

Springfield Family Chiropractic, P.C.

Dr. Gary S. Miller

7 E. Woodland Avenue
Springfield, PA 19064
610-544-6336 fax 610-544-7059

Patient Information

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Occupation _____
Cell Phone _____ E-Mail Address _____
Age ___ Birth Date _____ Social Security # _____ # of children _____ Marital Status **S M W D**
Primary Doctor's Name: _____ Phone Number: _____

Do you have insurance? Yes ___ No ___

Insurance Information

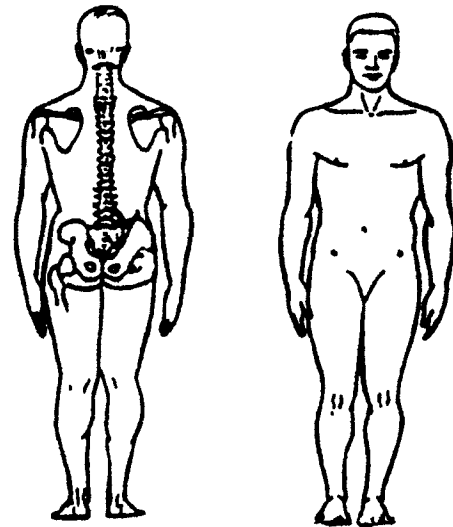
Insurance Company Name _____ Policy # _____
Policy Holder's Name _____ Date of birth _____ Work Phone _____
Policy Holder's Address _____ City _____ State _____ Zip _____
Policy Holder's Employer _____

If you have supplemental insurance

Insurance Company Name _____ Policy # _____
Policy Holder's Name _____ Date of birth _____ Work Phone _____
Policy Holder's Address _____ City _____ State _____ Zip _____
Policy Holder's Employer _____

Please complete these diagrams

If you are in pain, please mark the exact location of your pain on the diagram to the right. Also, describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example: dull, sharp, constant, intermittent, when standing, when sitting, etc.



Major Complaints

Please list your main health complaints

Accidents

Is your condition due to an accident or trauma? **Y N**

If yes, date of accident or trauma _____

Type of accident or trauma? Automobile ___ Work/On job ___ At home ___ Other _____

Have you ever been in an automobile accident? **Y N**

If yes, when? _____ Were you injured? **Y N** If yes, please explain _____

Who referred you to our office? _____

Have you ever been to a chiropractor before? **Y N**

If yes, when was the last date you were seen by a chiropractor? _____

Springfield Family Chiropractic, P.C.

Dr. Gary S. Miller

7 E. Woodland Avenue
Springfield, PA 19064
610-544-6336 fax 610-544-7059

I agree to pay for services rendered to the above mentioned patient as charges are incurred. I understand and agree that my insurance policy is an arrangement between my insurance carrier and me and that I am personally responsible for payment of any and all services covered or not covered by my policy. I, also, understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's/ Guardian's signature _____ Date _____

Notice to our patients: Payment is due at the end of each visit. If for any reason this request cannot be met, financial arrangements should be made as soon as possible.

Name _____

Date _____

Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

Current Symptom: (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section)

1. Check only one body location below <input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head <input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Other locations: _____			2. Types of pain Other types of pain: _____ <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting																																																																
3. Pain Frequency <input type="checkbox"/> Upto 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time <input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time		6. Actions affecting this pain <table border="1"> <thead> <tr> <th></th> <th>Brings On</th> <th>Aggravates</th> <th>Relieves</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> In the A.M.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> In the P.M.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending forward</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending back</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending left</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending right</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Twisting left</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Twisting right</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Coughing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Sneezing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Straining</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Standing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Sitting</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Lifting</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Other Actions:</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>			Brings On	Aggravates	Relieves	<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Brings On	Aggravates	Relieves																																																																
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
4. Pain Intensity (How it affects your daily activities) <input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects <input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities			5. Does this pain radiate into other body parts? <table border="1"> <thead> <tr> <th></th> <th>Left</th> <th>Right</th> <th>Both</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Head</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Shoulder</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Arm</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hand</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hip</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Leg</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Foot</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> Other locations of radiation: _____			Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																											
	Left	Right	Both																																																																
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																

Current Symptom: (Please check off the boxes below to describe your next symptom).

