PROUGH CHIROPRACTIC

3402 Washington Rd., Suite 201

McMurray, PA 15317

PATIENT INFORMATION & CONDITION FORM

Today's Date: ____/_____/_____

Patient Name: _____Birth Date: ___/___/___ Age: ____ Gender: F M

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (_____) _____ Cell Phone (_____) _____ E Mail Address _____

If you are under 18 years of age, who are your legal parents or guardians?_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed How many children? _____

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Who should we contact in the event of an emergency? _____ Phone (_____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

How did you learn about us or who referred you to us? _____

General Information Related to the Condition:

Approximately when did the conditions or symptoms begin to occur? _____/_____/_____

Describe the conditions, symptoms or purpose of the appointment: _____

_____

_____

_____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Additional Information Related to the Condition:

Describe your pain: ☐ Sharp ☐ Stabbing ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numbness ☐ Burning ☐ Stiffness

What caused it? How did it happen?

_____

What aggravates or makes it worse?

_____

What relieves or makes it better?

_____

Have you ever had the same or similar condition or symptoms previous to this most recent occurrence? ☐ Yes ☐ No

When/What date? _____/_____/_____

Describe:

_____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

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Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Please check any of the following symptoms you are now experiencing:

☐ Headache	☐ Dizziness	☐ Thyroid	☐ Diarrhea	☐ Constipation
☐ Neck Pain/Stiffness	☐ Loss of Memory	☐ Stroke	☐ Seizures	☐ Nausea
☐ Pain/tingling in arms/hands	☐ Ears Ring/Buzz	☐ Hands Cold/Feet	☐ Ulcer	☐Anemia
☐ Numbness in arms/hands	☐ Arthritis	☐ Diabetes	☐ Asthma	☐Hernia
☐ Chest pain/rib pain	☐ Nervousness	☐ Heart Condition	☐ Loss of Balance	☐ Cold Sweats
☐ Pain/tingling in legs/feet	☐ Shortness of Breath	☐High Blood Pressure	☐ Fever	☐ Fatigue
☐ Loss of arm/leg strength	☐ Loss of Smell	☐ Prostate	☐ Kidney Disorder	☐ Cancer
☐Numbness in legs/feet	☐ Back Pain	☐ Burning muscle pain	☐ Difficulty swallowing	

Other _____

What surgeries have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

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

Describe: _____

What prescription medications are you currently taking?

_____

Medication Allergies (please list all - medication and other):

_____

Do you smoke? ☐ NO ☐ Former Smoker ☐ Yes - # of packs/day: _____ Do you drink alcohol? ☐ NO ☐ YES

HEIGHT :_____ WEIGHT:_____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/____

****

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- NOT between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/____

Patient Questionnaire – Auto-Accident

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___ Time of Day when Accident Occurred or Started: ___:_____ AM / PM

Describe how the Accident took place: _____

_____

_____

_____

Describe the condition or symptoms caused by the Accident: _____

_____

_____

_____

Auto-Accident Specific Information:

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender

Damage Amount Estimate: $_____ : ☐ Minor ☐ Major ☐ Totaled

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender
☐ Minor ☐ Major ☐ Totaled

Where did the accident happen? Street Names: _____ City/State _____

Was it? ☐ Controlled Intersection ☐ Uncontrolled ☐ Not Intersection

Was there a traffic light? ☐ None ☐ Green ☐ Red ☐ Turn Arrow ☐ Stop Sign

Were you: ☐ Slowly Moving ☐ Moving ☐ Stopped

Weather Conditions: ☐ Sunny ☐ Rainy ☐ Cloudy

Street Surface: ☐ Dry ☐ Wet ☐ Slick ☐ Icy ☐ Pavement ☐ Other _____

Type of Impact: ☐ Rear end ☐ Front ☐ Side Impact ☐ Roll Over

Brakes on Impact: ☐ Locked Tight ☐ Loosely Applied ☐ Foot not on brake

How far did your car move? ☐ Did not move ☐ Moved 1-5 ft ☐ Moved 6-10 ft ☐ Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? ☐ Yes ☐ No

Shoulder harness: ☐ Yes ☐ No Headrest: ☐ Yes ☐ No Headrest Position: ☐ Up ☐ Down

Is the car equipped with airbags? ☐ Yes ☐ No Did they deploy? ☐ Yes ☐ No

Did you see the impact coming? ☐ Yes ☐ No Did you brace yourself for impact? ☐ Yes ☐ No

On impact, your head was looking: ☐ Ahead ☐ Behind ☐ Up ☐ Down ☐ To the Right ☐ To the Left

On impact were you: ☐ Thrown forward ☐ Thrown backwards ☐ Thrown sideways ☐ Other _____

Did your body hit anything inside the car? ☐ Yes ☐ No Body Part: _____

What did it hit? _____

Head trauma? ☐ Yes ☐ No Loss of Consciousness? ☐ Yes ☐ No For how long? _____

Do you remember the accident happening? ☐ Yes ☐ No

Hospital? ☐ Yes ☐ No Name of hospital: _____ How long there? _____

Taken by ambulance? ☐ Yes ☐ No

X-rays taken? ☐ Yes ☐ No X-ray areas: ☐ Neck ☐ Mid-back ☐ Low-back ☐ Other X-rays

_____

Medication Given? ☐ Yes ☐ No RX: _____

Other instruction: _____ Follow-up: _____

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PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Prough Chiropractic

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Signature of Patient/Guardian:
_____Date:_____

Please print patient/guardian name and relationship: _____

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HIPPA AUTHORIZATION FORM

Information to be Used or Disclosed

This information covered by this authorization includes your registration, information and your medical records included but not limited to: diagnostic test & lab results, x-ray, MRI, CT findings as well as past and current clinical examination, treatment notes, charges appointment times and dates. The information will be disclosed to assist in the authorization and payment for services, to coordinate, pre-certify and authorize care.

Persons to Whom Information may be Disclosed

Information described above may be disclosed to: (Spouse, Children, Friend, Office Staff, etc.) Please include home, work, and cell numbers.
If we are unable to contact you or if there is an urgency or emergency, who may we contact?

*Name of person(s) and relation to the patient:*_____

The authorization remains effective unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Prough Chiropractic. You should contact the privacy officer to terminate this authorization.

Rights of the Individual

You may inspect or copy information used or disclosed under this authorization.

You may refuse to sign this authorization.

Signature of Patient/Guardian: _____Date:_____

Please print patient/guardian name and relationship: _____

Authorization Revoked : Effective through ___/___/_____

Refusing Authorization

I understand that I may refuse to sign this authorization and that treatment and payment cannot be conditioned upon my completion of this form.