SOUTHWESTERN CHIROPRACTIC CENTER
801 North State Street, Clairton, PA 15025
Phone: 412-233-3600 Fax: 412-233-3702

Date_____

Acct# _____

Patient Entrance Form

Photo ID copied & checked _____

Name _____ Phone ( ) _____ Social Security #_____

Address _____ City _____ State _____ Zipcode _____

Age _____ Birthdate _____/_____/_____ Gender: M / F No. Children _____ Cell Phone ( )_____

Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced □ Student E-mail _____

Occupation _____ Employer _____ Work Phone (___)_____

Employer Address _____ City _____ State ____ Zipcode _____

Spouse Name _____ Social Security #_____

Occupation _____ Employer _____ Work Phone (___)_____

Emergency Contact _____ Phone (___)_____ Relationship _____

Patient's Primary Care Physician (PCP) _____ Phone (___)_____

Date of Last Physical Exam _____ Referred by: _____

Please describe your current problem _____

Is your current problem the result of: Auto Accident? □Yes □No Work Accident? □Yes □No Slip & Fall? □Yes □No

How did your problem begin _____

Date Problem began _____ Other doctors seen for this condition _____

List other treatments or tests you've had for this condition _____

Have you been treated for any other health condition by a physician in the last year? □Yes □No If yes, please explain:

_____

How often are your symptoms present? □ Constantly □ Frequently □ Occasionally □ Intermittently

Describe your current pain/symptoms: □ Sharp/Stabbing □ Burning □ Throbbing □ Shooting □ Tingling □Gripping
□ Dull □ Numbness □Soreness □Aches □ Weakness □ Other _____

Since it began, is your problem: □ Improving □ Getting Worse □ No Change

What makes the problem better? □ Nothing □ Lying Down □ Standing □ Walking □ Sitting □ Movement
□ Exercise □ Inactivity/Rest □ Other _____

What makes the problem worse? □ Nothing □ Lying Down □ Standing □ Walking □ Sitting □ Movement
□ Exercise □ Inactivity/Rest □ Other _____

Can you perform your daily home activities: □ Yes □ Only with help □ Not at all

Do you exercise? □ Yes, almost daily □ Yes, occasionally □ Not at all

Describe your job requirements: □ Mainly Sitting □ Light Labor □ Heavy Labor

Can you perform your daily work activities: □ Yes, all activities □ Only some □ Not at all

Describe your stress level: □ None to mild □ Moderate □ High

Rev. 3-11

SOUTHWESTERN CHIROPRACTIC CENTER
Patient Health Questionnaire

Patient Name _____ Acct#_____

Please check all that apply. Knowledge of these conditions may influence the type of treatment/therapy you receive.

□ Angina
□ Anorexia
□ Aortic Aneurysm
□ Arthritis
□ Asthma
□ Bladder Infection
□ Blood Disorder
□ Breast Lump
□ Cancer
□ Chest Pain
□ Chronic Cough
□ Chronic Sinusitis
□ Colitis
□ Convulsions
□ Diabetes
□ Depression
□ Digestive Disorders
□ Dizziness
□ Emphysema
□ Epilepsy
□ Fainting
□ Headache
□ Heart Disease
□ Heartburn/Indigestion
□ Hepatitis
□ Herniated Disk
□ High Blood Pressure
□ Jaw Pain
□ Liver/Gallbladder Problems
□ Kidney Disorders
□ Loss of Bladder Control
□ Nervousness
□ Pacemaker
□ Pain - Neck
□ Pain - Mid Back
□ Pain - Low Back
□ Pain - Arm/Elbow
□ Pain - Hand
□ Pain - Wrist
□ Pain - Shoulder
□ Pain - Ankle or Foot
□ Pain - Leg
□ Pain - Knee
□ PMS
□ Prostate Problems
□ Rapid Heartbeat
□ Rheumatic Fever
□ Pregnancies
□ Scoliosis
□ Stroke
□ Swelling, Stiffness of Joints
□ Tinnitus (Ear Noises)
□ Tuberculosis
□ Ulcer
□ Vision Disturbances
□ Venereal Disease
□ Other _____