1. Check only one body location below <input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head <input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Other locations: _____			2. Types of pain Other types of pain: _____ <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting																																																																
3. Pain Frequency <input type="checkbox"/> Upto 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time <input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time		6. Actions affecting this pain <table border="1"> <thead> <tr> <th></th> <th>Brings On</th> <th>Aggravates</th> <th>Relieves</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> In the A.M.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> In the P.M.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending forward</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending back</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending left</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending right</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Twisting left</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Twisting right</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Coughing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Sneezing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Straining</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Standing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Sitting</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Lifting</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Other Actions:</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>			Brings On	Aggravates	Relieves	<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Brings On	Aggravates	Relieves																																																																
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
4. Pain Intensity (How it affects your daily activities) <input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects <input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities			5. Does this pain radiate into other body parts? <table border="1"> <thead> <tr> <th></th> <th>Left</th> <th>Right</th> <th>Both</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Head</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Shoulder</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Arm</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hand</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hip</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Leg</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Foot</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> Other locations of radiation: _____			Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																											
	Left	Right	Both																																																																
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																

Current Symptom: (Please check off the boxes below to describe your 3rd symptom).

1. Check only one body location below <input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head <input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Other locations: _____			2. Types of pain Other types of pain: _____ <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting																																																																
3. Pain Frequency <input type="checkbox"/> Upto 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time <input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time		6. Actions affecting this pain <table border="1"> <thead> <tr> <th></th> <th>Brings On</th> <th>Aggravates</th> <th>Relieves</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> In the A.M.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> In the P.M.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending forward</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending back</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending left</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending right</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Twisting left</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Twisting right</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Coughing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Sneezing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Straining</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Standing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Sitting</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Lifting</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Other Actions:</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>			Brings On	Aggravates	Relieves	<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Brings On	Aggravates	Relieves																																																																
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
4. Pain Intensity (How it affects your daily activities) <input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects <input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities			5. Does this pain radiate into other body parts? <table border="1"> <thead> <tr> <th></th> <th>Left</th> <th>Right</th> <th>Both</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Head</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Shoulder</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Arm</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hand</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hip</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Leg</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Foot</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> Other locations of radiation: _____			Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																											
	Left	Right	Both																																																																
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																

Health History

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT- Scan, Bone Scan _____

Have you ever had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Pressure H	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Pressure L	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insomnia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Memory Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors/ Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Menstrual Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical		Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nightsweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies _____	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pins & Needles	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Are you pregnant? Yes No N/A

Is there a family history of ... Heart disease Arthritis Cancer Diabetes

<p>Exercise</p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p>Work Activity</p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light labor <input type="checkbox"/> Heavy labor	<p>Habits</p> <input type="checkbox"/> Smoking _____ packs/day <input type="checkbox"/> Alcohol _____ drinks/day <input type="checkbox"/> Coffee/Caffeine drinks _____ cups or cans/day <input type="checkbox"/> High stress level reason: _____
---	---	--

Injuries you have had:

<input type="checkbox"/> Falls <input type="checkbox"/> Head injuries <input type="checkbox"/> Broken bones <input type="checkbox"/> Dislocations <input type="checkbox"/> Surgeries	<p style="text-align: center;">Description/Date</p> <hr/> <hr/> <hr/>
--	--

<p>Current Medications</p> 	<p>Vitamins/Herbs/Minerals</p>
---	---

Springfield Family Chiropractic, P.C.

Dr. Gary S. Miller

7 E. Woodland Avenue
Springfield, PA 19064
610-544-6336 fax 610-544-7059

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain 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 subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

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 it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation, nor do we offer advice regarding treatment prescribed by others. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

By signing below, I indicate that I have read and fully understand the above statements.

Signature

Date

Springfield Family Chiropractic, P.C.

