Name: ________________________________

How did you hear about our office?

☐ Referred by current patient/friend?

If checked please provide the patient/friend name ____________________________

☐ Referred by another doctor?

If checked please provide the doctor/office name ______________________________

☐ Online inquiry?

☐ Facebook, twitter or other forms of social media

☐ Health insurance website

☐ Online search

If checked online search, please tell us what you searched ________________________

☐ Other (please specify) ____

Chiropractic Case History/Patient Information

Date:____________ Patient #:____________ Doctor:____________

Name:____________ SSN:____________ Age:______ Birth Date:____________

Address:____________ City:____________ State:______ ZIP:____________

E-mail Address:____________ Cell Provider:____________ Cell Phone #:____________

Home Phone #:____________ Race/Ethnicity:____________ Marital Status (Circle): M S W D

Occupation:____________ Employer:____________

Employer's Address:____________ Office Phone:____________

Spouse:____________ Occupation:____________ Employer:____________

How many children?:______ Names and ages of children:____________

____

Emergency Contact:____________ Relationship:____________ Phone #:____________

Please check any and all insurance coverage that may be applicable in this case:

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident

☐ Medical Savings Account & Flex Plans ☐ Other

Name of Primary Insurance Company:____________

Name of Secondary Insurance Company (if any):____________

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The following person(s) have my permission to receive my personal health information:

____

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent form.

Patient's Signature: X____________________ Date:____________

Guardian's Signature Authorizing Care: X____________________ Date:____________

Name:______________________________ Date:______________

History of Present and Past Illness

Chief complaint/purpose of this appointment:______________________________

Date symptoms appeared/accident happened:______________________________

Is this due to: ☐ Auto ☐ Work ☐ Other:______________________________

Have you ever had the same condition or a similar condition? ☐ Yes ☐ No

If you answered "yes" to the above, describe the condition and when you had it:______________________________

____

Days lost from work:__________ Date of last physical examination:______________________

Do you have a history of stroke or of hypertension?: ☐ Yes ☐ No

Have you had any major illnesses, injuries, falls, auto accidents, or surgeries? If applicable, please include information about childbirth (include dates):______________________________

____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, describe:______________________________

What medications or drugs (including supplements and herbal products) are you taking?:______________________________

____

____

Do you have any allergies to any medications? ☐ Yes ☐ No

If yes, describe:______________________________

Do you have any allergies of any kind? ☐ Yes ☐ No

If yes, describe:______________________________

Do you have any congenital condition (condition acquired at or before birth)? ☐ Yes ☐ No

If yes, describe:______________________________

Are you pregnant?: ☐ Yes ☐ No ☐ N/A

Have you had, or do you now have, any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now**, or **P** if you have had these conditions **previously**.

N = Now   **P** = Previously

_____ Headaches (Frequency:__________)
_____ Neck Pain
_____ Stiff Neck
_____ Sleeping Problems
_____ Back Pain
_____ Nervousness
_____ Tension
_____ Irritability
_____ Chest Pains/Tightness
_____ Dizziness
_____ Shoulder/Neck/Arm Pain
_____ Numbness in Fingers

_____ Numbness in Toes
_____ High Blood Pressure
_____ Difficulty Urinating
_____ Weakness in Extremities
_____ Loss of Balance
_____ Fainting
_____ Loss of Smell
_____ Loss of Taste
_____ Unusual Bowel Patterns
_____ Feet Cold
_____ Hands Cold
_____ Arthritis

Name:____ Date:________________

N = Now P = Previously

_____ Muscle Spasms
_____ Frequent Colds
_____ Fever
_____ Sinus Problems
_____ Diabetes
_____ Indigestion Problems
_____ Joint Pain/Swelling
_____ Menstrual Difficulties
_____ Breathing Problems
_____ Fatigue
_____ Lights Bother Eyes
_____ Ears Ring
_____ Broken Bones/Fractures
_____ Rheumatoid Arthritis
_____ Excessive Bleeding
_____ Osteoarthritis

_____ Pacemaker
_____ Stroke
_____ Ruptures
_____ Eating Disorder
_____ Drug Addiction
_____ Gall Bladder Problems
_____ Ulcers
_____ Weight Loss/Gain
_____ Depression
_____ Loss of Memory
_____ Buzzing in Ears
_____ Circulation Problems
_____ Seizures/Epilepsy
_____ Low Blood Pressure
_____ Osteoporosis
_____ Heart Disease
_____ Cancer
_____ Coughing Blood
_____ Alcoholism
_____ HIV Positive

Social Activity

Please indicate whether you engage in the following activities. Indicate with the letter **O** if you engage in an activity **often**, **S** if you engage in it **sometimes**, or **N** if you **never** engage in it.

