Today's Date: / /

Welcome to Hands in Health, P.C.

1050-5 Benner Pike
1017 Washington Blvd., Ste. A
State College, PA 16801
814-954-7774

Williamsport, PA 17701
570-567-7765

Full Name:_____ Age: _____ Birth Date: _____
Address:_____City_____ State_____ Zip_____
Phone- Home:_____Cell:_____Work:_____ Email:_____
May we email/call you, if needed? Yes □ No □ May we email you information about our office and healthcare news? Yes □ No □
Married □ Separated □ Divorced □ Widow □ Single □ Other □_____ No. of Children _____

Social Security Number:_____-_____-_____ Employer: _____ Occupation:_____
Have you ever seen a chiropractor before? No □ Yes □ Who?_____ Referred By: _____

Emergency Contact:
Name: _____ Phone No. _____
Relationship: Spouse □ DOB _____ Child □ Sibling □ Parent/Guardian □ Friend □ Caregiver □ Life Partner □ Other □ _____
Address:_____City_____ State_____ Zip_____

Primary care physician?_____ Date of last physical?_____
Blood work No □ Yes □ Findings:_____ X-rays/MRI/CT/Other? No □ Yes □ Findings:
_____

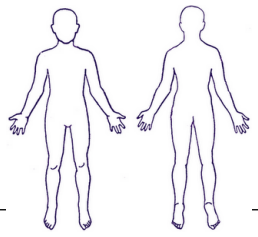
Please describe the location and nature of your concerns_____
_____ Happened before? Yes □ No □
Onset?_____ Severity of pain today ? _____/10
How did it occur?_____ Unknown □
What CAN'T you do because of your symptoms/condition (Activities of Daily Living)? _____
_____
What seems to help?_____ Nothing □
Worse in AM □ PM □ During night □ Constant □ Worse before meal □ During □ After □ No Effect □
What makes it hurt? Rest □ Movement □ Explain: _____
_____
What do you think is the cause?_____

Quality of Pain (front-back):
Achy □ Sharp □ Burning □ Dull □

Other □_____

Right-Handed □ Left-Handed □

Please circle area of concern ➔



Medications: Are you now taking any medications or supplements? Yes □ No □
If yes, list all medications:

Medication/Supplement	***Dosage***	***Purpose***	***Medication/Supplement***	***Dosage***	***Purpose***

Lifestyle - Smoking Status:
□ Never Smoker □ Former Smoker □ Light Tobacco Smoker □ Current Everyday Smoker □ Heavy Tobacco Smoker

Allergies: (Are you allergic to or had a reaction to the following? If yes, please check.
□ Penicillin □ Sulfa Drugs □ □ Other antibiotics _____
Other Medications □ (If yes, please list): _____
Allergies other than drug allergies? (Food / Environment) (Please List) _____
_____

General:
Are you in good health? □ Yes □ No Height: _____ Weight _____
Have there been any changes in your general health in the past year? □ Yes □ No
If so, for what are you being treated? _____
Have you had any illness, operation or been hospitalized in the past five years? □ Yes □ No
Please list and explain any major accidents, injuries, surgeries, major dental work, conditions: _____
_____

Have you had or do you currently have:	Yes	No
High/Low Blood Pressure	□	□
Heart Problems	□	□
Asthma	□	□
Hay Fever/Sinus Problems	□	□
Transplants/Artificial Replacements	□	□
Jaw Pain	□	□
C-Sections/Hysterectomy	□	□
Autoimmune Disease	□	□
Emotional Problems	□	□

Have you had or do you currently have:	Yes	No
Gallbladder Problems	□	□
Stroke	□	□
Thyroid Problems	□	□
Diabetes 1	□	□
Diabetes 2	□	□
Kidney Trouble	□	□
Arthritis/Joint Disease	□	□
Digestive Trouble/Heartburn	□	□
Sexual Problems	□	□

Family
History *(Past and Present- Parents; Siblings)*: (indicate relative below)
□ High/Low Blood Pressure *(relative)*_____ □ Heart Disease *(relative)* _____
□ Cancer (type) *(relative)* _____
□ Diabetes (1 / 2) *(relative)* _____ □ Arthritis *(relative)* _____
□ Autoimmune Disease (type) *(relative)* _____
□ Other, describe _____

How many times do you urinate each day? _____ during night?_____ How often do you have a bowel movement? _____/day
constipated □ diarrhea □
Circle your stress level (10 being the highest): 0 1 2 3 4 5 6 7 8 9 10
How many glasses of water do you drink in a day? 0 1 2 3 4 5 6 7 8 9 10 _____
How well do you eat (10 is the best)? 0 1 2 3 4 5 6 7 8 9 10
What is your energy level at the end of the day (10 is the best)? 0 1 2 3 4 5 6 7 8 9 10

Women:
Are you pregnant? □ No Yes □ Estimated delivery date _____
What was the date of your last menstrual cycle? _____ How many days do your menstruate? _____
How many days between cycle: _____ Please list any concerns/symptoms relating to your cycle: _____
_____
_____

Demographics: Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino
Preferred Language: _____ Race: _____

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: _____ Date: _____
(Parent or guardian if Minor)

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For **personal injury, auto injury, or work-related** injury cases, please list your information below.

Date of injury _____/_____/_____ Place of injury _____ State _____
Name of Insurance company _____ Claim # _____

WORKERS COMPENSATION AND PERSONAL INJURY CASES

If workers compensation, auto, or other personal insurance (NOT health insurance) is going to pay for your treatment, please inform us before your initial exam begins. We will submit these claims for you as long as you have provided us with the claim number, insurance company name and address, and have completed any additional forms required. If the claim is denied by the insurance, saying that it is not work or auto-related, ***YOU WILL BE RESPONSIBLE*** for the amount due.

HEALTH INSURANCE POLICY *AND* PAYMENT POLICY

v HIGHMARK, BLUECROSS BLUESHIELD, & FIRST PRIORITY LIFE INSURANCE are the only health insurance plans that we participate with. If you have any of these Insurances, *you will be responsible for the specialist copay at time of visit*.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

We accept cash, check, Visa, MasterCard and Discover. Debit cards will go through our machine as a credit card.

A finance charge of 1-1/2% (18% per year) will be added to any balances unpaid after 30 days.

A "returned-check fee" of $50 will be charged for insufficient funds. Post-dated checks will not be accepted.

A "no-show fee" of $60 will be charged after the third missed appointment.

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Patient Release & Assignment of Insurance Benefits:

A notice of Patient Rights & Responsibilities has been made available to me.

I certify the information I have provided is correct. I authorize the release of medical information to insurance companies or their agencies (including Medicare) for the purposes of processing insurance claims and payment of medical claims.

I understand that I am financially responsible for services due at the time of service and other costs and fees.

_____ _____|_____|_____
Patient or Legal Guardian Signature *Date*

Acknowledgement of Receipt of Notice of Privacy Policy:

I have been presented with the Notice of Privacy Policy Practices, detailing how my health information may be used and disclosed, under federal and state law, and outlining my rights regarding my health information. I may request a copy of the Notice of Privacy Practices if I so desire.

_____ _____|_____|_____
Patient or Legal Guardian Signature *Date*

11-7-13