UNIONTOWN CHIROPRACTIC CENTER, INC.
665 CHERRY TREE LANE
UNIONTOWN, PA 15401

Proper Name _____ Home Phone _____
Address _____ City _____ State ___ Zip ____
Age _____ Birth Date _____ Marital Status S M W D SS# _____
Occupation _____ Employer _____
Address _____ Office Phone _____ Cell _____

Have you ever treated at this office ___ Yes ___ No By Whom _____

Name of Spouse _____ Birth Date _____ Employer _____
Number of Children _____

In case of emergency (not in household) _____ Phone _____
Address _____ City _____ State ____ Zip _____

Type of insurance coverage: Group __ Cash __ WC __ AA __ Medicare __ MA __
If work or auto related, please indicate date of occurrence _____

Present family doctor _____ Date of last exam _____

List of present Complaints: **Why are you here today** (please be specific):

1. _____ Date of Occurrence _____
2. _____ Date of Occurrence _____
3. _____ Date of Occurrence _____

Have you had any of the conditions before? __ Yes __ No
If so when and explain _____

What activities of daily living are you not able to perform that you were able to perform prior to present condition _____

Please list other doctors you have consulted for this condition (s):

Name _____ Address _____
Diagnosis _____ Results _____

Name _____ Address _____
Diagnosis _____ Address _____

Referred by _____

Have You had Any Of The Following Diseases? (If so, please check)

__ Pneumonia	__ Anemia	__ Heart Disease	__ Arthritis
__ Rheumatic Fever	__ Measles	__ Epilepsy	__ Venereal Disease
__ Polio	__ Diabetes	__ Pleurisy	__ Mental Disorder
__Tuberculosis	__ Cancer	__ Alcoholism	__ A.I.D.S.

Operations and Approximate Date:

Gall Bladder _____ Appendectomy _____ Female Organs _____
Rectal _____ Hernia _____ Others _____

Vaccinations and Injections:

Small Pox _____ Spinal Tap or Injection _____ D.P.T. _____
Polio _____

Accidents or Falls (please describe fully): _____
_____
_____
_____
_____

Fractures or Dislocations _____
_____

Were You Ever Knocked Unconscious or Stunned? _____
_____

Habits: Sleep (hours) _____ Coffee _____ Tea _____ Alcohol _____ Tobacco _____
Exercise _____ Hobbies _____

Are You Taking Any Prescriptions or Non-prescription Drugs or Medications? _____
Please List _____
_____

Previous Medical Treatment: For What? _____
By Whom _____
Previous Hospitalization: (If Other Than Operations Listed Above)
For What and Where? _____
_____

Have You Ever Had a Nervous Breakdown? _____
Have You or any Member of Your Family Been Treated for a Mental Disorder?_____
_____

Please check the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. Your health report is confidential and is treated as such by our staff.

GENERAL SYMPTOMS

__ Headaches
__ Allergic
__ Migraine
__ Tension
__ Fainting
__ Dizziness
__ Fatigue
__ Loss of Weight
__ Numbness or Pain in Arms, Hands or Legs
__ Neuralgia

E.E.N.T.

__ Failing Vision
__ Earache
__ Ear Noises
__ Sore Throat
__ Asthma
__ Enlarged Thyroid
__ Sinus Infection
__ Enlarged Glands

SKIN

__ Skin Eruptions
__ Bruises Easily
__ Varicose Veins
__ Sensitive Skin
__ Hives or Allergy

RESPIRATORY

__ Chronic Cough
__ Spitting up Blood
__ Chest Pain
__ Difficult Breathing

CARDIO VASCULAR

__ Rapid Beating Heart
__ Slow Beating Heart
__ High Blood Pressure
__ Low Blood Pressure
__ Pain Over Heart
__ Previous Heart Stroke
__ Hardening of Arteries
__ Swelling of Ankles
__ Poor Circulation

GENITOURINARY SYMPTOMS

__ Frequent Urination
__ Painful Urination
__ Blood in Urine
__ Kidney Infection or Stone
__ Bed Wetting
__ Inability to Control Urine
__ Prostrate Trouble

GASTROINTESTINAL SYMPTOMS

__ Difficult Digestion
__ Nausea
__ Vomiting
__ Pain over Stomach
__ Distention of Abdomen
__ Constipation
__ Diarrhea
__ Colon Trouble
__ Hemorrhoids (Piles)
__ Liver Trouble
__ Gall Bladder Trouble
__ Jaundice
__ Colitis

MUSCLE & JOINT SYMPTOMS

__ Sciatica
__ Arthritis
__ Swollen Joints
__ Tremors
__ Painful Tailbone
__ Pain Between Shoulders
__ Herniated Disc
__ Faulty Posture
__ Stiff Neck
__ Back Ache
__ Tremors
__ Painful Joints
__ Foot Trouble
__ Spinal Curvature
__ Muscle Spasms

FOR WOMEN ONLY

__ Painful Menstrual Periods
__ Hot Flashes
__ Irregular Cycle
__ Cramps or Backache
__ Lumps in Breast
__ Menopausal Symptoms

ARE YOU PREGNANT?

__ Yes __ No

I hereby state that the information on all pages of this form is true and correct. I authorize the Uniontown Chiropractic Center, Inc. to examine, take x-rays, treat me and do whatever they deem necessary in accordance with the state statutes, for the care and management of my condition. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Uniontown Chiropractic Center, Inc. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be pain directly to the Uniontown Chiropractic Center, Inc. will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ SS# _____-____-_____

Date _____

Guardian or Spouses (Signature Authorizing Care)_____

Date _____

Informed Consent for Chiropractic Treatment

TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other _____

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: _____

_____

_____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as: _____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____
witness to patient's signature

_____
translated by

_____
date

_____
date

Revised March 2010