ If yes, Name of Chiropractor _____

Primary Care Physician: _____ Phone Number: _____

Please list all of the medications *with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)* that you are currently taking. Include over-the-counter, prescriptions, herbals, and vitamins/minerals:

Drug Name: _____ _____
_____ _____
_____ _____
_____ _____

Allergies: _____
_____
_____
_____

Surgeries: _____ year_____
_____ year_____
_____ year_____
_____ year_____
_____ year_____

Family History:
Please list any conditions affecting your immediate family.

Spouse:_____
Son:_____
Daughter:_____
Mother:_____
Father:_____
Grandchildren:_____

Physician Notes:
_____
_____
_____
_____
_____
_____
_____
_____

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____
Parent or Guardian: _____ Signature: _____ Date: _____
Witness Name: _____ Signature: _____ Date:_____

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant, and that the doctor and his/her associates have my permission to perform an x-ray evaluation, if needed. I have been advised that x-ray can be hazardous to any unborn child.
Date of last menstrual cycle:_____

Patient Signature:_____ Date:_____

Pace Maker or Other Internal Medical Devices

This is to certify, that I do not have a Pacemaker or any other internal medical device and that the doctor and his/her associates have my permission to perform a Body Composition Analysis, if needed. I have been advised that this piece of equipment sends a weak electrical current through the body during measurement and causes a risk of malfunction to the device.

Patient Signature:_____ Date:_____

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HIPPA Acknowledgement

I acknowledge that I have reviewed/received a copy of Peak Family Chiropractic LLC's Notice of Privacy Practices.

_____
Name of Patient (Please Print)

_____ _____
Signature of Patient Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one)

- ☐ Parent
- ☐ Guardian
- ☐ Power of Attorney
- ☐ Other:_____

Please note: It is your right to refuse to sign this Acknowledgement

Office Use Only

I tried to obtain written acknowledgement by the individual noted above of the receipt of our Notice of Privacy Practices, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.
__ A communication barrier prevented us from obtaining acknowledgment.
__ The individual was unwilling to sign
__ Other: _____

_____ _____
Staff Member Signature Date

Financial Policy

Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

"ON THE JOB" INJURY (Workman's Compensation)
If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees for services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 6 months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE
We do accept assignment from Medicare. Our office completes and files the forms for Medicare at no cost.

SUBMITTING CHARGES TO INSURANCE
The providers Peak Family Chiropractic want to decide what care is in the best interest of each individual patient. For that reason, Peak Family Chiropractic and its providers are not a participating with your insurance company unless listed above. Under no circumstance will we submit claims to your insurance company for your care. If you would like to submit claims to your insurance, we will supply you a superbill upon request.

I have read and understand the payment policy of Peak Family Chiropractic.

_____
Patient signature (or guardian if patient is a minor) Date