PATIENT QUESTIONNAIRE

NAME:_____**DATE**_____
ADDRESS:_____**CITY:**_____**STATE:**____**ZIP:**_____
TELEPHONE#:_____**BIRTHDATE:**_____**AGE:**_____
OCCUPATION:_____**MARITAL STATUS:**_____**SPOUSE:**_____
SOCIAL SECURITY #:_____**EMAIL:**_____**CHILDREN**_____
EMPLOYER:_____**WORK #:**_____
PRIMARY CARE PHYSICIAN:_____
IS THIS DUE TO AN AUTO ACCIDENT? ___Y____N WORK ACCIDENT____Y____N
OTHER ACCIDENT?____Y____N DATE OF ACCIDENT:_____

WHY ARE YOU HERE TODAY? BE SPECIFIC:_____

WHAT CAUSED TODAY'S PROBLEM? GIVE DATE OF INJURY/ILLNESS:_____

HOW LONG HAVE YOU HAD TODAY'S PROBLEM?_____

HAVE YOU HAD THE SAME OR SIMILAR PROBLEM IN THE PAST?_____

IS THE PAIN LOCALIZED TO ONE AREA? WHERE?_____

DOES THE PAIN MOVE? CAN YOU DESCRIBE THE PAIN?_____

WHAT MAKES THE PROBLEM BETTER OR WORSE?_____

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?_____
HAVE YOU HAD ANY TESTS FOR THIS PROBLEM?_____

PAST HISTORY

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? _____
FOR WHAT PROBLEM?_____
HAVE YOU BEEN SEEN IN THIS OFFICE BEFORE? _____**WHEN?**_____
IS THERE A HISTORY OF BACK PROBLEMS IN YOUR FAMILY?_____
LIST ANY PREVIOUS WORK INJURIES, AUTOMOBILE ACCIDENTS, FALLS:_____

LIST ANY SIGNIFICANT ILLNESSES, SURGERIES OR HOSPITILAZATIONS:_____

LIST ANY CURRENT MEDICATIONS OR OVER THE COUNTER DRUGS:_____

DO YOU USE ALCOHOL, TOBACCO OR RECREATIONAL DRUGS?_____

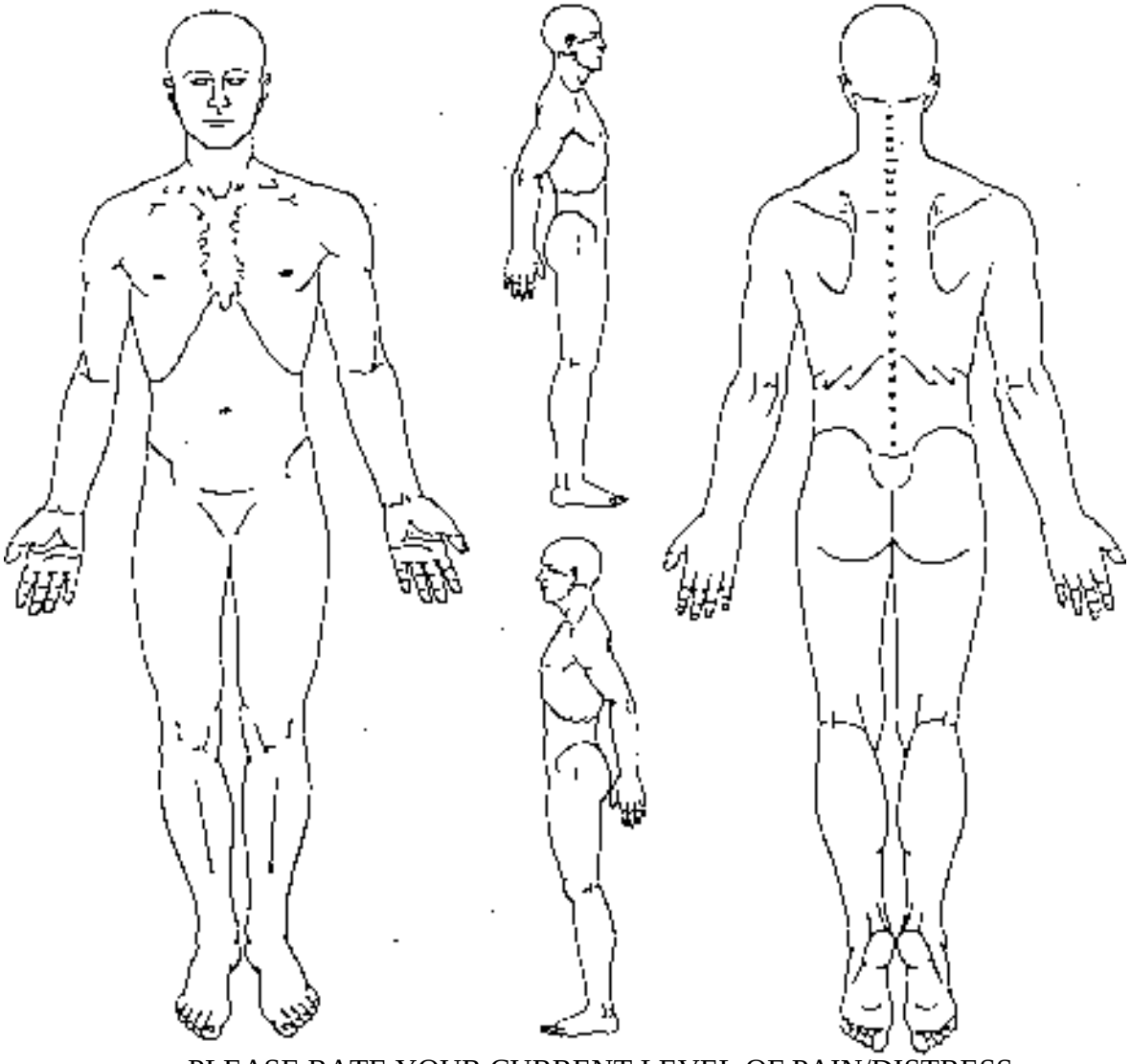
LIST ANY ALLERGIES:_____
ARE YOU UNDER DOCTOR'S CARE FOR ANY CONDITION? LIST NAME(S):_____

