PATIENT FILE NUMBER:

Dr. Fawn Shaffer, DC
565 McElhattan Drive
Lock Haven, PA 17745
(570) 748-3590

PERSONAL INFORMATION: *Please Circle*: Mr. Mrs. Ms. Miss Dr. Male Female

Name: _____ Nickname: _____ Age: ____ DOB: _____

Address: _____ City/State/ Zip: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ (Ext: _____)

Cell Phone: (_____) _____-_____ Which Phone Number is Best to Contact You? *Home Cell Work*

Email Address: _____ Occupation: _____ Full / Part Time

Employer: _____ School (If Student) _____

Best Time to Contact: _____ Status: Single Married Divorced Separated Widowed

Of Children: _____ Children's Names and Ages: _____

Spouse's Name: _____ _____

Whom May We Thank For Referring You? _____

If You Weren't Referred, How Did You Hear About Our Office? _____

INSURANCE INFORMATION:

Do you have insurance? **YES** **NO** If so, please choose: Medicare BC/BS Other_____

Policyholder's Name _____ Date of Birth _____

Who carries this policy? SELF SPOUSE PARENT

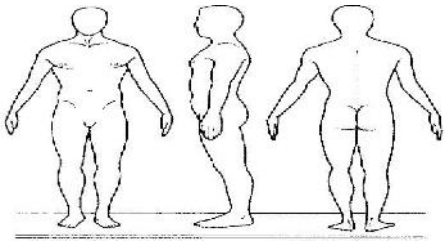
Emergency Contact Name: _____ Phone: (_____) _____-_____

Relationship to Emergency Contact: _____

"THE BEAUTY ABOUT CHIROPRACTIC IS THE FACT THAT IT WORKS WITH NATURAL MEANS. IT PUTS NOTHING NEW INTO THE BODY, NOR DOES IT TAKE AWAY ANY NATURAL GLAND OR ORGAN. CHIROPRACTIC SIMPLY RELEASES LIFE FORCES WITHIN THE BODY, SETS FREE RIVULETS OF ENERGY OVER NERVES, AND LETS NATURE DO HER WORK IN A NORMAL MANNER."

~BJ PALMER, DEVELOPER OF CHIROPRACTIC

Please Circle Any Problem Areas/Areas Of Discomfort Below:



YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern below, including the impact it has had on your life.

**** *If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please check here* _____****

_____

_____

_____

When did you first notice your current symptoms? _____

Since the problem started, it is…____The Same _____Getting Better _____Getting Worse

What makes the problem worse? _____

If anything, what makes it feel better?__ _____

Does this interfere with your: _____Work _____Leisure _____Sleep _____Sports

Other: *(Please Describe Any Specific Daily Activities This Problem Keeps You From Doing)*

_____

Is This Condition Due To An Auto Accident or Work Injury? Yes No

Have you seen a chiropractor before? Yes No

Who_____ **When**_____

Reason for visits: _____

Please describe your experience_____

_____

Did your previous chiropractor take x-rays? Yes No

Have you seen anyone else for this issue? (Massage therapist, acupuncturist, physical therapist, medical doctor/other) Yes No

If yes, who and when? What treatment did you receive?

_____

Who Is Your Medical Doctor? _____

GENERAL HISTORY:

Do you take medications regularly for:

Heart/BP Depression Diabetes Pain Arthritis Sleep Other _____

List Medications: _____

_____

Have you had any surgeries or hospitalizations? (Please include all surgeries with dates)

_____

_____

_____

_____

Do you have any surgically implanted devices? YES NO Describe: _____

Briefly describe your job duties: _____

Have you ever had any work-related injuries? _____

Have you ever had any slips, falls or auto accidents? _____

SOCIAL HISTORY:

Do you smoke/use tobacco? Yes No How Much? _____ **Daily / Weekly**

Do you drink alcohol? Yes No How Much? _____ **Daily / Weekly**

On a scale of 1-10, rate and describe your stress levels in the following areas:
(1 = no stress & 10 = extremely high)

