BULL FAMILY CHIROPRACTIC

223 Tioga Street
Wellsboro, PA 16901
570-723-5000
www.bullfamilychiro.com

Name _____ Today's Date_____
What do you prefer to be called?_____
Date of Birth _____SS# _____
Gender: Male ☐ Female ☐ Other ☐
Home Phone _____ Cell Phone _____
Email: _____ Preferred method of contact: ☐ Call ☐ Text ☐ Email
Address _____ City_____ State _____Zip_____
Emergency Contact Name _____ Phone _____Relation _____

Employer _____ City _____ State_____ Zip_____
Occupation _____ Your Job Description _____

How did you hear about our office/referred by? _____
When did your condition begin? _____ Date of Last Physical Exam _____
Other Doctors seen for this condition? _____
Have you had the same or similar symptoms before? ☐ Yes ☐ No Date of prior condition _____
Have you had chiropractic care before? ☐ Yes ☐ No Date: _____ Provider: _____
May we move forward our findings to your doctor? ☐Yes ☐ No

List chief symptoms in order of severity:
(1)_____
(2)_____
(3)_____

List previous surgeries:
_____
_____
_____
_____

Any KNOWN allergies? (Drugs, Food, Environment)
NO or YES----please list:_____
Current Medications (Including Vitamins and Supplements)

_____
_____

Circle any that apply:
Do you take blood thinners (heparin, coumadin, warfarin), steroids? ☐ Yes ☐ No
Do you have any family history of; rheumatoid arthritis, gout, ankylosing spondylitis, lupus, stroke? ☐ Yes ☐ No

Check all symptoms that apply to you:

☐Headache ☐Tingling/numbness in arms/hands ☐Chest pain ☐Unexplained weight loss
☐Neck Pain/Stiffness ☐Tingling/numbness in legs/toes ☐Knee pain ☐Fatigue
☐Back pain/Stiffness ☐Loss of balance/dizziness ☐Hip pain ☐Night Sweats
☐Shoulder Pain ☐Shortness of breath ☐Fever ☐Blood in Urine
☐Other _____ ☐Night Pain ☐Pain unrelieved by rest

For women: Are you pregnant? ☐Yes ☐No Are you taking birth control? ☐Yes ☐No

Review of Systems- (check box if you have had trouble with any of the following)

☐ **I currently do not have, or have had any of these conditions in the past.**

Cardiovascular	Past	Present
Poor Circulation		
Hypertension		
Aortic Aneurysm		
Heart Disease		
Heart Attack		
Chest Pain		
High Cholesterol		
Pacemaker		
Jaw Pain		
Irregular Heartbeat		
Swelling of Legs		

Neurologic	Past	Present
Stroke		
Seizures		
Head Injury		
Concussion		
Brain Aneurysm		
Numbness		
Severe Headaches		
Pinched Nerves		
Parkinson's		
Carpal Tunnel		
Vertigo		

Constitutional	Past	Present
Weight Loss/Gain		
Low Energy Level		
Difficulty Sleeping		

Musculoskeletal	Past	Present
Gout		
Arthritis		
Joint Stiffness		
Muscle Weakness		
Osteoporosis		
Broken Bones		
Joints Replaced		
Neck Pain		
Low Back Pain		
Upper Back Pain		