DO ANY DISEASES RUN IN YOUR FAMILY?_____

NAME:_____DATE:_____

PLEASE INDICATE ON THE DRAWINGS BELOW WHERE YOU ARE EXPERIENCING PAIN. CHOOSE THE KEYS THAT BEST DESCRIBE THE NATURE OF YOUR PRESENT SYMPTOMS.

DULL/ACHE: ++ SHARP/STABBING: // NUMBNESS/TINGLING:00



PLEASE RATE YOUR CURRENT LEVEL OF PAIN/DISTRESS:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 SEVERE

PAIN LEVEL AT TIME OF FIRST ONSET:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 SEVERE

WHAT ELSE WOULD YOU LIKE US TO KNOW ABOUT YOUR PRESENT HEALTH PROBLEMS:

_____

_____

_____

ASSIGNMENT OF BENEFITS

OUR OFFICE WILL SUBMIT, ON YOUR BEHALF, CLAIMS TO YOUR INSURANCE COMPANY FOR SERVICES RENDERED IN OUR OFFICE. BECAUSE EACH INSURANCE POLICY IS DIFFERENT, IT IS THE RESPONSIBILITY OF THE PATIENT TO CONTACT THEIR INSURANCE COMPANY TO VERIFY THE SPECIFIC TERMS OF THEIR POLICY. OUR OFFICE WILL NOT BE HELD RESPONSIBLE FOR MISQUOTED BENEFITS BY YOUR INSURANCE COMPANY.

I HEREBY INSTRUCT AND DIRECT THE PAYMENT OF ALL PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY TO *PENNELL FAMILY CHIROPRACTIC CENTER* AS PAYMENT FOR PROFESSIONAL SERVICES RENDERED. *THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.* THIS PAYMENT WILL NOT EXCEED MY INDEBTNESS TO THE ABOVE MENTIONED ASSIGNEE, AND I HAVE AGREED TO PAY, IN A CURRENT MANNER, ANY BALANCE OF SAID PROFESSIONAL CHARGES OVER AND ABOVE THE INSURANCE PAYMENT.

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, THEN WE HEREBY INSTRUCTYOU TO COUNTERSIGN THE CHECK AND MAIL IT TO:

PENNELL FAMILY CHIROPRACTIC CENTER
20421 ROUTE 19
CRANBERRY TOWNSHIP, PA 16066

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER, REFERRING PHYSICIAN OR ATTORNEY INVOLVED IN THIS CASE. MY SIGNATURE CONFIRMS THAT I HAVE READ AND FULLY UNDERSTAND MY ASSIGNMENT OF BENEFITS TO PENNELL FAMILY CHIROPRACTIC CENTER.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

DATE:_____

SIGNATURE:_____WITNESS:_____
PATIENT OR GUARDIAN

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

EFFECTIVE APRIL 14, 2003, HIPAA GUIDELINES REGARDING PRIVACY AND CONFIDENTIALITY OF PATIENT HEALTH INFORMATION TOOK EFFECT. THESE NEW LAWS AFFECT HOW PERSONAL HEALTH INFORMATION MAY BE SHARED. BELOW IS A BRIEF OVERVIEW OF HOW THESE NEW I.AWS WILL AFFECT OUR USE OF YOUR PERSONAL HEALTH INFORMATION.