Occupational: _____

Personal: _____

On a scale of 1-10, (1 = very poor & 10 = excellent) please describe your:

Eating habits: ____ Exercise habits:____ Sleep: _____ General Health: _____ Mind-set:_____

How many times a week do you exercise? ___ Type of exercise? _____

How many hours of sleep do you average per night? _____

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

_____

ILLNESSES:

Check the Illnesses you have HAD in the past or HAVE now:

HAD	HAVE	ILLNESS	NOTES
		AIDS	
		ALCHOLISM	
		ALLERGIES	
		ARTERIOSCLEROSIS	
		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	
		TUBERCULOSIS	
		TYPHOID FEVER	
		ULCER	
		OTHER:	

Family Health Profile:

Some health issues are hereditary. Please tell Dr. Shaffer about the health of your immediate family.

RELATIVE	AGE (If Living)	HEALTH (Good or Poor)	ILLNESSES	AGE AT DEATH
MOTHER				
FATHER				
SISTER 1				
SISTER 2				
BROTHER 1				
BROTHER 2				
OTHER:				

FRESH START CHIROPRACTIC
DR. FAWN SHAFFER

PATIENT NAME:
FILE NUMBER:

REVIEW OF SYSTEMS:

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please indicate which conditions you have HAD or currently HAVE:

HAD	HAVE	*MUSCULOSKELETAL*	HAD	HAVE	*SENSORY*
		Osteoporosis			Blurred Vision
		Arthritis			Ringing in Ears
		Scoliosis			Hearing Loss
		Neck Pain			Chronic Ear Infection
		Back Problems			Loss of Smell
		Hip Disorders			Loss of Taste
		Knee Injuries			
		Foot/Ankle Pain			***SKIN***
		Shoulder Problems			Skin Cancer
		Elbow/Wrist Pain			Psoriasis
		TMJ Issues			Eczema
		Poor Posture			Acne
					Hair Loss
		NEUROLOGICAL			Rash
		Anxiety			
		Depression			***ENDOCRINE***
		Headache			Thyroid Issues
		Dizziness			Immune Disorders
		Pins & Needles			Hypoglycemia
		Numbness			Frequent Urination
					Swollen Glands
		CARDIOVASCULAR			Low Energy
		High Blood Pressure			
		Low Blood Pressure			***GENITOURINARY***
		High Cholesterol			Kidney Stones
		Poor Circulation			Infertility
		Angina			Bedwetting
		Excessive Bruising			Prostate Issues
					Erectile Dysfunction
		RESPIRATORY			PMS Symptoms
		Asthma			
		Apnea			***CONSTITUTIONAL***
		Emphysema			Fainting
		Hay Fever			Low Libido
		Shortness of Breath			Poor Appetite
		Pneumonia			Fatigue
					Sudden Weight Gain/Loss
		DIGESTIVE			Weakness
		Anorexia/Bulimia			
		Ulcer			
		Food Sensitivities			
		Heartburn			
		Constipation			
		Diarrhea			

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient. _____ _____
Doctor Signature Date

Please initial your agreement to the following statements and then sign below:

_____ I instruct the chiropractor to deliver the care that, in 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.

_____ I authorize the release of any information concerning my health and health care services to my insurance companies or Medicare. If at any time I want to revoke this consent it must be done in writing.

_____ I authorize and direct payment of any and all insurance benefits allowable to the doctor as payment toward the total charges for professional services rendered. 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.

_____ 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.

_____ I grant permission to be called to confirm, reschedule or discuss appointments and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.

_____ 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.

Signature_____ **Date:** _____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

If we make a change to privacy practices, we will notify you in writing when you come for treatment or by mail.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions the restriction is binding on us.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have the right to a copy of this notice and have received one if requested.

_____ _____

Patient Printed Name **Authorized Provider Representative**

_____ _____

Patient Signature **Date**

_____

Date