



PATIENT FILE NUMBER:

Dr. Fawn Shaffer, DC
Dr. Kayla Wagoner, 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: _____ Birth Date: _____

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?

Do you have Medicare? **YES** or **NO** If yes, Please supply cards to front desk staff.

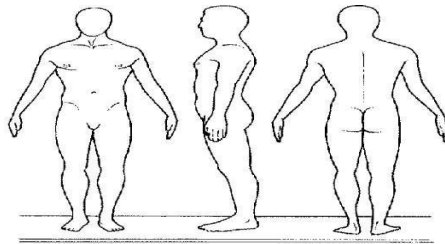
Emergency Contact Name: _____ Phone: (_____) _____ - _____

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)

What is your: Height _____ Weight _____

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: _____

(FEMALES) Are you currently pregnant? YES NO How many weeks? _____

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:				

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 may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf.

_____ 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.

_____ I grant permission for the doctor to send a thank-you note to the person(s) who referred me to 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.

We will provide you with a copy of our full privacy policy upon request.

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

OFFICE & FINANCIAL POLICY

The precious gift of health is an investment that takes both time and money. In order to help you to get the most out of this worthwhile investment we would like to share our office policy.

Please initial your acknowledgment of each item and then sign and date below.

_____ 1. **Keep your appointments.** Each chiropractic adjustment builds upon previous ones. It is important to follow through with your care plan in order to receive the maximum benefit. If you must reschedule an appointment, please call us as soon as possible not only so that we can offer your spot to another patient but also so that we can get you into another time slot to continue with your care plan.

_____ 2. **Do your homework.** In many ways what you do at home, at work and at play affects your progress. You will often be given at-home instructions such as stretching and icing to help you to reach your health goals. Please follow these important tasks to help us help you heal properly.

_____ 3. **Give it time.** As with any medical treatment, healing with chiropractic is a process, not a magic pill. It takes time and is influenced by many factors. Over time, things should improve and if necessary, we will adjust your treatment plan as we proceed. Changes to your condition can happen faster than anticipated, so enjoy them!

_____ 4. **Keep a positive attitude and EXPECT positive results.** As we follow through on your treatment plan, look for signs of improvement and take encouragement from them. Build an attitude that expects positive results and knows that profound healing is possible. Your belief and expectation has an incredibly strong influence on your body, and is a key factor in healing.

_____ 5. **Missed appointments.** Each time a patient misses their appointment without proper notification, another patient is prevented from receiving care. Therefore, we reserve the right to charge a fee of \$30 for all missed appointments and appointments that are not cancelled 24 hours prior to the appointment time. The missed appointment fee will be billed to you and will need to be paid prior to having your next appointment. Please help us to serve you better by keeping your appointments.

_____ 6. **Be on time.** The doctors respect your time and strive to maintain an efficient schedule. We ask that you do the same and arrive at your appointments on time. If you are running late you may have to wait for the next available opening, or you may be asked to reschedule.

_____ 7. **Payment at the time of service.** Full payment is due at the time of service. For your convenience we accept cash, check and credit card for payment. If you have trouble paying your bill, we are willing to work with you as much as we can within reason. No balances above \$150 are allowed.

_____ 8. **Talk to us.** If you have questions or concerns about your care or any other issue in our office, please know that we are willing to listen and help to improve it in any way that we can. Please feel free to talk with any of the doctors or staff to have your needs heard.

I have read and agree to the statements above.

Signature _____ Date _____