CONFIDENTIAL
HEALTH INFORMIATION

Please allow our staff to photocopy your driver's license and Insurance details. All information you supply is confidential.
We comply with all federal privacy standards.
Please print clearly.

Elevate Sport and Spine Center
2878 Freeport Road
Natrona Heights, PA 15065
(724)226-0100 (p)
(724) 226-0400 (f)
elevatesportandspine@gmail.com
www.elevatesportandspinecenter.com

______________________ **Today's Date (MM/DD/YYYY)**

______________________ **Patient Number (office use only)**

______________________ **How did you hear about us?**

Have you consulted a chiropractor before? O No O Yes **When?** ________________ **If so, whom?** ______________________

______________________ **Your Last Name**

______________________ **Your Social Security Number**

______________________ **Birth Date (MM/DD/YYYY)**

______________________ **Age**

______________________ **Your First Name**

______________________ **Your Middle Name (or initial)**

Gender
O Male O Female

______________________ **Address**

Marital Status O Married
O Single O Divorced
O Widowed O Separated

______________________ **City**

______________________ **State/Province**

______________________ **Zip/Postal Code**

______________________ **Home Phone**

______________________ **Cell Phone**

______________________ **Spouse's Name**

______________________ **Email Address**

______________________ **Child's Name and Age**

______________________ **Emergency Contact**

______________________ **Emergency Contact's Phone**

______________________ **Child's Name and Age**

______________________ **Your Occupation**

______________________ **Child's Name and Age**

______________________ **Your Employer**

______________________ **Work Phone**

______________________ **Address**

May we contact you at work?
O Yes O No

______________________ **City**

______________________ **State/Province**

______________________ **Zip/Postal Code**

Preferred method of contact?
O Home Phone O Cell Phone
O Work Phone O Email

______________________ **Primary Care Provider's Name**

______________________ **Insurance Carrier**

______________________ **Policy Number**

______________________ **Insured's Last Name**

______________________ **Birth Date (MM/DD/YYY)**

Who carries this policy?
O Self O Spouse O Parent

______________________ **Insured's First Name**

______________________ **Insured's Middle Name (or initial)**

______________________ **Insured's Employer**

______________________ **Address**

______________________ **City**

______________________ **State/Province**

______________________ **Zip/Postal Code**

______________________ **Employer's Phone**

Patient Name

Patient Number (office use only)

1. **The symptom(s) that have prompted me to seek care today include**:____

2. **And are the result of (darken circle):** O An accident or injury
   O Work O Auto O Other ______________________________
   O A worsening long-term problem
   O An interest in: O Wellness O Other______________________________

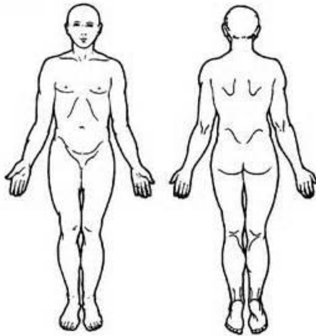
3. **Onset** (When did you first notice Your current symptoms?) ___________________________

4. **Intensity** (How extreme are your current systems?)
   0- O-O-O-O-O-O-O-O-O-O-10
   Absent Uncomfortable Agonizing

5. **Duration and Timing** (When did it start and how often do you feel it?)
   O Constant O Comes and goes. How Often?___________________________

6. **Quality of symptoms** (What does it feel like?)
   - O Numbness
   - O Tingling
   - O Stiffness
   - O Dull
   - O Aching
   - O Cramps
   - O Nagging
   - O Sharp
   - O Burning
   - O Shooting
   - O Throbbing
   - O Stabbing
   - O Other ______________________________

7. **Location**(Where does it hurt?) Circle the area(s) on the illustration.
   "O" for current condition
   "X" for conditions experienced in the past



8. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
   ____

9. **Aggravating or relieving factors** (What makes it better or worse, such as time of the day, movements, certain activities, etc.)
   What tends to worsen the problem?______________________________
   What tends to lessen the problem?______________________________

10. **Prior Interventions** (What have you done to relieve the symptoms?)