O = Often **S** = Sometimes **N** = Never

_____ Vigorous Exercise
_____ Moderate Exercise
_____ Alcohol Use
_____ Tobacco Use
_____ Caffeine Use
_____ Other Drug Use
_____ Family Stress
_____ Financial Stress
_____ High-Stress Activity
_____ Other (Specify) ______________________

____

NECK DISABILITY INDEX

Name_______________________________ Date____/____/____ File#__________
(Please Print)

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (Washing, Dressing etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are covenlently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Reading

- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5 - Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 - Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7- Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

SECTION 8 - Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9 - Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr.sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs.sleepless.).
- ☐ My sleep is moderately disturbed (2-3 hrs.sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs.sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs.sleepless).

SECTION 10 - Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

From Vernon H, Mior S. JMPT 1991: 14(7): 409-415

Roland-Morris Low Back Pain and Disability Questionnaire (RMQ)

Instructions

Patient name:______________________________ File #:____________ Date:____________

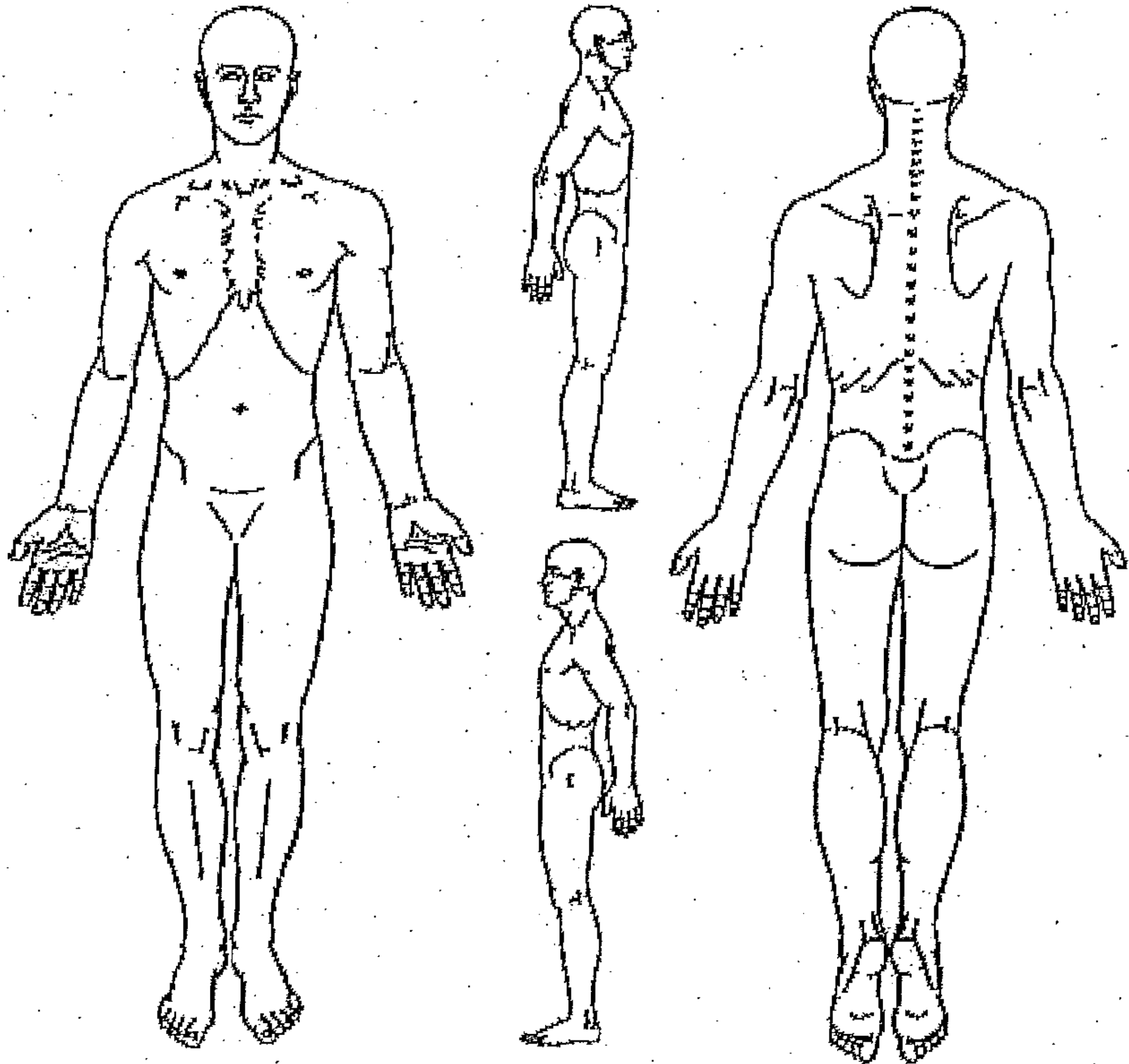
Please read instructions: When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try to get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back.
- ☐ I have trouble putting on my socks (or stockings) because of the pain in my back.
- ☐ I can only walk short distances because of my back pain.
- ☐ I sleep less well because of my back.
- ☐ Because of my back pain, I get dressed with the help of someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.