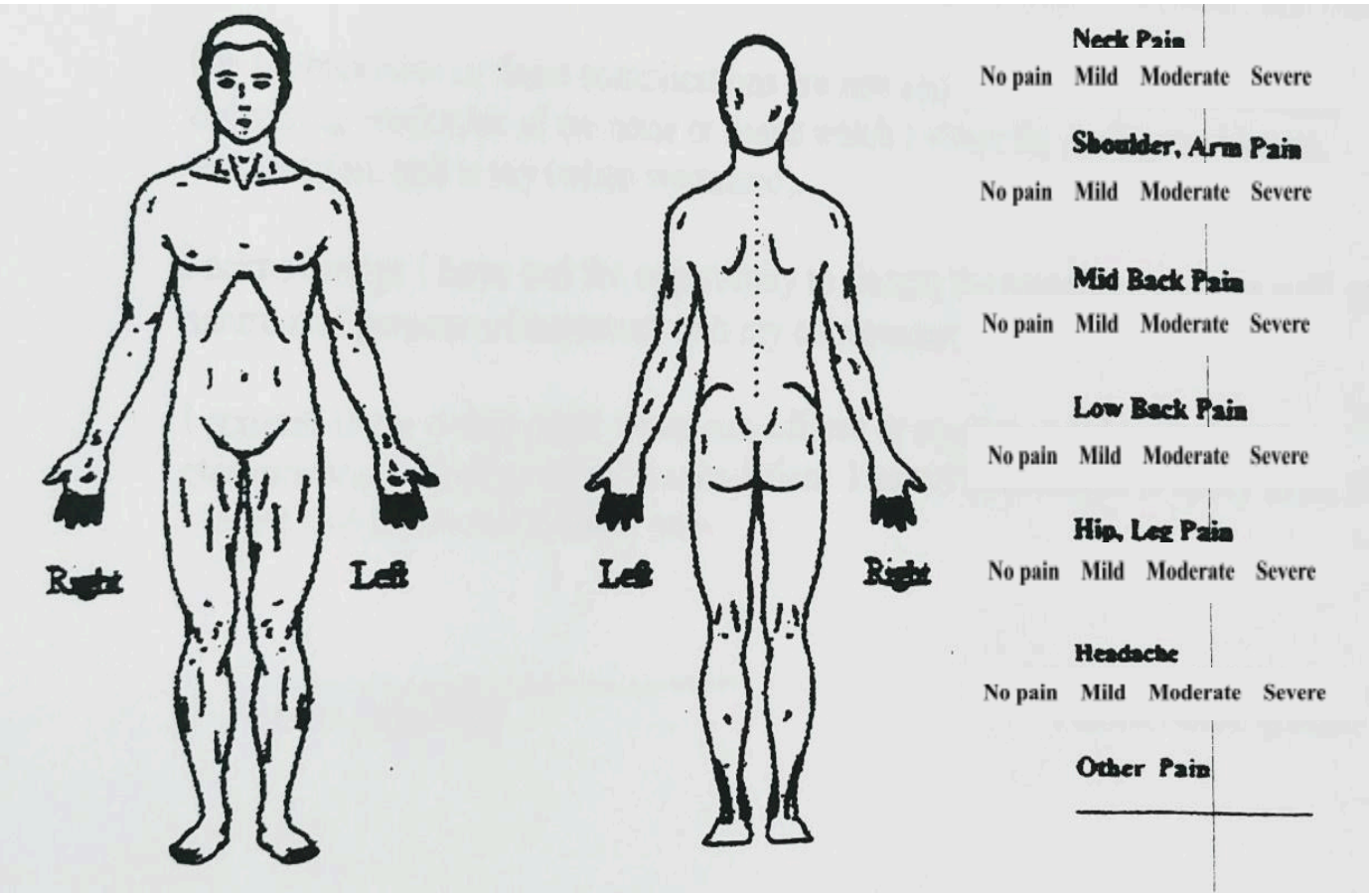
Hematologic	Past	Present
Hepatitis		
Blood Clots		
Cancer		
Bruising		
Bleeding		
Fever, Chills		
Sweating		
Varicose Vein		

Time of day when pain is worst: _____ Morning _____Afternoon _____Evening

Does this pain radiate? _____

Is the pain: Mild Moderate Severe No Pain

Please circle on the scale from, no pain to severe pain, and what you feel with this condition. Mark the type of pain below and where it pertains to the area on the left.



Type of pain:

Stiffness _____

Burning _____

Numb/Tingling _____

Sharp_____

Soreness/Achy _____

INSURANCE INFORMATION, CONSENT TO TREAT, AND RELEASE OF INFORMATION (PLEASE READ AND SIGN)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, **I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment.** I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Bull Family Chiropractic and their affiliated providers for any reason, I will be responsible for payment of my entire outstanding balance.

I hereby request, consent and authorize Bull Family Chiropractic and their affiliated providers to administer treatment, physical examination, chiropractic care, therapeutic rehabilitation, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. In particular, soreness is the most common symptom to feel after chiropractic care. If symptoms progress further than 72 hours, please consult your chiropractor. Some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques, but these are rare. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures; There are reported cases of stroke associated with visits to medical doctors and chiropractors. The scientific evidence and research does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. Essentially, a stroke is already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote; There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment; Some electrical therapies offered by doctors of chiropractic can cause burns or skin irritation; however, this reported cases are infrequent.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent. I have had my questions answered to my satisfaction. I also understand that there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including but not limited to medication and/or surgery.

I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, or the patient's employer.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

We invite you to discuss any questions you might have with us.

_____ _____

Signature of Patient or Personal Representative **Date**

BULL FAMILY CHIROPRACTIC

HIPAA Authorization/ Privacy Practices

Patient Name: _____ Date of Birth: _____

Cell Phone: _____ Home Phone: _____ Email: _____

By signing below, I acknowledge that in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, that I have the right to revoke this consent, in writing, except to the extent that Bull Family Chiropractic (BFC) has taken action in reliance on this consent.

With this consent, BFC can call me at home or an alternate location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, or healthcare operations (TPO), such as appointment reminders, obtaining insurance information, billing, and any calls pertaining to my clinical care. Bull Family Chiropractic also has my consent to mail any items that assist the practice in carrying out TPO, such as appointment cards, statements, and insurance information. I am consenting to BFC, the use of my Protected Health Information (PHI) to carry out the TPO.

I also understand that BFC will uphold the privacy of my medical records unless this information is requested to be released by myself or someone who I have given permission to access my records. I am also fully aware that Bull Family Chiropractic will not share my medical records with anyone without an authorization, except in the event of an emergency or patient's condition that deems the situation medically necessary.

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name: _____ Relationship:_____ Phone#: _____

Name: _____ Relationship:_____ Phone#: _____

By signing my name below, I acknowledge my understanding of the terms of this agreement. This authorization shall supersede any prior written authorization I have made regarding the use, disclosure, and release of my medical information. This authorization will expire 2 years from the date it is signed.

_____ _____

Signature of Patient or Personal Representative **Date**

CONSENT TO TREAT A MINOR

I, being the parent, guardian, or custodian of the minor _____, age _____, do hereby authorize, request & direct Bull Family Chiropractic and it's doctors and staff to perform examinations and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

_____ _____

Parent/Guardian or Custodian Signature **Date**