O Prescription medication	O Surgery	O Ice
O Over-the-counter drugs	O Acupuncture	O Heat
O Homeopathic Remedies	O Chiropractic	O Other_______________
O Physical Therapy	O Massage	___________________________

11. **What else should Elevate Sport & Spine know about your current condition?**
    ____
    ____

12. **How does your current condition interfere with your**:

    Work or career:______________________________
    Recreational activities:______________________________
    Household responsibilities:______________________________
    Personal relationships:______________________________

13. **Review of Systems**
    Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle besides any condition that you've **Had** or currently **Have**.

a. Musculoskeletal

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE O
O O Osteoporosis	O O Arthritis	O O Scollosis	O O Neck pain	O O Back problems	O O Hip disorder	
O O Knee Injuries	O O Foot/Ankle pain	O O Shoulder problems	O O Elbow/wrist pain	O O TMJ Issues	O O Poor posture	

b. Neurological

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE O
O O Anxiety	O O Depression	O O Headache	O O Dizziness	O O Pins & Needles	O O Numbness	

c. Cardiovascular

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE O
O O High Blood pressure	O O Low Blood pressure	O O High cholesterol	O O Poor Circulation	O O Angina	O O Excessive bruising	

d. Respiratory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE O
O O Asthma	O O Apnea	O O Emphysema	O O Hay fever	O O Shortness of breath	O O Pneumonia	

e. Digestive

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE O
O O Anorexia/ bulimia	O O Ulcer	O O Food sensitivities	O O Heartburn	O O Constipation	O O Diarrhea	

f. Sensory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE O
O O Blurred vision	O O Ringing in ears	O O Hearing loss	O O Chronic ear infection	O O Loss of smell	O O Loss of taste	

g. Skin

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE O
O O Skin cancer	O O Psoriasis	O O Eczema	O O Acne	O O Hair Loss	O O Rash	

Doctor's Initials

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE O
O	O	Thyroid issues	O	O	Immune disorders	O	O	Hypoglycemia	O	O	Frequent infection	O	O	Swollen glands	O	O	Low energy	initials____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE O
O	O	Kidney stones	O	O	Infertility	O	O	Bedwetting	O	O	Prostate issues	O	O	Erectile dysfunction	O	O	PMS symptoms	initials_____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE O
O	O	Fainting	O	O	Low libido	O	O	Poor appetite	O	O	Fatigue	O	O	Sudden weight Gain/loss (circle one)	O	O	Weakness	initials_____

Past Personal, Family and Social History

Please Identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section completely.

PERSONAL

14. Illnesses

Check the Illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
O	O	AIDS	O	O	Tuberculosis
O	O	Alcoholism	O	O	Typhoid fever
O	O	Allergies	O	O	Ulcer
O	O	Arteriosclerosis	O	O	Other:______________
O	O	Cancer			___________________________
O	O	Chicken pox			___________________________
O	O	Diabetes			___________________________
O	O	Epilepsy			___________________________
O	O	Glaucoma			___________________________
O	O	Goiter			___________________________
O	O	Gout			___________________________
O	O	Heart disease			___________________________
O	O	Hepatitis			
O	O	HIV positive			
O	O	Malaria			
O	O	Measles			
O	O	Multiple Sclerosis			
O	O	Mumps			
O	O	Polio			
O	O	Rheumatic fever			
O	O	Scarlet fever			
O	O	Sexually transmitted Disease			
O	O	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- O Appendix removal
- O Bypass surgery
- O Cancer
- O Cosmetic surgery
- O Elective surgery:___________
- ______________________________
- O Eye surgery
- O Hysterectomy
- O Pacemaker
- O Spine _____________________
- ________________:____________
- ______________________________
- O Tonsillectomy
- O Vasectomy
- O Other:____________________
- ______________________________
- ______________________________
- ______________________________

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
O	O	Acupuncture
O	O	Antibiotics
O	O	Birth control pills
O	O	Blood transfusions
O	O	Chemotherapy
O	O	Chiropractic care
O	O	Dialysis
O	O	Herbs
O	O	Homeopathy
O	O	Hormone Replacement
O	O	Inhaler
O	O	Massage therapy
O	O	Nutritional supplements

List:__________________________

____

____

____

O O Medications (prescriptions and over-the-counter):

____

____

____

17. Injuries

Have you ever…

- O Had a fractured or broken bone
- O Had a spine or nerve disorder
- O Had been knocked unconscious
- O Been injured in an accident
- O Used a crutch or other support
- O Used neck or back bracing
- O Received a tattoo
- O Had a body piercing

