CONFIDENTIAL HEALTH INFORMATION

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.

Allison Chiropractic Center
James W. Allison, Jr. D.C.
Timothy R. Allison, D.C.
310 S. Chestnut St.
Derry, PA 15627
724-694-9700

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes

When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Age

Gender ○ Male ○ Female

Race ○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American ○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White ○ Decline to answer

Ethnicity ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over) ○ Never A Smoker ○ Former Smoker ○ Current Every Day Smoker ○ Current Some Day Smoker ○ Heavy Smoker ○ Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

City | **State/Province** | **ZIP/Postal Code** | **Preferred Language**

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? ○ Yes ○ No

City | **State/Province** | **ZIP/Postal Code**

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

Primary Care Provider's Name

Insurance Carrier | **Policy Number**

Insured's Last Name | **Birth Date (MM/DD/YYYY)**

Who carries this policy? ○ Self ○ Spouse ○ Parent

Insured's First Name | **Insured's Middle Name (or Initial)**

Insured's Employer

Address

City | **State/Province** | **ZIP/Postal Code** | **Employer's Phone**

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ○ An accident or injury
  - ○ Work ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ○ Prescription medication ○ Acupuncture
- ○ Over-the-counter drugs ○ Chiropractic
- ○ Homeopathic remedies ○ Massage
- ○ Physical therapy ○ Ice
- ○ Surgery ○ Heat
- ○ Other _____

Secondary Complaint
The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ○ An accident or injury
  - ○ Work ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ○ Prescription medication ○ Acupuncture
- ○ Over-the-counter drugs ○ Chiropractic
- ○ Homeopathic remedies ○ Massage
- ○ Physical therapy ○ Ice
- ○ Surgery ○ Heat
- ○ Other _____

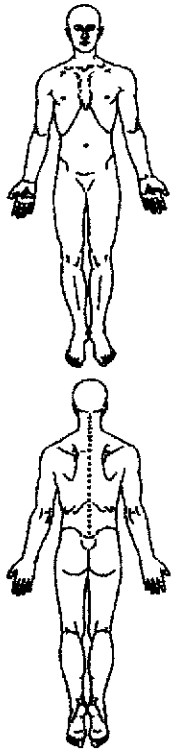
Additional Complaint
The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ○ An accident or injury
  - ○ Work ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ○ Prescription medication ○ Acupuncture
- ○ Over-the-counter drugs ○ Chiropractic
- ○ Homeopathic remedies ○ Massage
- ○ Physical therapy ○ Ice
- ○ Surgery ○ Heat
- ○ Other _____

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



1. What else should Dr. Allison know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

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

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture

NONE ○ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness

NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising

NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea

NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste

NONE ○ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash

NONE ○ Initials ____

Patient name _____

Patient Number (office use only) _____

Doctor's initials _____

Allison Chiropractic Center
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(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○ ○	Low energy	Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○ ○	PMS symptoms	Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	Initials ____

Patient name _____

Patient Number (office use only) _____

○ All other systems negative

Past Personal, Family and Social History

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

PERSONAL

4. Illnesses

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

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

5. Operations

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

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

6. Treatments

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

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): _____

7. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: _____

8. Injuries

Have you ever...

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

Consultation Notes

9. Family History

Some health issues are hereditary. Tell Dr. Allison about the health of your immediate family members.

FAMILY

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

10. Are there any other hereditary health issues that you know about? _____

11. Social History

Tell Dr. Allison about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much?	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much?	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much?	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much?	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much?	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much?	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much?			

Hobbies: _____

Doctor's Initials _____

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12. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. What is the major stressor in your life? _____ **14. How much sleep do you average per night?** _____ **Hours**

15. What is the type and approximate age of your mattress and pillow? _____ **16. What is your preferred sleeping position?** _____

17. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

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

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

Consultation Notes

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.

Initials ____ **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 my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an 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 and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement 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.**

_____ Patient (or Guardian's) signature

_____ Date (MM/DD/YYYY)

Patient name

Patient Number
(office use only)

Doctor's Initials

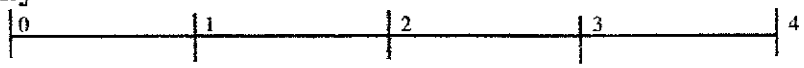
Allison Chiropractic Center
James W. Allison, Jr. D.C.
Timothy R. Allison, D.C.

Functional Rating Index

For use with **Neck and/or Back Problems** only.

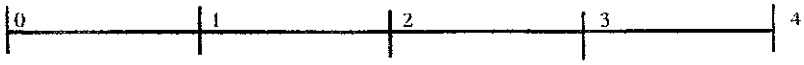
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



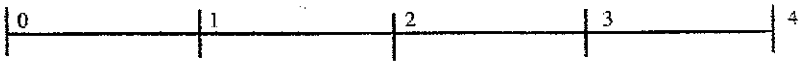
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



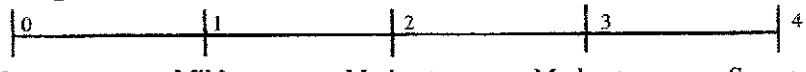
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



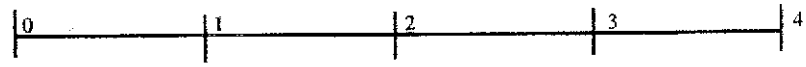
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

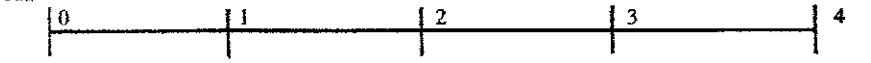
5. Work



Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

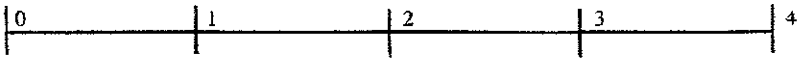
Please Turn Over

6. Recreation



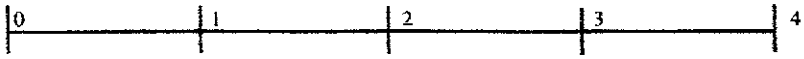
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



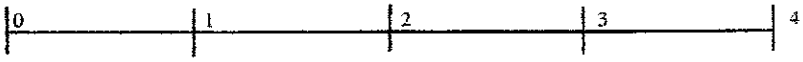
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



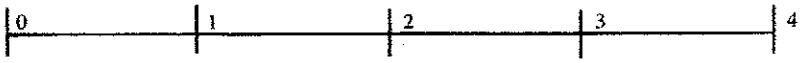
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Patient's Signature _____ **Date** _____

ALLISON CHIROPRACTIC CENTER
724 694-9700

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to [ALLISON CHIROPRACTIC CENTER].

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 310 S. CHESTNUT ST. DERRY, PA. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative _____ Printed Name of Patient

Date of Signing _____ Description of Personal Representative's Authority