Dr. Gary S. Miller

7 E. Woodland Avenue
Springfield, PA 19064
610-544-6336 fax 610-544-7059

Authorization for Assignment

In consideration of Springfield Family Chiropractic undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute any action in my name as you see fit and further authorize you to compromise, settle or otherwise receive any claim as you see fit. However it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amount you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this Commonwealth of Pennsylvania.
5. I further agree that this Authorization for Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization for Assignment will be in continual effect until revoked by both parties.

Patient/Insured signature

Date

Authorization for Records Release

To Springfield Family Chiropractic, I hereby authorize you to release to any insurance company, attorney or adjuster any information including the diagnosis and records of treatment or examination rendered to me for any and/or all the care I receive.

Patient/Insured signature

Date

Springfield Family Chiropractic PC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Key Issues

Uses and Disclosures:

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty:

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:

Jeanne Miller
7 E. Woodland Ave.
Springfield, PA 19064
610-544-6336

Further Details

1. Uses and Disclosures of Protected Health Information

Following are examples of the types of uses and disclosures of your protected health care information that the provider is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, in activities related to obtaining payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health insurance company or governmental plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support our business activities. For example, when we review employee performance, we may need to look at what an employee has documented in your medical record.

Business Associates: We may share your protected health information with a third party 'business associate' that performs various activities (e.g., billing, transcription services). Whenever an arrangement between us and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Marketing: We may use or disclose certain health information in the course of providing you with information about treatment alternatives, health-related services, or fund-raising. You may contact us to request that these materials not be sent to you.

Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing.

Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to object. If you are not present or able to object, then your provider may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.

Emergencies: In an emergency treatment situation, we will provide you a Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

Communication Barriers: We may use and disclose your protected health information if we have attempted to obtain acknowledgement from you of our Notice of Privacy Practices but have been unable to do so due to substantial communication barriers and we determine, using professional judgment, that you would agree.

Without Opportunity to Object: We may use or disclose your protected health information in the following situations without your authorization or opportunity to object:

Public Health: for public health purposes to a public health authority or to a person who is at risk of contracting or spreading your disease.

Health Oversight: to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: to an appropriate authority to report child abuse or neglect, if we believe that you have been a victim of abuse, neglect, or domestic violence.

Legal Proceedings: in the course of legal proceedings.

Law Enforcement: for law enforcement purposes, such as pertaining to victims of a crime or to prevent a crime.

Coroners, Funeral Directors, and Organ Donation: for the coroner, medical examiner, or funeral director to perform duties authorized by law and for organ donation purposes.

Research: to researchers when their research has been approved by an Institutional Review Board or Privacy Board.

Soldiers, Inmates, and National Security: to military supervisors of Armed Forces personnel or to custodians of inmates, as necessary. Preserving national security may also necessitate disclosure of protected health information.

Workers' Compensation: to comply with workers' compensation laws.

Compliance: to the Department of Health and Human Services to investigate our compliance. In general, we may use or disclose your protected health information as required by law and limited to the relevant requirements of the law.

2. Your Rights

You have the right to:

- inspect and copy your protected health information.
- request a restriction of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for treatment, payment or healthcare operations. You may also request that information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, but if we do agree, then we must act accordingly.
- request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.
- ask us to amend your protected health information. You may request an amendment of protected health information about you. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and your medical record will note the disputed information.
- receive an accounting of certain disclosures we may have made. This right applies to disclosures for purposes other than treatment, payment or healthcare operations. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.
- obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Acknowledgement of Receipt of Notice of Privacy Practices

Please print your name, sign and date this form to acknowledge that you have received our Notice of Privacy Practices. We strive to protect your personal information and offer professional service at Springfield Family Chiropractic. Please let us know if you have any questions or concerns about this notice.

Printed name: _____

Signature: _____

Date: _____

Springfield Family Chiropractic, P.C.

Dr. Gary S. Miller

7 E. Woodland Avenue
Springfield, PA 19064
610-544-6336 fax 610-544-7059

Consent to Treat a Minor Child

I hereby authorize Dr. Gary Miller and whomever he may designate as assistants to administer chiropractic care as deemed necessary to my child,

Name of child- please print

Parent Signature

Date

Witness

Date