FAMILY

18. Family History

Some health issues are hereditary. Tell Elevate Sport & Spine about the health of your immediate family members

Relative	Age (If living)	State of health		Illnesses.	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	___________	O	O	____________________________________	___________	O	O
Father	___________	O	O	____________________________________	___________	O	O
Sister 1	___________	O	O	____________________________________	___________	O	O
Sister 2	___________	O	O	____________________________________	___________	O	O
Brother 1	___________	O	O	____________________________________	___________	O	O
Brother 2	___________	O	O	____________________________________	___________	O	O

19. Are there any other hereditary health issues that you know about?____

____

SOCIAL

20. Social History

Tell Elevate Sport & Spine about your health habits and stress levels.

Alcohol use	**O Daily**	**O Weekly**	**How Much?**	______________________
Coffee use	**O Daily**	**O Weekly**	**How Much?**	______________________
Tobacco use	**O Daily**	**O Weekly**	**How Much?**	______________________
Exercising	**O Daily**	**O Weekly**	**How Much?**	______________________
Pain Relievers	**O Daily**	**O Weekly**	**How Much?**	______________________
Soft Drinks	**O Daily**	**O Weekly**	**How Much?**	______________________
Water Intake	**O Daily**	**O Weekly**	**How Much?**	______________________

Prayer or meditation?	**O Yes**	**O No**
Job pressure/stress?	**O Yes**	**O No**
Financial peace?	**O Yes**	**O No**
Vaccinated?	**O Yes**	**O No**
Mercury fillings?	**O Yes**	**O No**
Recreational drugs?	**O Yes**	**O No**

Hobbies ____

____

Patient Name

____

Patient Number
(office use only)

____

Doctor's Initials

21. Activities of Daily Living

How does this condition currently interfere with your life and abilities to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting----------------------	O	O	O	O	Grocery Shopping----------------	O	O	O	O
Rising out of chair------	O	O	O	O	Household chores----------------	O	O	O	O
Standing------ -------------	O	O	O	O	Lifting objects----------------------	O	O	O	O
Walking--------------------	O	O	O	O	Reaching Overhead--------------	O	O	O	O
Laying down-------------	O	O	O	O	Showering or bathing----------	O	O	O	O
Bending over ------------	O	O	O	O	Dressing myself-------------------	O	O	O	O
Climbing stairs----------	O	O	O	O	Love Life-----------------------------	O	O	O	O
Using a computer-----	O	O	O	O	Getting to sleep-------------------	O	O	O	O
Getting in/out of car--	O	O	O	O	Staying asleep---------------------	O	O	O	O
Driving a car-------------	O	O	O	O	Concentrating---------------------	O	O	O	O
Looking over shoulder-	O	O	O	O	Exercising---------------------------	O	O	O	O
Caring for family--------	O	O	O	O	Yard work---------------------------	O	O	O	O

22. What is the major stressor in your life?_______________________ **23. How much sleep do you average per night?________hours**

24. What is the type and approximate age of your mattress and pillow?___________ **25. What is your preferred sleeping position___________**

26. Describe your typical eating habits: **O** Skip breakfast **O** Two meals a day **O** Three meals a day **O** Snacking between meals

27. What would be the most significant thing that you could do to improve your health?____

____

28. In addition to the main reason for our visit today, what additional health goals do you have?___________________________________

____

ACKNOWLEDGEMENTS

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and Initial your agreement.

I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials__________

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on m behalf for seeking reimbursement from any involved third parties.

Initials___________

I realize that and X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.
Date of last menstrual period (MM/DD/YYYY)_________________________

Initials____________

I grant permission to be called to confirm or reschedule an appointment between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials____________

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Initials____________

If the patient is a minor child, print child's full name:____

Signature____ ____
Date (MM/DD/YYYY)

____
Patient Name

____
Patient Number
(office use only)

____
Doctor's Initials

Informed Consent to Chiropractic Treatment

All physicians are required by law to obtain your informed consent prior to starting treatment. I, ____ do herby give my consent to the performance of conservative, noninvasive treatment to the joints and tissues of the body. I understand that these procedures may consist of manipulations and adjustments involving the movement joints and soft tissues. Physical therapy, rehabilitative exercises, passive care modalities, and other procedures may be used.