Other than the use of your personal health information to send reports to referring physicians, to your insurance company, submitting insurance claims, for use in administrative issues and to contact you regarding your treatment in our office, we will not release any of your personal health information to anyone without your written consent.

You have the right to:
I. Request that we not release your health information to a specific individual, company or organization.
2. Revoke your authorization to us at anytime. This request *must* be in writing.
3. Amend your health information for a period of 7 years.
4. Inspect or request copies of your health information, also for 7 years.
5. Request an accounting of any disclosures made of your health information for a period of 6 years.
6. File a formal complaint if you feel your privacy has been violated.

- Please note there are certain instances where we have the right to deny your request, and or charge a nominal fee to supply this information. For more information, please request a full copy of the NOTICES OF PRIVACY PRACTICES from our office.

Our office will never use your personal health information in any marketing or advertising without your consent. We will never sell your health information to a third party.

If there is a place or method of contact that you would prefer we *not* contact you with issues related to your treatment in our office, please check all that apply; ____ Home ____ Work ____ Cell Phone ____ Email ____Postal Mail ____ Other _____

If you have any questions regarding our policies regarding patient privacy or our compliance with the HIPAA Guidelines, please request a full copy of the NOTICES OF PRIVACY PRACTICES from our office.

I acknowledge that I have been offered a copy of our full disclosure.

Signing this form also gives us your consent to request records from other treating physicians, hospitals or outpatient facilities from which you have received treatment.

_____ _____

Signature of Patient or legal Guardian Date

_____

Authorized Staff Representative

Functional Rating Index

In order to better assess your condition, we must understand how much your condition has affected your ability to manage everyday activities. For each item below circle the number which closely describes your condition right now.

1. Pain Intensity Today:	0. No Pain	1. Mild Pain	2. Moderate Pain	3. Severe Pain	4. Worst Possible Pain
2.Sleeping	0. Perfect Sleep	1. Mildly Disturbed	2. Moderately Disturbed	3. Greatly Disturbed	4. Totally Disturbed
3. Personal Care (washing, dressing, etc...)	0. No Pain	1. Mild Pain	2. Moderate Pain, need to go slowly	3. Moderate Pain, needs assistance	4. Severe Pain, needs 100% assistance
4. Travel (Driving)	0. No pain on long trips	1. Mild pain on long trips	2. Moderate pain on long trips	3. Moderate pain on short trips	4. Severe pain on on short trips
5. Daily Routine (Work)	0. Can do usual work plus limited extra work	1. Can do usual work; no extra work	2. Can do 50% of usual work	3. Can do 25% of usual work	4. Cannot work
6. Recreation (Fun activities you enjoy)	0. Can do all activities	1. Can do most activities	2. Can do some activities	3. Can do few activities	4. Cannot do any activities
7. Frequency of Pain	0. No pain	1. Occasional pain; 25% of the day	2. Intermittent pain; 50% of the day	3. Frequent pain; 75% of the day	4. Constant Pain; 100% of the day
8. Lifting	0. No pain with heavy weight	1. Increased pain with heavy weight	2. Increased pain with moderate weight	3. Increased pain with light weight	4. Increased pain with any weight
9. Walking	0. No pain at any distance	1. Increased pain after 1 mile	2. Increased pain after ½ mile	3. Increased pain after ¼ mile	4. Increased pain with all walking
10. Standing	0. No pain after several hours	1. Increased pain after several hours	2. Increased pain after 1 hour	3. Increased pain after ½ hour	4. Increased pain with any standing

Patient Signature:_____ Date:_____ Score:_____

Patient Name:_____

Dear Prospective Patient,

As a member of ChiroTrust™,

our office has taken The ChiroTrust Pledge™ to provide our patients convenient, affordable, and mainstream Chiropractic Care without any unnecessary long-term treatment plans and/or therapies.

To save you time and for your convenience, please take the time before your first visit to complete the attached paperwork.

For more information on Chiropractic and ChiroTrust™, visit: **www.Chiro-Trust.org**

We look forward to meeting you.

Sincerely,

Stephen J. Pennell, DC & Kenneth E. Pennell, DC