Revised Oswestry Pain Questionnaire

*Name*____________________________________ *Date*______________

On the below diagram please indicate where you are experiencing pain. Use the letters below to descibe what you are feeling and in what area.



A = Ache B = Burning N = Numbness
P = Pins and Needles S = Stabbing O = Other

Academy Injury & Health Chiropractic
2808 Southampton Road * Philadelphia * PA * 19154

X-Ray Consent Form

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. In addition, they may be required in order to administer treatment.

By signing below, I consent to having the diagnostic x-rays performed, which the doctor determines is clinically necessary.

Name:____ Date:________________

Patient's Signature: X______________________________________ Date:________________

THE FOLLOWING PORTION IS FOR **WOMEN** ONLY:

I understand that, if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I am aware that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am pregnant.	☐ Yes ☐ No
I could be pregnant.	☐ Yes ☐ No
I am late with my menstrual period.	☐ Yes ☐ No
I am taking contraceptives.	☐ Yes ☐ No
I have had a tubal litigation.	☐ Yes ☐ No
I have had a hysterectomy.	☐ Yes ☐ No
I have irregular menstrual periods.	☐ Yes ☐ No

My last menstrual period began on __________________.

With a full understanding of the above, and believing that I am currently not at risk, I wish to have an x-ray examination performed today if requested by the doctor.

Patient's Signature: X__________________________________ Date:________________

This form is for everyone; please see top portion.

Health and Medical Information Release Form

I, ____________________________, give permission to Dr. Francis J. McCaffery and staff at Academy Injury and Health Center to share medical information with my medical doctor, ____________________ as well as his/her staff.

Signature: X ____

Medical Doctor Information

Name of Doctor: ____

Street Address: ____

City, State, ZIP code: ____

Phone: ___________________________________ Fax: ______________________________

Informed Consent for Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me by the Doctor of Chiropractic at AIHC.

I have had an opportunity to discuss with the Doctor of Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as with the practice of medicine chiropractic carries some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I consent to rely on the doctor's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts.

I had had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present conditions(s) and for any future condition(s) for which I seek treatment.

Patient Name: ____ Date: _____________

Patient Signature: ____

Patient Representative Signature: ____

Name:______________________________ Date:______________

Authorization, Assignment, and Release Form

Authorization and Assignment

In consideration of your undertaking to care for me, I agree to the following:

You are hereby 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. I also agree to the following terms:

1. 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 obliged to make payment to me or you based in whole or in part upon the charges made for your services.
2. 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 and action in my name as you see fit and further authorize you to compromise, settle, or otherwise receive and 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 or from me. I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.
3. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of ______________________.
4. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
5. This Authorization for Assignment will be in continual effect until revoked by both parties.

Patient/Insured Signature: X______________________________ Date:______________

Records Release

To ______________________________, I hereby authorize you to release to ______________________________ any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from ______________ to ______________.

Patient/Insured Signature: X______________________________ Date:______________

Staff Signature: X______________________________ Date:______________

Academy Injury and Health Chiropractic
2808 Southampton Road
Philadelphia, PA 19154

Fee for Medical Records

The Department of Health published the guidelines and fees that a health care provider or facility may charge in response to a request for production of medical charts or records. This notice updates the notice published at 47 Pa.B 7389.

Accordingly, effective January 1, 2019, the following fees may be charged by a health care facility or health care provider in response to a request for production of medical charts or records:

Amount charged per page for:	Not to Exceed:
Pages 1 - 20	$1.55
Pages 21 - 60	$1.15
Pages 61 – End	$0.39
Copy of X-Ray	$10.00
*Search and retrieval of records (cannot be charged if requestor is requesting their own personal health record)	$23.04
*Patient will be charged for postage if records are being sent via USPS/UPS/FedEx	

Date: ________________

Patient Signature: X____