Chiropractic care commonly involves the doctor using his/her hands or a mechanical device in order to mobilize the joints and soft tissues of the body. You may feel a "click" or "pop," much like when a knuckle is "cracked," and you may feel movement of the joint.

Although osseous manipulation is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

- Soreness: I am aware that it is common to experience muscle soreness following treatment. I am also aware that complications such as bruising, redness, and swelling are possible side effects of particular treatments.

- Dizziness: Temporary symptoms such as dizziness and nausea can occur but are extremely rare

- Fractures/Joint Injury: I understand that in isolated cases with underlying physical defects, deformities, or pathologies such as weakened bone structure due to osteoporosis may render the patient susceptible to injury. When these or other pathologies are detected, the physicians will proceed with extra caution.

- Stroke: The risk of stroke due to chiropractic manipulation is extremely rare. The risk of complications such as stroke due to chiropractic treatment has been estimated at one in one million to one in twenty million, and can be further reduced by taking extra precautions during screening measures during our physical exam. These tests will be performed on each patient to minimize the risk of any complication from treatment and the patient freely assumes these risks.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me, including:

- Medications (both over the counter and prescription): Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication can actually mask pathology, produce inadequate or short term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Medications can also involve serious health risks, including irritation to the stomach lining and liver and kidneys.

- Rest/Exercise: It has been explained that rest is always an option, as it may temporarily reduce pain and inflammation, however typically this is not likely to completely reverse pathology. The same is true for use of ice, heat, or other home therapies. Prolonged sedentary lifestyles contribute to weakened bones, muscle tightness, and joint stiffness. Exercises that are appropriate for my condition and executed properly can enhance healing, however it is in my best interest to be guided through appropriate rehab by my chiropractic physician in order to reduce the risk of further injury.

- Hospitalization/Surgery: In conjunction with medical care can add to risk of exposure of virulent communicable disease in a significant number of cases. While in some cases is necessary, I understand the risks involved with consenting to an invasive form of therapy without first seeking conservative management.

- Non-treatment: I understand the potential risks of refusing or neglecting care may include the formation of adhesions, scare tissue, increased pain, restricted motion, possible nerve damage, increased inflammation and degenerative changes, and an overall worsening of pathology. The aforementioned may complicate later treatments, making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. I have had any further unique and unusual risks of my individual condition explained to me. I have had the opportunity to have any questions or concerns answered and addressed to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely and voluntarily made my decision to undergo any recommended treatment, and hereby give my full consent to treatment.

I attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

____________________	____________________	__________
Printed Name	Signature	Date

____________________	____________________
Relationship to Patient	Witness Signature

Payment Policy

There are two acceptable forms of payment upon completion of services:

CASH: Payment required at the end of each office visit.

OR

INSURANCE ASSIGNMENT: You are responsible for your co-pay at EACH office visit. Insurance reimbursement is signed over to our clinic.

Insurance Assignment

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished corrective care and a wellness health care program may be recommended. We will notify you of this change.
2. It is your responsibility to pay all deductible amounts. You must stay current with your percentage of responsibility or co-payment. This must be paid at the end of each office visit. Prepayments may also be made. In certain individual circumstances, if payment at time of service is not possible we can work with the patient to create a reasonable payment plan.
3. Insurance carriers are billed on specific 7 day cycles. It is your responsibility to supply this office with necessary forms to complete billing if needed.
4. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within three days of receipt and endorse it over to the clinic. Failure to do so may result in collection action.
5. If you discontinue your care for any reason, you will be responsible for any unpaid balance remaining.
6. This clinic cannot guarantee an insurance provider will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay all charges and pursue reimbursement from the insurance company on his/her own.
7. Any bank fee incurred from returned or bounced personal checks will be the patient's responsibility. We reserve the right to add an additional fee of $50 for any returned or bounced checks.

I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by the provisions as specified above.

____________________ ____________________ ____________________

Signature Social Security # Date

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:________________________________ **Date of Birth:**__________________________

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Elevate Sport and Spine Center**

I understand that the Notice describes the uses and disclosures of my protected health information by **Elevate Sport and Spine Center** and informs me of my rights with respect to my protected health information. **Elevate Sport and Spine Center** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice upon request.

____ ____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

____ ____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):____

  ____

____ ____

Employee Name *Today's Date*

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