Height: _____ feet _____ inches

Weight: _____ pounds

For all patients over 13 yrs. old:
□ Smoking - Packs/Day_____
□ Alcohol - Drinks/Week _____
□ Coffee/Caffeine Drinks - Cups/Day _____
□ Alcohol Dependence
□ Drug Dependence

Please list all allergies including allergies to medications _____

_____

List all medications you are presently taking (including vitamins & supplements)

_____

List any surgeries, fractures, serious illnesses or hospitalizations _____

_____

Do you have a Living Will or Advance Directive? □ Yes □ No
In an emergency would you want CPR? □ Yes □ No
In an emergency would you want life support? □ Yes □ No

Pediatric Records: (under 17) Are your immunizations up to date? □ Yes □ No

Family Health History:
If a family member has had any of the following, please mark the appropriate box:

□ Cancer □ Diabetes □ Heart Problems □ High Blood Pressure □ Chronic Headaches
□ Epilepsy □ Lupus □ Lung Problems □ Chronic Back Problems □ Rheumatoid Arthritis
□ Alcoholism Other _____

I certify that all the personal health information, that I have supplied in this form, is complete and accurate to the best of my knowledge. I agree to notify Southwestern Chiropractic Center immediately with any changes in my health condition in the future.

Patient or Guardian Signature _____ Date _____

Rev. 3-11

SOUTHWESTERN CHIROPRACTIC CENTER

Patient Personal Health Insurance Information

Patient Name _____ Acct#_____

Please Note: We need to copy your insurance identification card for your file.

Is your Health Insurance yours through your employer, retired employer, or individual coverage? Yes or No
If YES, please go directly to the bottom of the page and provide your signature.
If NO, please provide the following information:

A. Subscriber Information: (Please complete A & B, if other than patient or lives at different address)

Subscriber Name _____ Birthdate _____/_____/_____ Phone (___)_____

Address_____ City _____ State _____ Zipcode _____

Relationship to patient _____ Subscriber's Social Security # _____

Employer Name _____ Work Phone (_____) _____

Insurance Co. Name _____ Ins Co. Phone (___) _____

Insured's ID # _____ Group # _____

Is patient covered under any other insurance? □Yes □No If yes, please complete the following:

B. Second Insurance:

Subscriber Name _____ Birthdate _____/_____/_____ Phone (___)_____

Address _____City _____ State _____ Zipcode _____

Relationship to patient _____ Subscriber's Social Security # _____

Insured's Employer _____ Work Phone (___)_____

Insurance Co. Name _____ Ins Co. Phone (___) _____

Insured's ID # _____ Group # _____

INSURANCE ASSIGNMENT, RELEASE OF INFORMATION, AND AUTHORIZATION

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Southwestern Chiropractic Center's Physicians all insurance benefits, if any, otherwise payable to me for the services rendered. If enrolled with an HMO and without the appropriate referral or authorization from my Primary Care Physician, I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Southwestern Chiropractic Center to verify healthcare benefits with my insurance company; to release all information necessary to secure the payment of benefits and to authorize the use of this signature on all insurance submissions. A copy of this document shall be considered as valid as the original.

Patient or Guardian Signature _____ Date _____

Rev. 3-11

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I was informed of Southwestern Chiropractic Center's Notice of Privacy Practices for protected health information.

Date: _____Name of Patient (print)_____

Signature of Patient/Personal Representative _____

PATIENT COMMUNICATION AUTHORIZATION

Southwestern Chiropractic Center's staff may need to contact you with appointment reminders, or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with the person who answers the phone. This contact could also be made through your e-mail or through the US Postal Service on a postcard. By signing this form, you are giving us authorization to contact you with this information and reminders.

Patient or Guardian Signature _____ Date _____

DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please know that we are very concerned with protecting the privacy of your personal health information. While the law requires us to notify you about this disclosure, please understand that we have, and always will, respect the privacy of your health information. However, please be advised that it may be necessary for us to disclose your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. I have read the above privacy pledge and agree to its terms.

Patient or Guardian Signature _____ Date _____

Rev. 3-11